

Consumer First Name, M.I., and Last Name Consumer Maiden Name MM DD YYYY Complete nos. below as indicated by LME, or may be assigned by LME upon receipt.

A. First Name® B. MI® C. Last Name® D. Maiden Name® E. Consumer DOB® F. LME Name® G. LME Facility Code® H. LME Consumer Record No.®

Instructions: In accordance with the August 10, 2006 DHHS Enhanced Services Implementation Update #14: Uniform Screening and Registration, located on the DMHDDSAS web site at <http://www.ncdhhs.gov/mhddsas/service/definitions/servdefupdates/dmadmh8-10-06update14.pdf>, the Consumer STR Interview and Registration Form is required to be completed by all LMEs operating or contracting for Screening, Triage, and Referral (STR) and by all Enhanced Benefits Service providers.

- STR Interview items (1 - 50) are required to be completed by all facilities performing STR. **STR is appropriate only for all new applicants for services, or for inactive consumers seeking services in a new episode of care** (minimum of no billable services within prior 60 days). STR is required to be conducted by a Qualified Professional (QP) as defined by NC Administrative Code.
- STR is designed as a brief inquiry, not an in-depth assessment, to determine need and to facilitate access to a more intensive clinical service by a provider.
- STR is intended to identify the nature of a presenting mh/dd/sas problem, recommend a Triage Severity of Need Determination, and facilitate referral to a provider of choice or other resource.
- STR is to be conducted as efficiently and effectively as possible, within the Screening method and time available, while imposing a minimum burden on the consumer or other requestor.
- Upon Determination of a Triage Severity of Need, prompt consumer referral to a provider of choice or other resource should be facilitated, with no delay in referral for services based on missing data.
- Registration items (1 & 51 - 57) are designated by "®", and are required to be completed for all new or previously inactive consumers initiating an Enhanced Benefits Service or any LME authorized service.

This form is required to be submitted to the LME **within five business days** of Screening or service initiation, per Division guidelines and HIPAA, 42 CFR, Part 2, and G.S. 122C regulations. Any electronic transmittal is required to conform to HIPAA standards for electronic health care transactions, and conform to a uniform format specified by the Division, including required encryption for secure transmission of data. For further reference, see current DMHDDSAS CDW Reporting Requirements and CDW Data Dictionary at <http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm>. **Note: Items outlined in brackets [] are included in required CDW Screening Record Type 71, 72, and 73.**

1. **Entry Type:** STR Only Registration Only STR & Registration
 (✓ One) (Items A-H & 1-50) (Items A-H & 1 & 51-57) (Items A-H & 1-57)

FOR SCREENING COMPLETE ITEMS 2 THROUGH 50.

[2.] **Date of Consumer Screening:** ___/___/___ (MM/DD/YYYY)

[3.] **Consumer Co. of Residence:** _____ or _____
 (Enter county name or county code from CDW Data Dictionary.) Co. Code

[4.] **Is consumer currently enrolled in Medicaid?** (✓ One) Yes No

5. **Screening Referral Source of consumer:** _____ or _____
 (Enter referral source name or source code from attached instructions.) Code

[6.] **Time Scr. Interview Began:** ___:___:___ [7.] **Time Scr. Interview Ended:** ___:___:___
 (Enter 24 Hr. Military Time) HH MM (Enter 24 Hr. Military Time) HH MM

[8.] **Screening Method:** (✓ One) Face-to-Face Telephone

9. **Name of Person Initiating Request for Services and Relationship to Consumer:**
 (May be the consumer)

10. **Phone # of Person Initiating Request:** _____ - _____ - _____

11. **Brief Description of Presenting Problem(s):** (Attachment should be included)

[12.] **Presenting Problem(s) by Consumer Age/Disability:** (Not Target Population determination)

- [12a] 1st: (✓ One) AMH CMH ADD CDD ASA CSA
 [12b] 2nd: (✓ One, if applic.) AMH CMH ADD CDD ASA CSA
 [12c] 3rd: (✓ One, if applic.) AMH CMH ADD CDD ASA CSA

13. **Current Risk to Consumer Safety (especially for DD or MH consumer):**

(✓ One box for each row)

	NONE	MILD	MOD.	SEV.	NOT SCREENED
13a) Instability of Care Provider Supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13b) Safety Issues in Living Arrangement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13c) Aggression or Self-Injurious Behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. **Does Screening indicate consumer is in need of Detox due to risk for acute alcohol or drug withdrawal symptoms?** (If "Yes", ✓ All that apply)

- Agitation Nausea and Vomiting Sweats Seizures
 Tremors Other (Describe) _____

15. **Current Risk of Potential Harm to Self or Others:**

SCALE: NONE, no current ideation (within past 30 days)
 MILD, current ideation only to hurt self or others (within past 30 days)
 MODERATE, ideation with EITHER plan or history of attempts to hurt self or others
 SEVERE, ideation AND plan, with EITHER intent or means to hurt self or others
 (✓ One box for each row)

	NONE	MILD	MOD.	SEV.	NOT SCREENED
15a) Consumer's Potential Risk to Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15b) Consumer's Potential Risk to Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[16.] **Triage Severity of Need Determination with Response Timeline:** (✓ One)

Determine appropriate severity of need. Clinical judgment may override criteria below to indicate higher level of need determination. All consumers presenting with a potential substance-related problem should receive at least an "Urgent" level of need determination, and be scheduled for appointment or service initiation within 48 hours.

- Emergent:** (2 hours maximum for service initiation)
 a. Consumer has a moderate or severe risk related to safety or supervision, or
 b. Consumer is at moderate or severe risk for substance abuse withdrawal symptoms, or
 c. Consumer presents a mild, moderate, or severe risk of harm to self or others, or
 d. Consumer has **severe incapacitation** in one or more area(s) of physical, cognitive, or behavioral functioning related to mh/dd/sa problems.
- Urgent:** (48 hours maximum for service initiation)
 Consumer presents with **moderate risk or incapacitation** in one or more area(s) of physical, cognitive, or behavioral functioning related to mh/dd/sa problems.
- Routine:** (14 calendar days maximum for service initiation)
 Consumer presents with **mild risk or incapacitation** in one or more area(s) of safety, or physical, cognitive, or behavioral functioning related to mh/dd/sa problems.
- Non-Threshold Clinical Need:** (Referral to Community Resources only)
 Consumer presents with a problem that **does not meet** any of the above minimum required thresholds of clinical need for referral to an assessment by a professional provider through the state or federally funded MH/DD/SAS system.

[17.] **Where Consumer is Being Referred for Response After Triage:** (✓ One)

B = Basic Benefits Service Provider E = Enhanced Benefits Service Provider
 R = Crisis Service Provider C = Community Resources
 (Specify Name of Community Resource) _____

If Item No. 17 above is checked for "Community Resources", skip to Item 23.

18. **What initial service(s) does Screener recommend for consumer?** (✓ All that apply)

- Diagnostic Assessment Community Support Targeted Case Mgt. Other
 Clin. Intake/Eval. (90801) Beh. Hlth. Assess. (H0001) Men. Hlth. Assess. (H0031)

19. **Has provider appointment date and time (or crisis service) been offered to consumer?**

- Yes No N/A If "Yes", complete Item 20. If "No" or "N/A", skip to Item 23.

Consumer First Name, M.I., and Last Name _____ Consumer Maiden Name _____ MM DD YYYY _____ Complete nos. below as indicated by LME, or may be assigned by LME upon receipt.

A. First Name [®] B. MI [®] C. Last Name [®] D. Maiden Name [®] E. Consumer DOB [®] F. LME Name [®] G. LME Facility Code [®] H. LME Consumer Record No. [®]

20. Has provider appointment (or crisis service) that was offered been accepted by the consumer?
 Yes No *If "Yes", complete Items 21 – 22. If "No", skip to Item 23*

21. Provider Agency Referred to and Location: _____

22. Phone No. of Provider Referred to: _____

Complete Item 23 based on appointment or actual initiation of a service. (Enter date & time)

[23.] Appointment Date & Time Scheduled: ____/____/____ and ____:____ (or Crisis Service Initiated) MM DD YYYY HH : MM
(If N/A, insert 99 in all mo./day/yr./hr./min. spaces above.) (Enter 24 Hr.)

[24.] How was Provider Chosen? (✓ One)
 Consumer Choice Family/Legal Guardian Choice Screener Decision
 Other Person Decision (Identify): _____ N/A

[25.] Why was Provider Chosen? (✓ One) Consumer Coverage Benefits
 Crisis or Urgent Access 1st Available Hours Location
 Cultural Reasons Reputation/Recommended by Others Provider Specialty
 Other Reason (Describe) _____ N/A

[26.] Accommodation of Special Consumer Needs: (✓ One) Not Applicable
 Wheelchair/Mobility Needs Sign Language Interpreter Deaf/Hearing Impaired
 Intellectual Disability Childcare Visually Impaired Physical Disability
 Frail Senior Foreign Language Interpreter Other _____

27. Primary Care Medical Provider:
(List name & practice of licensed MD, PA, or NP) _____

28. What special arrangements were made for services access? (✓ One)
 None Transportation Site Accessibility Other (Describe): _____

29. Marital Status: (✓ One) Annulled Single (Never Married) Married
 Separated Divorced Widowed Domestic Partners

30. Education Level (highest grade/degree completed): _____
(Enter code from attached instructions.)

31. Ethnicity: (✓ One) Hispanic, Mexican American Hispanic, Puerto Rican
 Hispanic, Cuban Hispanic, Other Not Hispanic Origin

32. Race: (✓ One)
 Black/Afric. Amer. White/Anglo/Cauc. Amer. Ind./Native American
 Alaska Native Asian Pacific Islander
 Multiracial Other (Describe): _____

[33.] Is consumer proficient in English? (✓ One) Yes No

[34.] Primary Language: (✓ One) English Sign Language
 French Spanish Other None

35. Gender: (✓ One) Male Female

[36.] Active Military, Military Reserve, or National Guard Status:
 [36a] *Indicate if you or a member of your immediate family or household is currently serving in or has served in, the Active Military, Military Reserve, or National Guard?* (✓ One)
 Yes – Active Military, Reserve or Guard Yes - Family Member No
(Immediate family is parent, grandparent, sibling, spouse, partner, child, or other significant person in the household or family constellation)

[36b] *If "Yes" above, please check (✓) one or more:* Operation Iraqi Freedom (OIF) (2003 to Present) Operation Enduring Freedom (OEF) (2001 to Present) Other War or Conflict
 Non-Combat Service Only

37. Consumer's Residence Street Address: _____
 City: _____ State: _____ Residence Zip Code: _____

38. Consumer's Phone # (_____) _____

39. Consumer's Mailing Address: _____
 City: _____ State: _____ Zip Code: _____

40. Consumer's Legal Guardian (if applicable): _____

41. Phone # of Legal Guardian (if applicable): (_____) _____

42. Emergency Contact Name & Relationship: _____

43. Phone # of Emergency Contact: (_____) _____

44. Consumer Unique Identifier: _____

45. Type of Agency Hosting STR: (✓ All that apply)
 LME Operated or Contracted STR Enhanced Benefits Service Enrolled Provider
 LME Contracted Service Provider Crisis Service Provider

46. _____
Name of Provider Agency or LME Completing this Screening/Triage/Referral Form

47. _____
First & Last Name of Qualified Professional (QP) who Conducted this STR Interview

48. STR Staff Qualifications: (✓ All that apply) QP in MH QP in SA QP in DD

49. _____ 50. _____/_____/_____
STR Staff Area Code, Phone No., & Extension Date STR Form Submitted to LME

◆ CONSUMER REGISTRATION FOR ENHANCED BENEFITS SERVICES OR LME AUTHORIZED SERVICES ◆

51. [®] Date of Consumer's First Receipt of a Service: ____/____/____
 MM DD YYYY

52. [®] Consumer Social Security Number: _____
(Needed for cross referencing with CNDS)

53. [®] Consumer Medicaid Number (if applic.): _____
(Required for cross referencing with CNDS)

54. [®] _____
First and Last Name of Registration Provider Staff Submitting Registration Form to LME

55. [®] _____
E-Mail Address of Registration Provider Staff

56. [®] _____ 57. [®] _____/_____/_____
Registration Provider Area Code, Phone No., & Ext. Date REG Form Submitted to LME

Note: A LME Consumer Admission and Discharge Form is required to be submitted to LME within 30 calendar days of initiation or provision of services or upon completion of an episode of care (discharge) for Enhanced Benefits Services consumers & Division funded consumers.

INSTRUCTIONS FOR STANDARDIZED CONSUMER STR INTERVIEW AND REGISTRATION FORM

STR-REG A

- A. **Consumer First Name:** Enter consumer’s First Name.
 - B. **Consumer Middle Initial:** Enter consumer’s Middle Initial.
 - C. **Consumer Last Name:** Enter consumer’s Last Name.
 - D. **Maiden Name:** Enter female consumer’s Maiden Name (required for females). *Use maiden name when constructing unique ID for females in Question #44.*
 - E. **Consumer DOB:** Enter consumer’s date of birth, by month, day, and year: *8 characters.*
 - F. **LME Name:** Enter name of consumer’s Local Management Entity (LME).
 - G. **LME Facility Code:** LME Facility Code may be completed as indicated by LME, or may be assigned by LME upon receipt of Form: *5 characters.*
 - H. **LME Consumer Record No:** LME Consumer Record Number may be completed as indicated by LME, or may be assigned by LME upon receipt of Form: *10 characters.*
1. **Entry Type:** Indicate whether the Form is being completed for a STR Interview Only, a Consumer Registration Only, or both a STR Interview and Consumer Registration: *(✓ One).*
 - [2.] **Consumer Screening Date:** Enter month, day, and year which represents the date that this consumer was screened for the current episode of care: *8 characters. Included in LME’s CDW Screening Record.*
 - [3.] **Consumer Co. of Residence:** Enter a county name or valid county code (*3 characters*) for the state of North Carolina as listed in the CDW Data Dictionary. *Included in LME’s CDW Screening Record.*
 - [4.] **Consumer Enrollment in Medicaid:** Indicate whether the consumer is currently enrolled in Medicaid: *(✓ One). Included in LME’s CDW Screening Record.*
 5. **Screening Referral Source:** Enter the appropriate Screening Referral Source name or code from the below for principal source that referred the consumer to the facility for the screening: *2 characters. Included in LME’s CDW Screening Record.*
 - 01= Self or no referral
 - 10= Family or friends
 - 21= Other outpatient and residential non-state facility
 - 22= State facility
 - 23= Psychiatric service, General hospital
 - 32= Non-residential treatment/habilitation program
 - 41= Private physician
 - 44= Nursing home board and care
 - 46= Veteran’s Administration
 - 48= Other health care
 - 60= Community agency
 - 71= Court, corrections, prisons
 - 80= Schools
 - 99= Other

- [6.] **Time Screening Call or Interview Began:** Enter the time, in hours and minutes, using a 24 hour time clock format to indicate when the STR Interview began: *4 characters. Included in LME’s CDW Screening Record.*
 - [7.] **Time Screening Call or Interview Ended:** Enter the time, in hours and minutes, using a 24 hour time clock format to indicate when the STR Interview ended: *4 characters. Included in LME’s CDW Screening Record.*
 - [8.] **Screening Method:** Indicate whether the Screening Method was in-person face to face or by telephone: *(✓ One). Included in LME’s CDW Screening Record.*
 9. **Name of Person Initiating Request for Services:** Enter the name of the individual who is initiating this request for services, and the individual’s relationship to the consumer. This individual may be the consumer who is making a direct request on their own behalf.
 10. **Phone Number of Person Initiating Request for Services:** Enter the phone number of the individual who is initiating this request for services: *10 characters.*
 11. **Brief Description of Presenting Problem:** Provide a brief description of the consumer’s presenting problem. *(Complete narrative).*
 - [12.] **Presenting Age/Disability Problem(s) of Consumer:** Indicate the presenting age/disability problem(s) in order of importance. *This item is not a determination of Target Population eligibility. (✓ One box for first row for primary problem, and up to one box each for the second and third rows for secondary and tertiary problems). Included in LME’s CDW Screening Record.*
 13. **Current Risk to Consumer Safety:** Indicate the current risk to the consumer’s safety using the five point Scale provided: *(✓ One box for each of three dimensions).*
 14. **Need for Detox Services:** Indicate whether the consumer is in need of detox services due to risk for acute alcohol or drug withdrawal symptoms. If “yes”, check all symptoms that apply.
 15. **Current Risk of Potential Harm to Self or Others:** Indicate the current risk of potential harm to self or others using the five point Scale and the criteria provided: *(✓ One box for each of two dimensions).*
 - [16.] **Triage Severity of Need Determination:** Indicate the consumer’s Triage Severity of Need Determination of Emergent, Urgent, Routine, or Non-Threshold Clinical Need: *(✓ One). Included in LME’s CDW Screening Record.*
 - [17.] **Consumer Referral after Triage:** Indicate where the consumer is referred for response after Triage: *(✓ One). Included in LME’s CDW Screening Record.*
- “Basic Benefits Service Provider” refers to a licensed independent practitioner who is enrolled by the Division of Medical Assistance (DMA) to provide designated non-enhanced Medicaid services to a consumer without the requirement for initial prior authorization.

INSTRUCTIONS FOR STANDARDIZED CONSUMER STR INTERVIEW AND REGISTRATION FORM

STR-REG B

“Enhanced Benefits Service Provider” refers to an agency that is endorsed by the LME or the Division of MH/DD/SAS and enrolled by the Division of Medical Assistance (DMA) to provide designated specialty services to a consumer. Enhanced Services require prior authorization by Value Options or a Local Management Entity.

“Crisis Service Provider” refers to a LME contracted agency or entity to provide MH/DD/SAS crisis services within a service area.

“Community Resources” refers to a variety of community-based consumer supports that are provided through voluntary, charitable, and faith-based organizations and affiliations to support individuals in social connectedness and social integration, health and wellness, and recovery lifestyles. These resources are not paid for through public funds.

If Item No. 17 is checked for “Community Resources”, skip to Item 23.

- 18. **Initial Services(s) Recommended for Consumer:** Indicate what initial services are recommended by the Screener for the consumer. (✓ All that Apply).
- 19. **Offer of Provider Appointment to Consumer:** Indicate whether an appointment date and time (or crisis service) has been offered to the consumer by the provider: (✓ One). If “Yes”, complete Item 20. If “No” or “N/A”, skip to 23.
- 20. **Acceptance of Provider Appointment by Consumer:** Indicate whether the appointment date and time that has been offered to the consumer by the provider has been accepted by the consumer: (✓ One). If “Yes”, complete Items 21 – 22. If “No”, skip to Item 23.
- 21. **Provider Agency Referred to and Location:** Identify the provider agency and location that the consumer has been referred to.
- 22. **Phone Number of Provider Referred to:** Identify the phone number of the provider that the consumer has been referred to.
Complete Item 23 based on appointment or actual initiation of a service. (Enter date and time).
- [23.] **Appointment Date and Time Scheduled:** Enter the provider scheduled appointment date and time in a 24 hour format, or the date and time that the crisis service was initiated: 8 characters followed by 4 characters. *Included in LME’s CDW Screening Record. (If not applicable, enter 99 or 9999 in all spaces for month, day, year, hour, and minutes.)*
- [24.] **How Provider was Chosen:** Indicate how the provider was selected. (✓ One). *Included in LME’s CDW Screening Record. Check N/A as needed.*
- [25.] **Why Provider Was Chosen:** Indicate why the provider was selected. (✓ One). *Included in LME’s CDW Screening Record. Check N/A as needed.*
- [26.] **Accommodation of Special Consumer Needs:** Indicate any accommodation made to meet special needs of the consumer. (✓ One). *Included in LME’s CDW Screening Record.*

- 27. **Consumer’s Primary Medical Provider:** Enter the name of the consumer’s primary health care provider – physician, physician’s assistant, or nurse practitioner.
- 28. **Special Arrangements for Services Access:** Indicate any special arrangements made for services access. (✓ All that apply).
- 29. **Marital Status:** Indicate the Marital Status: (✓ One).
- 30. **Education Level:** Indicate the Educational Level: (✓ One). Enter the appropriate Education Level code from CDW list below for highest grade/degree completed by the consumer at time of the current admission: 2 characters.

00= None, never attended school	01= First grade
02= Second grade	03= Third grade
04= Fourth grade	05= Fifth grade
06= Sixth grade	07= Seventh grade
08= Eighth grade	09= Ninth grade
10= Tenth grade	11= Eleventh grade
12= Twelfth grade/high school graduate	14= Some college
16= Baccalaureate degree	17= Post graduate school (after MA/MS)
18= Post bachelor’s degree	20= GED
30= Kindergarten	35= Associate degree
50= School for special skills	80= Technical trade school
81= Ungraded	82= Special education
99= Unknown	
- 31. **Ethnicity:** Indicate the consumer’s Hispanic origin: (✓ One).
- 32. **Race:** Indicate the consumer’s primary racial affiliation: (✓ One).
- [33.] **English Proficiency:** Indicate whether English is spoken and understood by the consumer at a relatively high level of proficiency, e.g. no interpreter is required: (✓ One). *Included in LME’s CDW Screening Record.*
- [34.] **Primary Language:** Indicate the language spoken and/or understood by the consumer: (✓ One). *Included in LME’s CDW Screening Record.*
- 35. **Gender:** Indicate the consumer’s sex: (✓ One).
- [36.] **Active Military, Military Reserve, or National Guard:** *Included in LME’s CDW Screening Record.*
 - [36a] Indicate whether the consumer or an immediate family or household member (parent, grandparent, sibling, spouse, partner, child, or other significant person in the family constellation) is serving in, or has served in, the Active Military, Military Reserve, or National Guard.
 - [36b] If “Yes”. indicate whether such service is or was associated with Operation Iraqi Freedom (OIF) (2003 to Present), Operation Enduring Freedom (OEF) – (2001 to Present), an Other War or Conflict, or Non-Combat Service Only: (✓ One or More).
- 37. **Consumer’s Residence Street Address/City/State/Zip Code:** Enter this information for consumer as appropriate and available.
- 38. **Consumer’s Phone Number:** Enter this information for consumer as appropriate and available.
- 39. **Consumers’ Mailing Address/City/State/Zip Code:** Enter this information for consumer as appropriate and available.

INSTRUCTIONS FOR STANDARDIZED CONSUMER STR INTERVIEW AND REGISTRATION FORM

STR-REG C

- 40. **Consumer's Legal Guardian (if applicable):** Enter this information for consumer as appropriate and available.
- 41. **Phone No. of Consumer's Legal Guardian (if applicable):** Enter this information for consumer as appropriate and available.
- 42. **Emergency Contact Name and Relationship for Consumer:** Enter this information for consumer as appropriate and available.
- 43. **Phone Number of Emergency Contact for Consumer:** Enter this information for consumer as appropriate and available.
- 44. **Consumer Unique Identifier:** Enter consumer number: *10 or 11 characters*. The unique identifier consists of the first three characters of last name, 1st character of first name, 6 character birth date, and an identifier if more than one LME consumer has the same unique identifier number. *Use maiden name when constructing unique ID for females.*
- 45. **Type of Agency Hosting STR:** Indicate type of agency hosting STR. (*✓ All that apply*).
- 46. **Name of Provider Agency or LME Completing STR Form:** List provider.
- 47. **Name of Qualified Professional (QP) conducted STR Interview:** List first and last name of the QP staff who conducted the STR Interview.
- 48. **STR Staff Qualifications:** Indicate the QP qualifications by disability group. (*✓ All that apply*).
- 49. **STR Staff Area Code, Phone No., & Extension:** Enter the area code, phone number, and extension of the provider staff who conducted the STR Interview.
- 50. **Date STR Form Submitted to LME:** Enter the date by month, day, and year that this form was submitted to the LME.

⚠ CONSUMER REGISTRATION FOR ENHANCED BENEFITS SERVICES OR LME AUTHORIZED SERVICES ⚠

- 51. **Ⓜ Date of Consumer Service Initiation:** Enter the date by month, day, and year that services to the consumer were initiated: *8 characters*.
- 52. **Ⓜ Consumer Social Security Number:** Enter consumer number: *9 characters*. This number is needed for cross-referencing with the Department's Common Name Database Services (CNDS). A consumer SSN will not always be available to a provider when completing this Form.
- 53. **Ⓜ Consumer Medicaid Number:** Enter consumer number: *10 characters*.
- 54. **Ⓜ First and Last Name of Provider Staff submitting this Registration Form to LME:** Enter first and last name of staff submitting this form to LME: *up to 24 characters*.
- 55. **Ⓜ E-Mail of Provider Staff submitting this Form to LME:** Enter e-mail address of staff submitting this form to LME: *up to 24 characters*.
- 56. **Ⓜ Area Code and Phone No.:** Enter area code and phone number of staff submitting this form to the LME: *10 characters*.
- 57. **Ⓜ Date Registration Form Submitted to LME:** Enter date by month, day, and year that this Registration Form was submitted to the LME by the provider: *8 characters*.

Note: A separate LME Consumer Admission and Discharge Form is required to be submitted to the LME by all providers within calendar 30 days of initiation or provision of services and upon completion of an episode of care (discharge) for all Enhanced Benefits Services consumers and all Division funded consumers. The above Consumer Registration serves only to provide notice to the LME of the initiation of Enhanced Benefits Services or Division funded services.