

## MACSIS Client (Member) Enrollment Form Completion Procedures

Within the MACSIS system, the term Member is used to represent those enrolled in the system and receiving services from providers being reimbursed by the system. Since the MACSIS screens and documentation utilize Member when describing those enrolled and receiving services through the system, we have adopted the term when we refer to client information contained in MACSIS to reduce the confusion.

In completing the form it is imperative that the person completing the form to remember to write legibly.

For those that are entering the data into Diamond it is important to remember that all data entered into MACSIS is to be done in CAPITAL LETTERS.

1. **ADAMH/ADAS/CMH Board Consortium:** This is the name of the Board to which the enrollment form is forwarded.
2. **MACSIS UCI:** **Required upon change to existing member.** This field will be completed by the board designated enrollment staff after the form has been processed for new members. A form prepared to change data on an existing member must have this field completed.
3. **FORM TYPE:** **Required.** This indicates whether this form is being completed for enrolling a new member or updating or correcting information on a currently enrolled member. The UCI is required in order for the form to be considered as a change.
4. **Submitting Provider:** **Required.** Enter the name of the agency providing the service.
5. **Date Faxed to Enrollment Center:** Enter the date the form was faxed to the enrollment center.
6. **Submitting Provider UPI:** **Required.** Enter the MACSIS Universal Provider ID for your agency.
7. **Contact Person:** **Required.** Enter first and last name of the person at your agency that the board designated enrollment staff should contact in case there are questions about the data reported on this form. In most cases, this will be the name of your agency's enrollment contact person.
8. **FAX Number:** **Required.** This is the secured agency fax number to which completed enrollment forms should be faxed back to the submitting provider.
9. **Contact Phone number:** **Required.** Enter the phone number at which the "Contact Person" may be reached during business hours.
10. **Last Name:** **Required.** This is the member's second or family name. It must be upper case alphabetic. The only non-alphabetic character allowed is a dash, used in hyphenated last names.
11. **First Name:** **Required.** This is the member's legal first name.
12. **Middle Initial:** This refers to the member's middle initial as his/her second given name. Use one character. If member has no middle name leave blank.
13. **DOB:** **Required.** Enter the member's Date of Birth as a two number month, two number day of the month and four number year (example: 03/15/1956). If not obtainable, use 07/04/1876.
14. **Sex:** **Required.** Indicate the member's gender.
15. **Address 1:** **Required.** Indicate the first line of member's physical address. If the member is homeless, write "HOMELESS".
16. **Address 2:** Indicate second line of member's physical address. If there is no second line, leave blank.
17. **City:** **Required.** Indicate the member's physical city of residence. If the member is homeless and living in a shelter, enter the shelter's city; otherwise, enter the board's city.
18. **State:** **Required.** Indicate the member's physical state of residence. If the member is homeless and living in a shelter, enter the shelter's state abbreviation; otherwise enter "OH".
19. **ZIP:** **First five digits are required.** Indicate the member's physical address zip code (ZIP + 4). If you don't know the last four digits, leave the last four spaces blank. If the member is homeless and living in a shelter, enter the shelter's zip code. If the zip code is unknown, enter "5555".
20. **Race:** **Required.** Indicate the member's self-report of his/her race, selecting all appropriate code(s).

The official policy of the State of Ohio is to use the stated codes for all information entries to the race field. All blanks and entries that do not conform to the code list will be changed to 'U'.

The following codes will be used as the standard for maintaining, collecting, and presenting data on race for all Federal-reporting purposes. \*

Code	Race	Definitions (for documentation purposes)
N	American Indian	A person having origins in any of the original peoples of North (excluding Alaska) and South America (including Central America), and who maintains tribal affiliation or community attachment.
M	Alaskan Native	A person having origins in any of the original peoples of Alaska, and who maintains tribal affiliation or community attachment.
A	Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Code	Race	Definitions (for documentation purposes)
B	Black or African American.	A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
P	Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands [which includes: Carolinian, Fijian, Kosraean, Melanesian, Micronesian, Northern Mariana Islander, Palauan, Papua New Guinean, Ponapean (Pohnpelan), Polynesian, Solomon Islander, Tahitian, Tarawa Islander, Tokelauan, Tongan, Trukese (Chuukese), and Yapese.]
W	White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
U	Unknown	This code should be used only if the race of the member is unknown

\* The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature. They are not to be used as determinants of eligibility for participation in any Federal program. The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on race by Federal agencies.

**Note:** Those with nationality or ancestry of Mexico are usually classified for federal reporting purposes as White, or American Indian depending on whether the individual feels that they are maintaining tribal affiliation or community attachment.

21. **Ethnicity: Required.** Indicate the member’s self-report of his/her ethnicity, selecting all appropriate code(s).

The official policy of the State of Ohio is to use the stated codes for all information entries to the ethnicity field. All blanks and entries that do not conform to the code list will be changed to E.

The following codes will be used as the standard for maintaining, collecting, and presenting data on ethnicity for all Federal-reporting purposes. \*

Ethnicity Codes and Definitions	
Code	Ethnic Designation
A	Puerto Rican
B	Mexican
C	Cuban
D	Other Hispanic
E	Not Hispanic or Latino

\* The categories in this classification are social-political constructs and should not be interpreted as being either scientific or anthropological in nature. They are not to be used as determinants of eligibility for participation in any Federal program. The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on ethnicity by Federal agencies. Although OMB only requires the “header classification,” Hispanic and Not Hispanic, SAMHSA will continue to require the same breakdown for ethnicity. Instead, they will collapse down to OMB.

22. **Home Phone Number:** Indicate the member’s home phone number including the area code. If not known or member prefers not to provide this information leave field blank.
23. **Business Phone Number:** Indicate the member’s business phone number including the area code. If not known or member prefers not to provide this information leave field blank.
24. **Non-English Language Code:** Enter the code if the member’s primary language is not English. If the member’s primary language is English, leave blank. Non-English language codes are located on the back of the form.
25. **Marital Status: Required.** Select the appropriate code for the marital status of the member. Do not fail to select one of the categories. If the member is “separated”, check “married”.
26. **Medicaid Number:** If you know the member’s 12-digit Medicaid Recipient number, enter it here.
27. **Social Security Number: Required.** Enter the nine-digit social security number for the member. This information is crucial to determination of the member’s eligibility for Medicaid, and for identifying if they are currently enrolled in MACSIS. Value to “55555555” if unobtainable (report as soon as found).
28. **Client ID at Provider (medical record no.):** Enter the client ID in your provider system that you use for the member.
29. **Start Date: Required.** This is the date that the member is admitted to your agency (Admission Date). This date must be equal to or before the first date of service provided as identified on your claim. This information should be entered in the following format: Two number month, two number day of the month, and four number year (example: 07/13/1998).

30. **Family Size (01-99): Required.** In this field, enter the number of individuals, including the member, who live in the home and are dependent upon the family income. The number of dependents in the family is determined as it would be on the federal income tax return. If unobtainable, value to “01”.
31. **Adjusted Gross Monthly Income: Required.** Enter the family’s Adjusted Gross Monthly Income.
32. **County of Residence: Required.** Enter the first four characters of the county responsible for adjudicating the client’s behavioral health claims or check “out of state”. The Residency Determination Guidelines outline how to determine the county responsible for adjudication, including for special populations such as foster children, out-of-county clients, college students, homeless clients, migrant workers, out-of-State clients, adults in specialized institutions and forensic clients.

Please note that a Residency Verification Form is required along with the enrollment form in the following circumstances:

- The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county)
- The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (ex. domestic violence shelter case, client temporarily living with relatives, etc., child or adult, out-of-county)
- The child’s physical address as noted on the enrollment form does not match the legal custodian’s address (child only, in or out-of-county)

A Residency Verification Form is not required for adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories. The latter populations require proof of residency as outlined in the Residency Determination Guidelines.

#### County Table

<b>ADAM</b>	ADAMS	<b>ALLE</b>	ALLEN	<b>ASHL</b>	ASHLAND
<b>ASHT</b>	ASHTABULA	<b>ATHE</b>	ATHENS	<b>AUGL</b>	AUGLAIZE
<b>BELM</b>	BELMONT	<b>BROW</b>	BROWN	<b>BUTL</b>	BUTLER
<b>CARR</b>	CARROLL	<b>CHAM</b>	CHAMPAIGN	<b>CLAR</b>	CLARK
<b>CLER</b>	CLERMONT	<b>CLIN</b>	CLINTON	<b>COLU</b>	COLUMBIANA
<b>COSH</b>	COSHOCTON	<b>CRAW</b>	CRAWFORD	<b>CUYA</b>	CUYAHOGA
<b>DARK</b>	DARKE	<b>DEFI</b>	DEFIANCE	<b>DELA</b>	DELAWARE
<b>ERIE</b>	ERIE	<b>FAIR</b>	FAIRFIELD	<b>FAYE</b>	FAYETTE
<b>FRAN</b>	FRANKLIN	<b>FULT</b>	FULTON	<b>GALL</b>	GALLIA
<b>GEAU</b>	GEAUGA	<b>GREE</b>	GREENE	<b>GUER</b>	GUERNSEY
<b>HAMI</b>	HAMILTON	<b>HANC</b>	HANCOCK	<b>HARD</b>	HARDIN
<b>HARR</b>	HARRISON	<b>HENR</b>	HENRY	<b>HIGH</b>	HIGHLAND
<b>HOCK</b>	HOCKING	<b>HOLM</b>	HOLMES	<b>HURO</b>	HURON
<b>JACK</b>	JACKSON	<b>JEFF</b>	JEFFERSON	<b>KNOX</b>	KNOX
<b>LAKE</b>	LAKE	<b>LAWR</b>	LAWRENCE	<b>LICK</b>	LICKING
<b>LOGA</b>	LOGAN	<b>LORA</b>	LORAIN	<b>LUCA</b>	LUCAS
<b>MADI</b>	MADISON	<b>MAHO</b>	MAHONING	<b>MARI</b>	MARION
<b>MEDI</b>	MEDINA	<b>MEIG</b>	MEIGS	<b>MERC</b>	MERCER
<b>MIAM</b>	MIAMI	<b>MONR</b>	MONROE	<b>MONT</b>	MONTGOMERY
<b>MORG</b>	MORGAN	<b>MORR</b>	MORROW	<b>MUSK</b>	MUSKINGUM
<b>NOBL</b>	NOBLE	<b>OTTA</b>	OTTAWA	<b>PAUL</b>	PAULDING
<b>PERR</b>	PERRY	<b>PICK</b>	PICKAWAY	<b>PIKE</b>	PIKE
<b>PORT</b>	PORTAGE	<b>PREB</b>	PREBLE	<b>PUTN</b>	PUTNAM
<b>RICH</b>	RICHLAND	<b>ROSS</b>	ROSS	<b>SAND</b>	SANDUSKEY
<b>SCIO</b>	SCIOTO	<b>SENE</b>	SENECA	<b>SHEL</b>	SHELBY
<b>STAR</b>	STARK	<b>SUMM</b>	SUMMIT	<b>TRUM</b>	TRUMBULL
<b>TUSC</b>	TUSCARAWAS	<b>UNIO</b>	UNION	<b>VANW</b>	VAN WERT
<b>VINT</b>	VINTON	<b>WARR</b>	WARREN	<b>WASH</b>	WASHINGTON
<b>WAYN</b>	WAYNE	<b>WILL</b>	WILLIAMS	<b>WOOD</b>	WOOD
<b>WYAN</b>	WYANDOT				

For data items 33 through 45, some of this information may not be pertinent. Contact the board you contract with to determine need for and specific instructions for completing these fields.

33. **Plan Type:** Select the appropriate plan type.
34. **Sliding Fee Percentage:** Enter the percentage as required per the provider’s contract with the enrolling board. If no contract with the enrolling board, leave blank.

35. **Member Copay:** This amount is the amount that the member is required to pay. Enter the amount as required per the provider's contract with the enrolling board. If no contract with the enrolling board, leave blank.

### MEMBER DISCLOSURE STATEMENT SECTION

This section confirms that the member has been notified that for billing purposes, information will be released to the appropriate board, the State of Ohio and other entities necessary to recoup the cost of services provided. These documents will be kept in the member's clinical record at the provider agency. If the member is unable to sign these forms, follow your policy on documentation of such situations.

36. **Client is potentially SMD/SED?** Check the yes box if you feel it is likely that the client will qualify as "severely mentally disabled" (SMD) or "severely emotionally disabled" (SED) per the definitions published by the Ohio Department of Mental Health. For clients receiving only AOD services, check "no". The answer to this question may or may not be used to determine the designation of a plan by the enrolling board.
37. **AOD release of information signed (AOD only)?** Required for AOD or dual-diagnosis clients. Check the yes box if the AOD release of information was signed. If not applicable, do not check either box.
38. **Consent for treatment signed?** Required. Check the yes box if the member has signed the consent for treatment document.
39. **Client refused to sign consent for treatment (MH only)?** Required for MH or dual-diagnosis clients only. Check the yes box if the client refused to sign the consent for treatment to receive mental health services.
40. **In crisis at enrollment?** Required. Check the yes box if the member is crisis and is not able to sign the Consent to Treatment at the time of enrollment. If the box is checked "yes", then the enrolling board must accept the enrollment request, if the provider has included, at a minimum, the client's last name, first name, gender (best guess) and actual or "default" date of birth on the enrollment form. Every effort should be made by the provider to subsequently obtain complete enrollment information.
41. **Referred to Provider Name:** Enter the name of the lead provider agency to whom the member has been referred for further treatment.
42. **Referred to UPI:** Enter the provider agency's MACSIS UPI (Universal Provider ID).
43. **Other 1:** Indicate "90W" if the client is enrolling or terminating in the Women's Setaside Program. This field may also be used to indicate plan, panel or affiliation codes as instructed by your contracting board
44. **Other 2:** Same as "Other 1" field.
45. **Other 3:** Same as "Other 1" field.

### Items Completed by the Enrollment Staff

Items below the line titled "Items Completed by the Enrollment Staff" on the form, do not need to be completed by the provider. Contact your contracting board/boards to know how to interpret information returned to you in these fields.

46. **Group Level 3:**
47. **Plan:**
48. **Panel:**
49. **Riders:**
50. **Term Date**
51. **Term Reason:**
52. **Staff Entering Data:**
53. **Date Entered:**
54. **Date Faxed to Provider:**