BENEFICIARY REGISTRATION SHEET

Last Name	First Name	Middle Name

Beneficiary's Birth Name (if different from name listed above)

Sex	Birthdate	Social Security Number
☐M ☐F	/ /	

Ethnicity (Race) (Check 2 if appropriate)

White ☐	Laotian ☐	Samoan ☐
Black ☐	Cambodian ☐	Asian Indian ☐
Native American ☐	Japanese ☐	Hawaiian ☐
Mexican American/ Chicano ☐	Filipino ☐	Guamanian ☐
Latin American ☐	Other Asian ☐	Amerasian ☐
Other Spanish ☐	Other Non White ☐	Korean ☐
Chinese ☐	Unknown ☐	Vietnamese ☐
	Other Southeast Asian ☐	Multiple ☐

Primary Spoken Language (If Obtainable)

English ☐	Cantonese ☐	Polish ☐
Spanish ☐	Korean ☐	Russian ☐
Other Chinese ☐	Mandarin ☐	Portuguese ☐
Japanese ☐	Armenian ☐	Italian ☐
Filipino Dialect ☐	Ilacano ☐	Arabic ☐
Vietnamese ☐	Mien ☐	Samoan ☐
Laotian ☐	Hmong ☐	Thai ☐
Cambodia ☐	Turkish ☐	Farsi ☐
Sign Language ☐	Hebrew ☐	Other Sign ☐
Other ☐	French ☐	Unknown/not reported ☐

Home Address

City	CA	Zip

Mailing Address (if different than above)

City	CA	Zip

Home Phone	Work Phone
( ) -	( ) -

Marital Status: Never Married ☐ Now married/remarried/living together ☐ Separated ☐ Widowed ☐ Divorced/dissolved/annulled ☐ Unknown ☐

Please indicate where the beneficiary resides. (check all that apply)

Alone ☐	Single Room (hotel, motel) ☐	Board and Care Home ☐	Alternative to Hospitalization (<6 beds) ☐
Family ☐	Group Quarters ☐	Small Board & Care (<7) ☐	Alternative to Hospitalization (>6 beds) ☐
Group Home ☐	Homeless, no residence ☐	Large Board & Care (>6) ☐	SNF/1CF/Nursing home, for physical health reasons ☐
SNF ☐	Homeless, in Transit ☐	House or Apartment ☐	
IMD ☐	Chaparral Residential ☐	SNF/1CF, for Psychiatric Reasons ☐	Adult Res./Social Rehab ☐
Charlee ☐	Chaparral Intensive ☐	House or Apartment w. support ☐	House or Apartment w/supervision ☐
FFA ☐	Lives w/adopt Parent ☐	General Hospital ☐	Other: _____ ☐
Foster Family ☐			

Please indicate the beneficiary's Legal Status:

Voluntary ☐	72 Hour Hold for Minor ☐	Judicial Commitment DD ☐	Temporary Conservatorship ☐	Second 14 Day Hold ☐
72 Hour Hold ☐	First 14 Day Hold ☐	Commitment of Minor DD ☐	Permanent Conservatorship ☐	Unknown ☐

Medi-Cal Number	Education (Yrs)

First Name of Beneficiary's Mother	

Beneficiary's Place of Birth (County only if California)	County: State Country:

Name of Primary Care Physician	Primary Care Physician Phone Number ( ) -

Is Beneficiary on Conservatorship? Yes ☐ No ☐	Conservator Name

Conservator Address	Conservator Phone Number ( ) -

Name of Provider

Provider Phone Number	Provider Fax Number
( ) -	( ) -

Referral Source ☐ Self ☐ Family ☐ Friends ☐ Employer ☐ Other _____

When completed please retain in client record and fax to (909) 890-0353

or mail to: Access Unit, 303 E Vanderbilt Way., San Bernardino, CA 92410

REVISED 11/15