**MHS 31 - ENHANCED CARE SERVICES CENSUS REPORT**

**ECS Program: Completed by: Date:**

Please email completed forms to AMHcontract.Administrator@dhsoha.state.or.us by the first working day of each month.

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| **Resident** | **Birthdate** | **Admission Date** | **Medicaid** **Number** | **Status\*** | **Comments (optional)** |
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 \*S=stable P=problems DP=D/C pending T=trial visit or pass

DEATHS DURING MONTH HOSPITALIZATIONS DURING MONTH

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| Resident | Date | Resident | Type (Medical or Psychiatric) | Facility/Locale | Dates(from \_\_\_\_\_ to \_\_\_\_\_\_) |
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