

**MENTAL HEALTH SERVICES
CLIENT REGISTRATION DATA FORM**

Confidential Patient Information
See Welfare & Institutions Code: 5328

Please Print Legibly

Highlighted fields are **required**

*asterisk fields are required for CSI data reporting

Program (tab):

*Primary Program Name: _____

Program Status: Enrolled

*Assigned Staff: _____ (Staff Client is Assigned To)

Requested Date: *Field not used*

*Enrolled Date: _____ (Date Client is Enrolled to begin Treatment)

Comment: _____ (Optional field)

Episode (tab):

Case Information:

Initial Referral/Screening Date:- *Field not used*

Registration Date: _____ (required on first initial registration into program only, Date should be same as Enrollment Date)

Information: *System informational data field only*

Registration Comment: _____ (Optional field)

CSI Episode Information ONLY COMPLETE FOR INPATIENT/RESIDENTIAL REGISTRATIONS

Transaction Type: Admission

First Date of Service: *Field not used*

Last Date of Service: *Field not used*

Discharge Date: *Field not used for admissions*

* Patient Status: _____

(Data field used for counting days of admission to discharge)

* Legal Class of Admission: _____

(Reference global code appendix "legal status" code table)

Legal Class of Discharge: *Field not used for admissions*

* Admission Necessity: _____

(Data field used to identify the type or reason for the client's admission into the facility)

Referral Resource: *Section not used*

Referral Reason: *Section not used*

General (tab):

General Information:

Type Of Client: *System Informational Field Only*

Client SSN _____ (enter clients 9-digit Social Security Number, if no SSN enter all 9's)

Primary Care Coordinator: *Field not used at this time*

Medical Provider: *Field not used at this time*

Prefix: _____ (Enter the Client's Prefix) optional field

Client's Email: _____ optional field Active: *System Informational Field Only*

Client's Medi-Cal ID: *System Informational Field Only*

Professional Suffix: *Field not used at this time*

***Client's First Name At Birth:** _____ (enter Same if same as client's current First Name)

Client's Middle Name At Birth: _____ (enter Same if same as client's current Middle Name)

***Client's Last Name At Birth:** _____ (enter Same if same as client's current Last Name)

Client's Suffix at Birth: _____ (enter Same if same as client's current Suffix name)

Phone Numbers:

Home: (____) _____ - _____ (Client's Home Phone Number) Optional

Mobile: (____) _____ - _____ (Client's Secondary Phone Number) Optional

DNC: *Field not used at this time*

DNLM: *Field not used at this time*

Addresses:

Address Details: Enter Clients Home Address (If homeless Enter the Zip Code for the City Hall of the city where the client indicates they most often sleep (in a shelter or on the street).

Street: _____

City: _____

State: _____

Zip: _____ (zip +4 not required)

Billing: (Check If The Billing Address Is The Same As Home Address)

Comment: *Field not used at this time*

Demographic And Client Information (tab):

Identifying Information:

***Date Of Birth:** _____ (Date Client Was Born)

***Sex:** _____ (Client's Sex At Birth)

Marital Status: _____

Gender Identity: _____

Sexual Orientation: _____

Deceased On: *Do Not Complete this field*

Cause Of Death: *Do Not Complete this field*

Preferred Pronoun: _____ (optional)

*Ethnicity: (multi-select field; select as many ethnicities as applicable)

- Cuban
- Mexican/Mexican American
- Other Latino
- Nicaraguan
- Non-Hispanic
- Puerto Rican
- South American
- Other Hispanic
- Salvadoran

*Race: (multi-select field; select as many races as applicable)

- Alaskan Native
- American Indian
- Asian Indian
- Black or African American
- Cambodian
- Chinese
- Filipino
- Guamanian
- Hmong
- Japanese
- Korean
- Laotian
- Mien
- Mixed Race/Multiracial
- Other Asian
- Other Pacific Islander
- Other Southeast Asian
- Unknown/Not Reported
- Vietnamese
- White or Caucasian

Client Declined To Provide: Field not used

Additional Identifying Information:

*Place Of Birth – Country: _____ (If client was not born in the United State, then Birth State and Birth County are not required)

*Place Of Birth – State: _____ (If client was not born in CA, then the County is not required)

*Place Of Birth – County: _____ (required if client was born in CA)

Special Population: Field not used

*Conservatorship or Juvenile Court Status: _____

(Identifies whether or not the client has a conservatorship or juvenile court status)

*Has The Client Experienced A Traumatic Event: _____

*General Medical Condition(s) 1: _____

(If No GMC in field #1, the GMC #2 and #3 is not completed. Otherwise, all three fields are required.)

*General Medical Condition(s) 2: _____ (required field conditionally)

*General Medical Condition(s) 3: _____ (required field conditionally)

*Does the client have a Substance Abuse/Dependence Issue? _____

If answered **Yes** to above indicate the Substance abuse diagnosis (**F10-F19.99**) _____

*What Type of Disability/Disabilities Does the Client Have, If Any (multi-select field; select as many disabilities as applicable)

- Client Declined to State
- Client Unable to Answer Due to Disability ONLY
- Developmentally Disabled
- Hearing
- Mobility
- Mental
- None
- Other Disability (not SUD)
- Other Physical Impairment
- Physical Impairment/Mobility
- Severe Hearing Impairment
- Severe Visual Impairment
- Speech
- Speech Impairment
- Unknown
- Visual

Primary Care Physician: (Optional)

Primary Care Physician: _____ (The Name Of The Client’s Primary Care Physician)

Client Does Not Have PCP: (Check If the Client Does Not Have A Primary Care Physician)

Client Name: _____

Financial Information: Field not used at this time

Family Information:

Pregnancy Status: _____ (Check Yes/No If the Client Is Pregnant)

***Mother's First Name:** _____ (If mother name is unknown enter UNKNOWN)

***# Of Dependents Under The Age Of 18:** _____ (number of persons the client cares for/is responsible for at least 50% of the time)

***# Of Dependents Over The Age Of 17:** _____ (number of persons the client cares for/is responsible for at least 50% of the time)

Living Arrangement:

***Living:** _____ (Indicate the living arrangement of the client)

***County Of Residence:** _____ (Indicate Which County the Client Lives In)

***County Of Financial Responsibility:** _____ (Indicate the County directly or indirectly Financially Responsible for the client's services)

Educational/Employment:

***Educational Status:** _____ (Indicate Client's Highest Level Of Education)

***Veteran Status:** _____ (Indicate Yes/No/Unknown if the client is a Veteran)

***Military Status:** _____ (Indicate Yes/No/Unknown if the Client serves In The Military)

***Employment Status:** _____ (Indicate Client's Current Employment Status)

Employment Information: _____ (Optional)

Language:

***Primary Language:** _____ (Indicate what Primary Language the client speaks)

***Preferred Language:** _____ (Indicate what Preferred Language the client speaks)

Client Does Not Speak English: Field not used at this time

***Hispanic Origin:** _____ (indicate the client's Hispanic Origin)

Interpreter Services Needed: Field not used at this time

Transportation Information: This section is not used at this time

Preferences: This section is not used at this time

Picture: This section is not used at this time

Alias (TAB):

First Name: _____

First Name: _____

Middle Name: _____

Middle Name: _____

Last Name: _____

Last Name: _____

Type: _____

Type: _____

Client Name: _____

Client Contacts (TAB): Optional at this time (if information is collected, must completed the required fields to insert and save the Client Contact information)

Relation: _____ (Enter Relationship)

First Name: _____ (enter Relationship First name)

Last Name: _____ (enter Relationship Last Name)

Suffix: _____ (enter Relationship suffix name if applicable)

Check Whether the Client's Relation Is the Following:

| | |
|--|--|
| <input type="checkbox"/> Financially Responsible | <input type="checkbox"/> Care Team Member |
| <input type="checkbox"/> Household Member | <input type="checkbox"/> Guardian |
| <input type="checkbox"/> Emergency Contact | <input type="checkbox"/> Healthcare Decision Maker |

Phone Numbers: OPTIONAL (enter Relationship's phone number)

Home: (____) _____ - _____

Mobile: (____) _____ - _____

DNC: Field not used at this time

DNLM: Field not used at this time

Addresses: OPTIONAL (enter Relationship's address)

Address Details: Enter Clients Home Address

Street: _____

City: _____

State: _____

Zip: _____

Billing: (Check If The Billing Address Is The Same As Home Address)

Comment: Field not used at this time

Insurance (tab): FOR USE BY BILLINGS STAFF ONLY

Forms & Agreement (tab): NOT USED AT THIS TIME

PFN Details (tab): FOR USE BY SANTA RITA STAFF ONLY