Alameda County Behavioral Health

MENTAL HEALTH SERVICES CLIENT REGISTRATION DATA FORM

Confidential Patient Information
See Welfare & Institutions Code: 5328

New Registration: ☐ Update: ☐ Data Entry Initials: ________

SmartCare Client ID Number: _______________ (***SmartCare data entry staff ONLY***, for new clients enter NEW)

Program: _______________________________

Client Last Name: _______________________

Client First Name: _______________________

Client Middle Name: __________________ **Client Suffix** if applicable _______

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

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: (ONLY for Inpatient/Residential programs) ____________________________________

(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

Client Name: ________________________________

Preferred Pronoun: ____________________(optional)

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

☐Cuban	☐Hispanic/Latino Origin Not Avail	☐Puerto Rican
☐Decline to Answer	☐Mexican/Mexican American	☐Salvadoran
☐Decline to State	☐Nicaraguan	
☐Guatemalan	☐Non-Hispanic	☐South American
☐Other Latino	☐Other Latino	☐Unknown

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

☐Alaskan Native	☐Guamanian	☐Other Asian
☐American Indian	☐Hmong	☐Other Pacific Islander
☐Asian Indian	☐Indigenous	☐Other Southeast Asian
☐Black or African American	☐Japanese	☐Other/Other Race
☐Cambodian	☐Korean	☐Race Not Available
☐Caribbean	☐Laotian	☐Samoan
☐Chinese	☐Mien	☐Unknown / Not Reported
☐Decline to State	☐Mixed Race/Multiracial	☐Vietnamese
☐Filipino	☐Native Hawaiian	☐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)

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 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:

☐Financially Responsible	☐Care Team Member	☐Legal Guardian
☐Household Member	☐Guardian	
☐Emergency Contact	☐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