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: ____________
Program: _____________
Client Last Name: _____________________
Client First Name: _____________________
Client Middle Initial: _______

Please Print Legibly

*Highlighted fields with asterisks are **required**.

Client Search:

Go to the Client Search in SmartCare and either select <Client Search> or start typing the client's name.
Go to the search icon and search for registration form, select the Mental Health Services Registration (Client) form.

Program:

*Primary Program Name: ____
*Program Status: ☐ Enrolled ☐ Requested ☐ Discharged
*Assigned Staff: ____________________________________ (Staff Client is Assigned To)
Requested Date: __ __/ __ __/ __ __ __ __ (Date Services are Requested)
*Enrolled Date: __ __/ __ __/ __ __ __ __ (Date Client is Enrolled)
Comment: ____

Episode:

Case Information:
Initial Referral/Screening Date: __ __/ __ __/ __ __ __ __ (Date Of Screening)
*Registration Date: __ __/ __ __/ __ __ __ __ (Date should be same as Enrollment Date)
Information: Information Needed.
Registration Comment: ____ (Registration Comments)
County Of Submission: ____ (County Entering Data)

When completing Outpatient enrollment, the CSI Episode Information Transaction Type fields are **not required**.
When completing Inpatient enrollment, the CSI Episode Information Transaction Type fields **are required.**

CSI Episode Information:
*Transaction Type: ☐ Admission ☐ Admission/Discharge (Select Admission from the dropdown menu)

First Date of Service: __ __/ __ __/ __ __ __ __
Last Date of Service: __ __/ __ __/ __ __ __ __
Discharge Date: __ __/ __ __/ __ __ __ __ (Required for Discharge)

*Patient Status: ____ (Select Still a Patient or Expected to Return)
*Legal Class of Admission: ______________________________ (Reference global code appendix "legal status" code table)
Legal Class of Discharge: ______________________________________ (Required for Discharge)
*Admission Necessity: ☐ Emergency ☐ Planned (Prior Authorization) ☐ Unknown/Not Reported

Referral Resource: Not Required.

General:

General Information:

Type Of Client: ☐ Individual ☐ Organization

SSN Modify: _ __ __ ___ (Verify the Last 4 Digits of the Client's Social Security Number)

Primary Care Coordinator: ________________________________ (Assign The Primary Care Coordinator)

Medical Provider: ________________________________ (Assign The Medical Provider)

Prefix: _____ (Enter The Client's Prefix)

Client's Email: ____ Active: ☐ (Check If Client's Email Is Active)

Client's Medi-Cal ID: ___________________________________

Professional Suffix: _______ (Enter The Client's Professional Suffix)

*Client's First Name: ____

*First Name At Birth: ____ (Client's First Name On Birth Certificate)

Same As Current First Name: ☐ (Check If Client's Current Name And Birth Name Are The Same)

Client's Middle Name: ____

Middle Name At Birth: ____ (Client's Middle Name On Birth Certificate)

Same As Current Middle Name ☐ (Check If Client's Current Name And Birth Name Are The Same)

*Client's Last Name: ____

*Last Name At Birth: ____ (Client's Last Name On Birth Certificate)

Same As Current Last Name: ☐ (Check If Client's Current Name And Birth Name Are The Same)

Client's Suffix: ____

Suffix At Birth: ____ (Client's Suffix On Birth Certificate)

Same As Current Suffix: ☐ (Check If Client's Current Suffix And Birth Suffix Are The Same)

*Phone Numbers:

Home: (__ __ __)__ __ __ - __ __ __ __ (Client's Home Phone Number)

Home 2: (__ __ __)__ __ __ - __ __ __ __ (Client's Secondary Phone Number)

Business 2: (__ __ __)__ __ __ - __ __ __ __ (Client's Business Phone Number)

DNC: ☐ (Check If You Cannot Call This Number)

DNLM: ☐ (Check If You Cannot Leave A Message At This Number)

*Addresses:

Home: ____ (Client's Home Address)

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

Comment:

List Any Special Needs Or Considerations Important To Note About The Client: ____

Waitlist Priority: Not Required.

Demographic And Client Information:

Identifying Information:

*Date Of Birth: __ __/ __ __/ __ __ __ __ (Date Client Was Born)

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

*Marital Status: _____________________ (Client's Marital Status)

*Gender Identity: ____________________ (Client's Gender Identity)

*Sexual Orientation: ____________________ (Client's Sexual Orientation)

Deceased On: __ __/ __ __/ __ __ __ __ (If Client Is Deceased – Date Deceased)

Cause Of Death: ______________________ (Cause Of Death – If Client Is Deceased)

Preferred Pronoun: _____________ (Pronoun Client Prefers To Be Identified By)

*Ethnicity: ______________________ (Client's Ethnicity)
*Race: _________________ (Client's Race)
Client Declined To Provide: ______________________________________ (List Any Demographic The Client Declines To Provide)

Additional Identifying Information:
*Place Of Birth – Country: ______________________________ (The Country The Client Was Born In)
*Place Of Birth – State: ___ __ (The State The Client Was Born In)
*Place Of Birth – County: _______________________________ (The County The Client Was Born In)
Special Population: ______________________________ (Indicate Special Population Type)
*Conservatorship Or Juvenile Court Status: _________________________ (Who Has Guardianship Over The Client)
*Has The Client Experienced A Traumatic Event: ☐ Yes ☐ No (Indicate Yes/No If Client Has Experienced A Traumatic Event)
*General Medical Condition(s) 1: ________________________________(List General Medical Condition, if unknown list unknown)
General Medical Condition(s) 2: ________________________________(List General Medical Condition, if unknown list unknown)
General Medical Condition(s) 3: ________________________________(List General Medical Condition, if unknown list unknown)
*Does The Client Have A Substance Abuse/Dependence Issue?☐ Yes ☐ No (Indicate Yes/No If Client Has SUD Issue)
If answered ***Yes*** to above indicate the Substance abuse diagnosis ______________________
*What Type Of Disability/Disabilities Does The Client Have, If Any: _______________________________ (Indicate Client Disability)

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: **(Optional)**
Financially Responsible: ☐ Yes ☐ No (Check Yes/No If The Client Is Responsible For The Bill)
Annual Household Income: __________________ (Total Annual Gross Income Of Everyone Living In The House)
Of Dependents: _____________ (Indicate How Many Dependents Live In The Household)

Family Information:
*Pregnancy Status: ☐ Yes ☐ No (Check Yes/No If The Client Is Pregnant)
*Mother's First Name: ______________________ (The First Name Of The Client's Mother)
*# Of Dependents Under The Age Of 18: __________ (Indicate How Many Children Under 18 Live With The Client)
*# Of Dependents Over The Age Of 17: ___________ (Indicate How Many Adult Dependents Live With The Client)

Living Arrangement:
*Living: _________________ (Indicate Where The Client Lives)
*County Of Residence: _____________________ (Indicate Which County The Client Lives In)
*County Of Financial Responsibility: _____________________ (Indicate Which County Has Financial Responsibility for The Client)

Educational/Employment:
*Educational Status: __________________________ (Indicate Client's Highest Level Of Education)
*Veteran Status: ___________________ (Indicate Yes/No If Client Has Served In The Military)
*Military Status: ____________________ (Indicate Yes/No If Client Currently Serves In The Military)
*Employment Status: _____________________ (Indicate Client's Current Employment Status)
Employment Information: ____ (Indicate Where The Client Works)

Language:
*Primary Language: _________________________________ (Indicate Which Primary Language The Client Speaks)
*Preferred Language: ________________________________ (Indicate Which Language The Client Prefers To Speak)
Client Does Not Speak English: ☐ (Check If The Client Does Not Speak English)
*Hispanic Origin: ☐ Yes ☐ No (Check Yes/No If The Client is Hispanic)

Interpreter Services Needed: ☐ (Check If The Client Needs An Interpreter)

Transportation Information: Not Required.

Preferences:
Communication Preference: ______________________________ (Indicate How The Client Prefers To Be Communicated With)
Mobile Phone Provider: ______________________ (Indicate Mobile Carrier)
Days: ☐ M ☐ T ☐ W ☐ Th ☐ F (Check The Days Of The Week When Client Can Be Reached)
Geographic Location: _____________________________ (Indicate Where The Client Lives)
Comment: _______________________________________ (Additional Comments)

Picture: Not Required.

Client Contacts: (Optional Not Required, if information is collected, complete yellow highlighted sections below)
Add/Edit Client Contacts:
Relation: ______________________ (Enter Relationship)
Relation Prefix: ____
Relation First Name: ______________________
Relation Last Name: ______________________
Relation Suffix: ____
Relation Date Of Birth: __ __/ __ __/ __ __ __ __
Relation Age: _____
Relation Sex: _______________
Relation SSN: __ __ __ __ (Last 4 Digits of Relation's Social Security Number)
List As: _____________________
Relation's Email: __________________________________
Assign Treatment Team Role: ☐ Yes ☐ No (Check Yes/No If Assigning Relation a Client Treatment Team Role)
Relation's Credentials: _______________
Relation's Department: _______________
Relation's Professional Suffix: __________
Relation's Organization: _____________________________
Relation's Organization's Mailing Name: _____________________________
Check Whether the Client's Relation Is the Following:
☐ Financially Responsible
☐ Household Member
☐ Emergency Contact
☐ Care Team Member
☐ Guardian
☐ Healthcare Decision Maker
Check Whether the Client's Relation Is:
☐ Active

Phone Numbers:
Phone Number: ☐ (Check If The Relation's Phone Number Is The Same As Client's Phone Number)
Home: (__ __ __)__ __ __ - __ __ __ __ (Relation's Home Phone Number If Different Than Client's)
Home 2: (__ __ __)__ __ __ - __ __ __ __ (Relation's Secondary Phone Number If Different Than Client's)
Business 2: (__ __ __)__ __ __ - __ __ __ __ (Relation's Business Phone Number If Different Than Client's)
DNC: ☐ (Check If You Cannot Call This Number)
DNLM: ☐ (Check If You Cannot Leave A Message At This Number)

Addresses:
Address: ☐ (Check If The Relation's Address Is The Same As Client's Address)
Address: ____ (Relation's Home Address If Different Than Client's Home Address)

Comments:
Comments: ____

Insurance Tab: Not Required.

Forms & Agreement Tab: Not Required.

PFN Details Tab: Required for Santa Rita Staff Only.

DATA FIELD TABLES

Employment Status: **Must enter data on this field**

	Rehabilitative work, less than 20 hours per week	Unemployed, actively seeking work
Competitive job market, 35 hours/more	Rehabilitative work, 20 to 35 hours per week	Unemployed, not actively seeking work
Competitive job market, 20 hours/ less	School, full-time	Retired
Competitive job market, 20 to 35 hours per week	Job training, full-time	Not in the labor force
Full-time home making responsibility	Part time school / job training	Unknown
Rehabilitative work, 35 hours or more per week	Volunteer work	Resident / Inmate

Education Status: **Must enter data on this field**

Never Attended	Grade 9	Grade 19	Client Declined to State
Kindergarten	Grade 10	Grade 20	Client Unable to Answer due to disability
Grade 1	Grade 11	Vocational Program	Grade 21
Grade 2	Grade 12	Associate degree	Grade 22
Grade 3	Grade 13	Bachelors	Grade 23
Grade 4	Grade 14	Masters	Grade 24
Grade 5	Grade 15	Professional Doctorate Degree	Grade 25
Grade 6	Grade 16	Doctoral degree	Grade 26
Grade 7	Grade 17	Other	Grade 27
Grade 8	Grade 18	Unknown	Grade 28; 29;30

Living Arrangement: **Must enter data on this field**

Alcohol Abuse Facility	Homeless, In transit	PHF/Inpatient Psych
Adult Residential Facility, Social Rehabilitation Facility	Homeless, no identifiable county residence	Residential Treatment Center (includes levels 13-14 for children)
Community Treatment Facility	House or Apartment (includes trailers)	Satellite Housing (applies to adults only)
Crisis Residential Facility	House or apt. requiring some support with daily activities of living (applies to adults only)	Single room (Motel, rooming hours)
CRTS long-term or transitional housing	House or apt. requiring daily support and supervision (applies to adults only)	Small Board & Care (6 rooms or less)
Drug Abuse Facility	Hotel	SNF/ICF/IMD. For Psychiatric reasons
Foster family home (for children)	Justice Related	SNF/ICF/Nursing Home for physical health reasons
General Hospital	Large Board & Care (7 beds or more)	State hospital
Group Home (includes Levels 1-12 for children)	Mental Health Rehabilitation Center (24-hours)	Supportive housing
Group Quarters (dorm, migrant barracks)	Other	Temporary Arrangement
Unknown	VA Hospital	

Conservatorship or Juvenile Court Status: (optional field)

Temporary Conservatorship (W&I Code, Section 5353)	PC 2974 (Penal Code, Section 2974)	PC 2974 (Penal Code, Section 2974)
Murphy (W&I Code, Section 5008)	Representative Payee Without Conservatorship (W&I Code, Section 5686)	Juvenile Court, Ward-Juvenile Offender (W&I Code 602)
Lanterman-Petris-Short (W&I Code, Section 5358)	Juvenile Court, Dependent of the Court (W&I Code 300)	Not Applicable
Probate (Probate Code, Division 4, Section 1400)	Juvenile Court, Ward-status offender (W&I Code 601)	Unknown/ Not Reported

General Medical Condition Summary Codes: Enter up to three General Medical Condition Summary Codes

Arterial Sclerotic Disease	Cirrhosis	Osteoporosis	Physical Disability
Heart Disease	Diabetes	Cancer	Stroke
Hypercholesterolemia	Infertility	Blind / Visually Impaired	Tinnitus
Hyperlipidemia	Hyperthyroid	Chronic Pain	Ear Infections
Hypertension	Obesity	Deaf / Hearing Impaired	Asthma
Birth Defects	Anemia	Epilepsy / Seizures	Sexually Transmitted Disease (STD)
Cystic Fibrosis	Allergies	Migraines	Other
Psoriasis	Hepatitis	Multiple Sclerosis	Unknown/Not Reported General Medical
Digestive Disorder	Arthritis	Muscular Dystrophy	No General Medical Condition

NOTE: For a list of all Data Field Tables please see "SmartCare Data Field" PDF located on the ACBH Providers Website