ALAMEDA COUNTY

BEHAVIORAL HEALTH DEPARTMENT

Mental Health Services

ACBHD SmartCare User Guide

Registration & Program Enrollment

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V6.0

ACBH - Billing and Benefits Support:

(800) 878-1313: Billing and Benefits Support (BBS)
bbsdataintegrity@acgov.org

(888) 346-0605: Medi-Cal Eligibility Help Desk (SmartCare)
eligibilityhelpdesk@acgov.org

ACBH - Information Systems:

Help Desk Phone #: (510) 817-0076
M – F: 8:30 am to 5:00 pm
FAX #: (510) 567-8161
E-Mail: HCSASupport@acgov.org

ACBH Provider's Website:

https://bhcsproviders.acgov.org/providers

MHS SmartCare User Guide – Registration and Program Enrollment Change Log

Description	Chapter (s)	Version
CalOMS Demographic Reporting - New data values	5 & 6	6.0
Client Address – data entry reminder to use the "Detail" button and other critical address information.	5	6.0
Client Information – **Zip code validation**	5	6.0
InPatient Process: The MHS Registration document, Diagnosis document, and Annual/Discharge document are now each covered in their own respective chapters.	6 - 8	6.0
OutPatient Process: The MHS Registration document, Diagnosis document, and Annual/Discharge document processes are now each covered in their own respective chapters.	9 - 11	6.0
Mental Health Service Registration Document: -Changed staff drop-downs as typeable search text boxes.	9	
Mental Health Registration Document -One program enrollment per Mental Health Registration document.	9	
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  - Search for an existing client
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  - Client ID generation
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3 . Mental Health Services (MHS) - Registration Document & Program Enrollment:
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- We will no longer have print queues

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ACBHD Systems & Data Confidentiality, Security and Usage Agreement Systems & Data Confidentiality, Security and Usage Agreement

Systems
SmartCare, Clinician's Gateway, eCURA, Yellowfin, CANS/ANSA, MEDS, etc.

Purpose
The purpose of this agreement is to establish an environment of security for the electronic storing and usage of client confidential information and records including the usage of portable electronic devices for this purpose.

Background
Any person accessing Alameda County ACBH (Behavioral Health Care) data is required to protect confidential information relating to clients, patients, and residents on a daily basis, and have a duty to protect this information from loss, theft, or misuse whether the information is in paper or electronic form. Additionally, users are required to protect any electronic device assigned to them or in their possession used to gain access to ACBH systems.

Confidential Information
Confidential Information shall include all Alameda County ACBH systems, documents, data, and other materials. User agrees that the Confidential Information is to be considered confidential and shall hold the same in confidence, shall not use the Confidential Information other than for the purposes of its business with ACBH, and shall disclose it only to its authorized employees or other authorized users with a specific need to know. User will not disclose, publish or otherwise reveal any of the Confidential Information and must use <u>secure email</u> for any communications outside of Alameda County regarding confidential information. _____Initial

Secure and Private Work Environment
User is responsible for taking proper security and privacy precautions ensuring a secure and private work environment while utilizing portable devices in order to safeguard client information displayed. _____Initial

Security Agreement
User agrees to the stated required security criteria in order to access and utilize the ACBH systems.

I understand that sharing my account ID and password, client information or any breach of security is a HIPAA (Health Insurance Portability and Accountability Act) violation which may result in prison, fines up to $25,000 and/or revocation of my license. _____Initial

I attest that I have completed HIPAA security and privacy requirements training for protecting the confidentiality, integrity, and availability of protected health information under HIPAA within the past 12 months.

_____   _____   _____
User Signature   User Printed Name   Date

The supervisor agrees 1) to employee's usage of the system and 2) to provide information and direction for secure uses and practices while utilizing network resources.

The supervisor attests that the user has 1) signed an Oath of Confidentiality, 2) signed an Ethical Conduct Policy and 3) been trained in HIPAA security and privacy requirements.

_____   _____   _____
Supervisor Signature   Supervisor Printed Name   Date

18 PHI Identifiers Under HIPAA

1. Names

2. Geographic subdivisions smaller than a state, Geocodes (e.g.-> zip, county, or city codes; street address, etc.)

3. Dates. All elements of dates except year, unless individual is > 89 yrs. (e.g.-> birth date, admission date, etc.)

4. Telephone numbers

5. Fax numbers

6. Electronic mail addresses

7. Social security numbers

8. Medical record numbers

9. Health plan beneficiary numbers

10. Account numbers

11. Certificate/license numbers

12. Vehicle identifiers and serial numbers (including license plate numbers)

13. Device identifiers and serial numbers

14. Web Universal Resource Locator (URL)

15. Internet protocol (IP) address number

16. Biometric identifiers (including finger or voice prints)

17. Full face photographic images and any comparable images

18. Any other unique identifying number, characteristic, or code

What Is SmartCare:

SmartCare™ is a web-based software designed for Substances Use Disorder and Mental Healthcare organizations. Its primary purpose is to facilitate the coordination, reporting, and management of payment for all service delivery processes. With SmartCare, organizations can effectively maintain, protect, and organize health information pertaining to their clients. Furthermore, it serves as a central repository for collecting data used in eligibility determination and for generating local, state, and federal reports.

One of the key strengths of SmartCare is its commitment to being the most open and user-friendly application available in the market. It recognizes the dynamic nature of the health and human services industry and strives to remain adaptable to changing market conditions. SmartCare achieves this by employing an open-architecture framework that allows customers to easily update and expand the system to meet their evolving needs.

By adopting SmartCare, organizations gain access to a comprehensive software solution capable of mapping and incorporating their entire range of business processes into a single platform. This integration enables streamlined operations and improved efficiency. Moreover, SmartCare is designed to grow and evolve alongside the organization, ensuring it can effectively support future business requirements.

Chapter 1: Portal & SmartCare Log In

Logging onto the ACBHD Web Portal

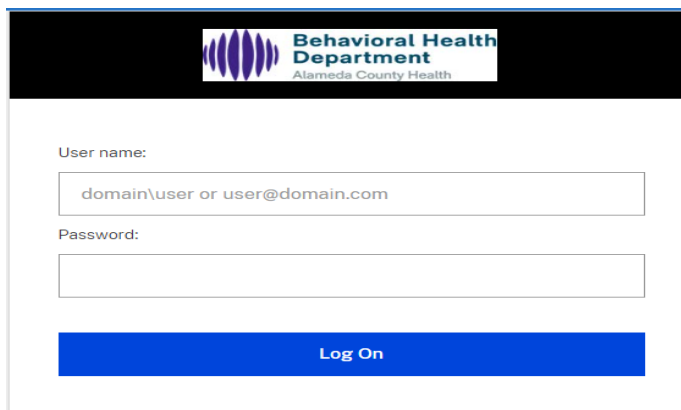You must log in to the ACBHD Web Portal to access SmartCare.

➢ **ACBH Staff** will use the below URL to open SmartCare in the Chrome browser once you log on to the County Secure Network, using ALCO AlwaysOnVPN.

> https://alameda.smartcarenet.com/AlamedaSmartcareProd/Login.aspx?

➢ **CBO Agencies** will use the ACBH Web Portal to access SmartCare.

If this is your first time logging in to the portal the system may prompt a Citrix Workspace installation message. Please follow the prompts and download the Citrix Workspace as needed. If this is your companies managed PC/Laptop, you will need your support team to install the software, as they have Administrative Credentials. If assistance is needed, please contact the Help Desk for assistance.

1. The ACBH Web Portal address is: https://bhcsportal.cloud.com/Citrix/StoreWeb/#/login

2. Type your network Username, and press Tab.

3. Type your network password and press Return or click the Log On button. To protect password secrecy, the password is displayed on the screen as dots.

4. To log in to SmartCare choose the Apps option and select the SmartCare Icon.
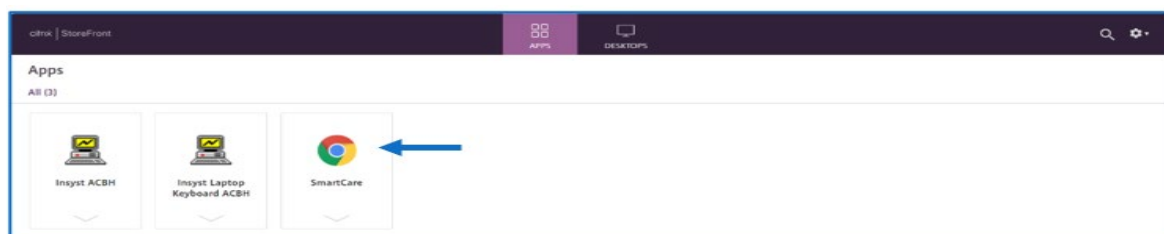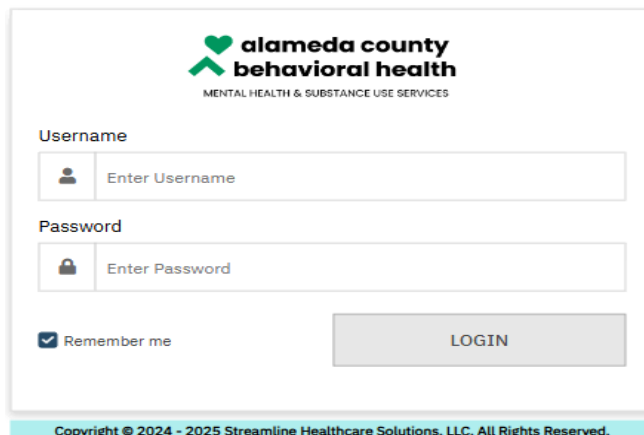
5. Click the SmartCare icon to prompt a new Chrome Window to open the SmartCare Log on Screen.

Logging into the SmartCare System
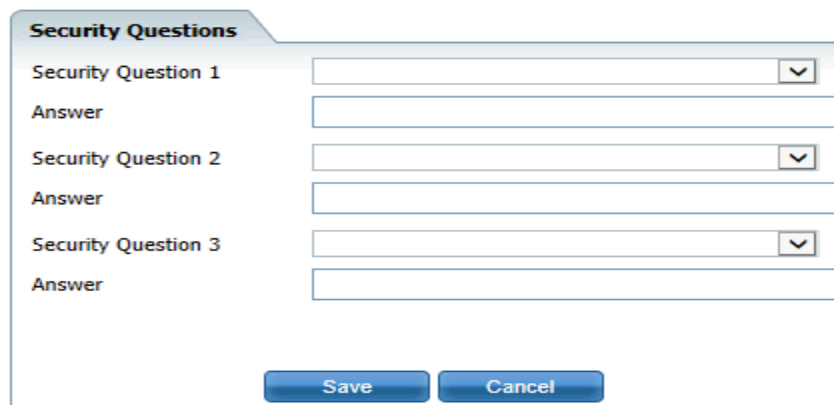
The first time you log in to the SmartCare system, follow these steps:

1. At the login page, you will be required to enter your Username and Password. After entering these two pieces of information, click "Remember Me" so that you will not have to repeatedly enter your password each time you open the application.

2. Click the LOGIN button.

3. After logging in for the first time, the system will now ask you to set security questions.

These questions are to ensure security for logged in users. The answers you enter <u>are **case sensitive**</u>.

If you have logged on previously, the logon will take you directly to one of the security questions you have selected.
Supply the answer and select the "Remember Me" radio button, then click the Submit button.

[What is CDAG](#)

Clinical Data Access Groups (CDAG) ensure that staff only have access to see client chart information in SmartCare that is applicable to the service program (Mental Health or Substance Use services programs) that they serve. When you login into SmartCare you will need to choose between SUD and MHS programs, or between MHS programs as appropriate.

If you are only in one organization/service area this should be seamless to you and you will not see the below screen and will not need to select anything. If a clinician provides both Mental Health and Substance Use services, the provider will be associated with both MH and Substance Use CDAG groups and will be prompted to select a CDAG group when logging into SmartCare. If a clinician provides Mental Health services at more than one program, the provider will be associated with both MH programs CDAG groups and will be prompted to select a CDAG group when logging into SmartCare.
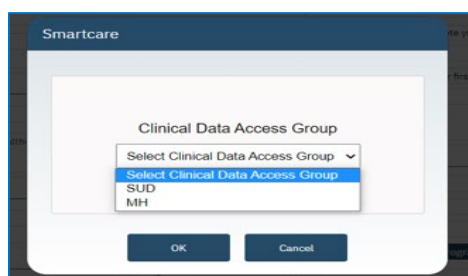
In the below example, Clinician A is logged in as a SUD staff person and therefore only sees the client's SUD services.

After you login, your default home page will be displayed.

Chapter 2: Basic Navigation & Overview of SC System

Users will experience SmartCare as a series of connected modules, all accessible from the Quick Links menu on the left side of screen or from the Search function. SmartCare was designed to enhance the user experience and to provide system users with tools to navigate easily.

Overview

How a user navigates the SmartCare system can vary by preference. See the following section which list the various ways a user can access documents, screens, and reports using the applicable methods.

Title Bar

The title bar sits horizontal across the home screen in SmartCare.

TIP: Hover over a specific tool to display its name.

Common Toolbar Items

The tools displayed on this bar can vary by screen or by the list page you are currently looking at. Below are some examples.

Sometimes the Toolbars are too large for the size of your screen, so if you hover your arrow to the far right of the screen, other tools will appear.

NOTE: Some tools are permissioned, and denied tools will still be visible, but they will appear grayed out.

SC Navigation

Navigation filters above the Quick Links section allow you to sort by Client, Provider, Other or display a list of Quick Links.

Icon	Name
👤	Client
🏠	Provider
📖	Other
☰	All
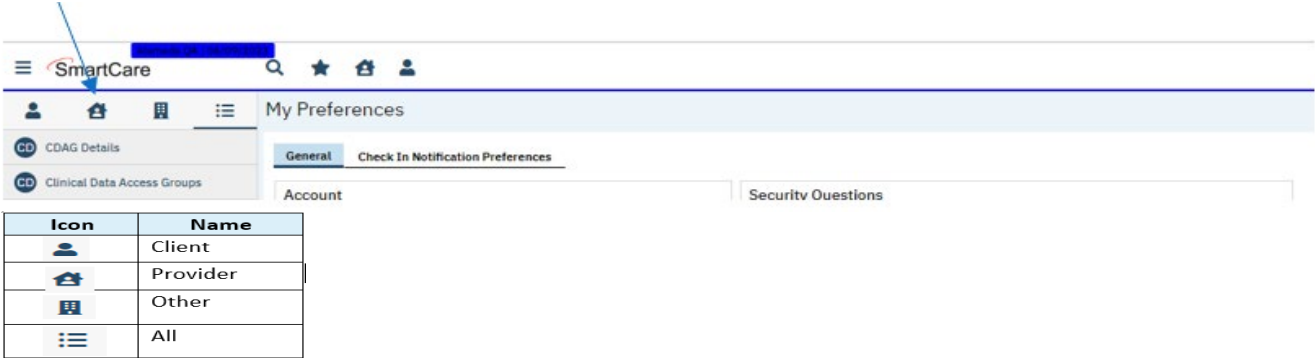
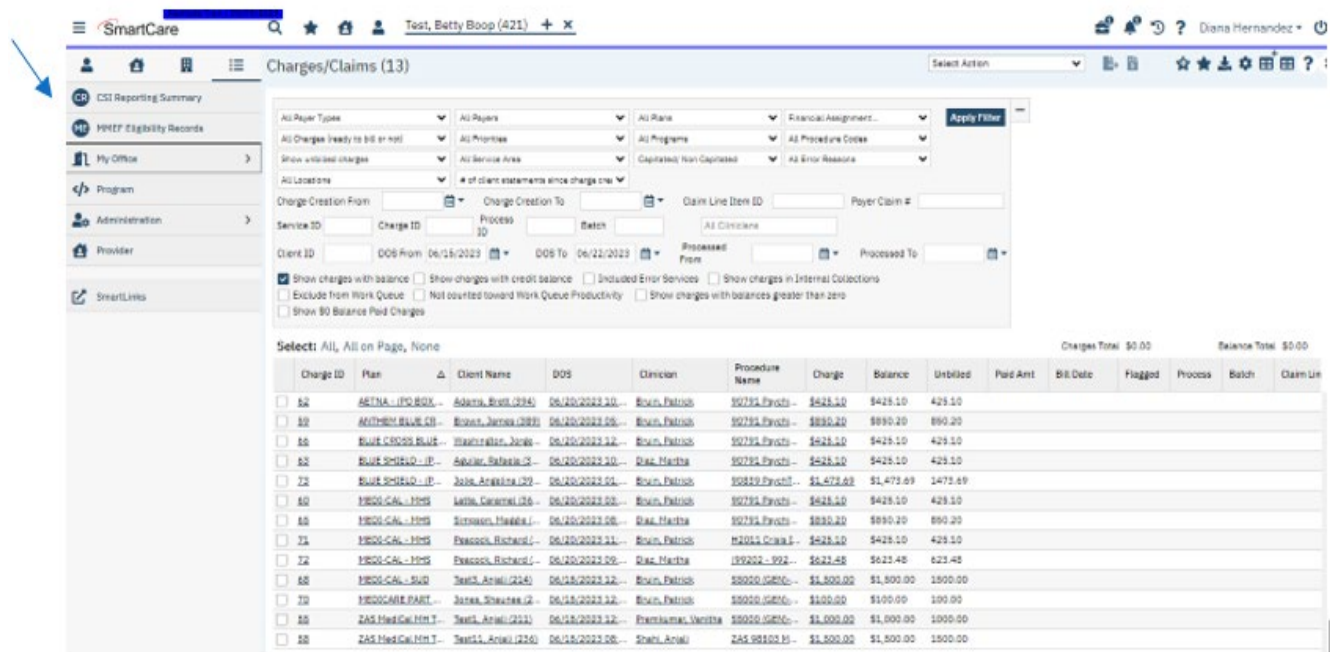**TIP:** By clicking on SmartCare Icon you land back on your SmartCare homepage.

When you log into SmartCare you will want to personalize it to meet your specific business needs. This can be done by personalizing the following areas and the below are descriptions of each one:

1. Quick Links
2. My Preferences
3. Dashboards
4. Widgets
5. List Pages
6. Smart Links

#1: Quick Links

Quick links are a quick way to navigate to specific screens and specific parts of SmartCare. These are meant to be at your fingertips and enable you to do your job. These can be found on the left-hand side of your screen.


You can build and tailor these "Quick Links" to allow you to efficiently navigate between the different aspects of your job, without having to type in what you are looking for. To access and organize your "Manage QuickLinks" feature:

1. Locate the drop-down arrow next to your username in the upper right-hand corner of the screen.
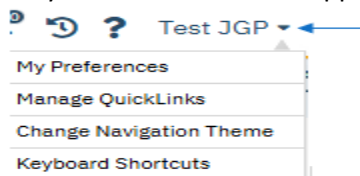
2. Click on the drop-down arrow to open a menu of options and you will see a variety of options.
3. Look for the "Manage QuickLinks" section and click on it.
4. Once inside the "Manage QuickLinks" section, you will have the ability to personalize the QuickLinks navigation according to your preferences.

You can use this section to Reorder, Delete or Edit the Quick Links displayed names.
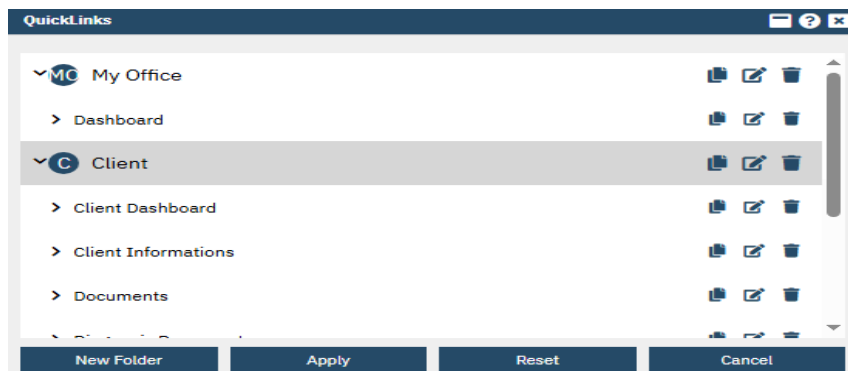
#2: My Preferences

Once you are logged into the system, the first screen you see may be My Preferences. On the General tab, sign-in to set up your default preferences section for the various sections of the SmartCare system.

If this is not the first screen you see, navigate to the "My Preferences" screen by clicking the drop list arrow next to your name in the top right corner of the screen, and select "My Preferences" button.

General Settings Section
In the General Settings section set the following settings:

General Settings

Home Page	Dashboard
Client Page Preference	Client Dashboard
Provider Page Preference	Provider Dashboard
Default Program View	[ ] New Program View...
Diagnosis Search Preference	
Current Clinical Data Access Group	ACBH Administrative

1. **Home Page Dropdown:** Select the name of the Page/Dashboard that you want to open in the "My Office tab" when you login to the SmartCare system or when you click on the My Office tab when in the system. This will be the main page when you login every time.

   Generally, this is set to view 'Dashboard' as shown in the screenshot above. After making your selection, click the 🖫 Save button located under your login name in the top right corner. (IMPORTANT: Be sure to perform a "Save" following any changes while logged into your account).
   NOTE: If a Home Page option is not selected, the system will default to the "My Preferences" screen when you log in.

2. **Client Page Preference Dropdown:** This is the client record that you want to first appear when you open a client page.
   NOTE: If the Client Page Preference is left empty, it will default to the the Client Summary screen which will display when opening a client when you perform a Search or select Open this Client.

3. **Provider Page Preference Dropdown:** This field identifies the Screen to which you are redirected upon selecting a provider in the system.

4. **Default Program View:** Setting a Program View lets you define the programs that you can filter for while using the Program Assignments page. The Program View you set up are displayed in the All Program Views dropdown list on the Filter portion of the Program Assignments page on the Program tab.

   ➢ **Click the New Program View button**. The Program Views window is displayed.
      1. Type the name of the Program View you are creating in the Program View Name field.

      2. Select the checkbox next to each program you want to include in your Program View.

-or-

3. Select the **All** Programs checkbox to have all programs set up in SmartCare listed in the Program View.

4. Click the Insert button.

5. The Program View is displayed in the Programs Views area of the window.

6. To set up another Program View, repeat steps 2 through 5.

   -or-

7. If you are finished setting up a Program View, click the Save button.

You will now be able to select your custom view from the Default Program View drop list.

1. **Diagnosis Search Preference Dropdown:** This is an obsolete. **Not Used.**

2. **Current Clinical Data Access Group:** This is the CDAG role that you have been assigned based on your access to see client information in SmartCare.

#3: Dashboards

The Dashboard is the central page of the SmartCare system. SmartCare main screens are either Dashboards or List Pages that display data and have links. From the Dashboard, you can quickly view pertinent information and access the detailed screens or list pages.

The Dashboard "My Office" is a central screen containing widgets, with real time data, as well as links to important screens for related workflows. Links and widgets can be clicked on to bring you to the displayed information.
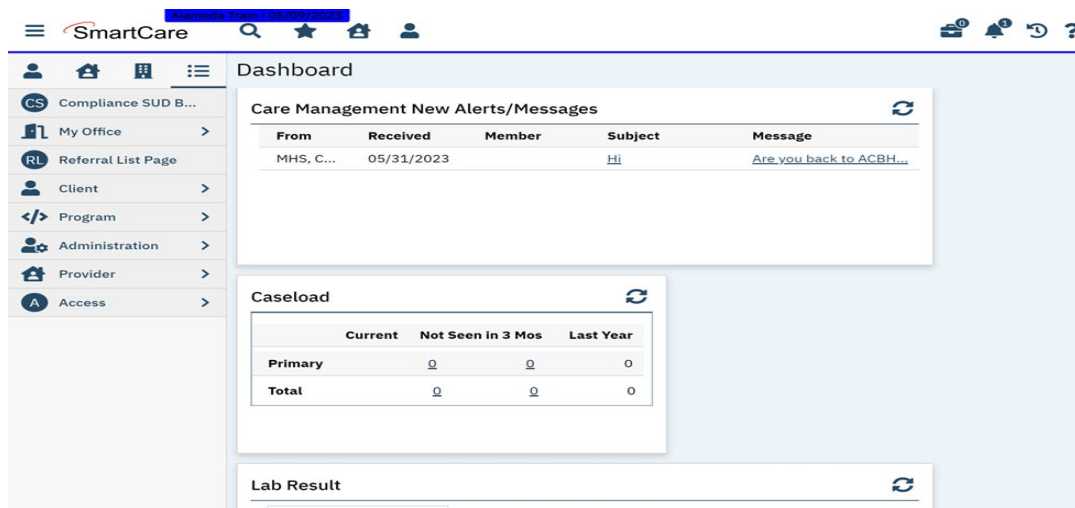
**NOTE:** Dashboards are hub pages, that can be customized and organized to meet your business needs.

In addition, there are specialized Dashboards, e.g. Billing Dashboard, Provider Dashboard, etc. that can be updated with widgets specific to you. You can select which screen is displayed when you sign on and these dashboards can be tailored to meet your specific needs.

TIP: A good Dashboard should never require much scrolling.

#4: Widgets

Widgets gather information that the staff may need to act on, and provide a hyperlink to the page/screen where the staff can drill down or complete the items listed. Information is presented on the Dashboard in the form of widgets.

Each tile on the Dashboard is a widget, that you can resize and edit the display. Widgets are part of the core functionality of SmartCare, and are displayed on the staff's dashboard. You tailor the dashboard through the use of widgets.
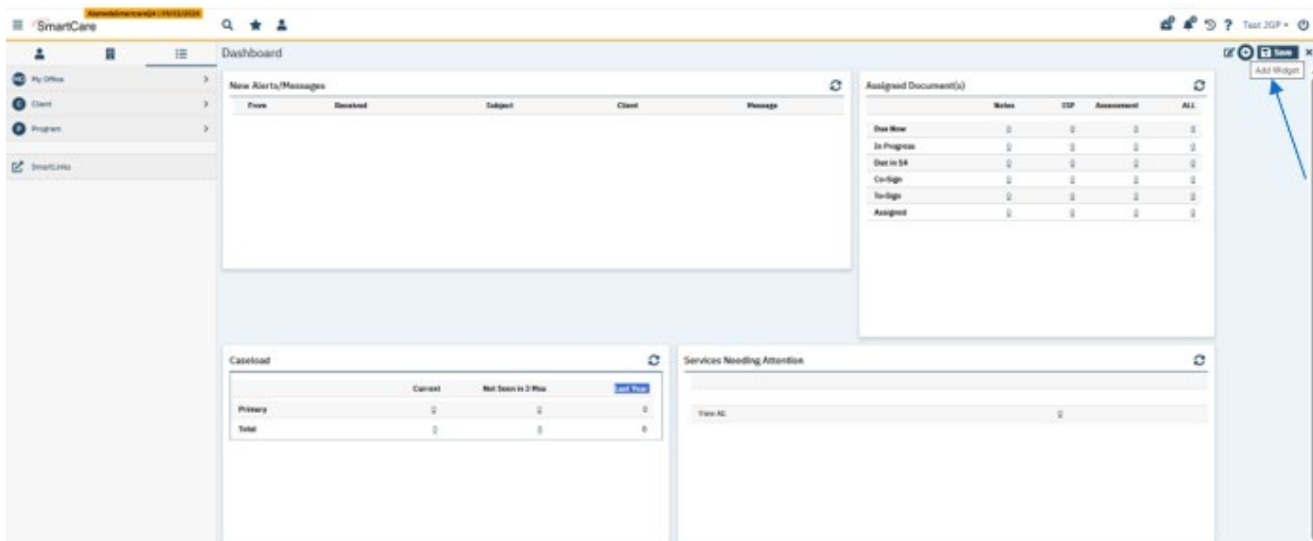
The great news is that you can customize these widgets by adding, removing or deleting a widget to meet your needs.

The order in which the widgets are displayed on the dashboard is determined by the default Order on the Widget Details screen. And widgets are permission based and they should be considered as part of your roles and permissions setup. Only the relevant widgets will be permissioned to each user. This means that although you may want the same widgets as your coworkers, you may not be permissioned the same as they are, and thus would not have exact options.

The "Warnings, Errors, Flags Widget" displays the total number of Services, Charges and Claims that have a system issue and need to be corrected. Like other Billing Widgets, the Warnings, Errors, Flags Widget can be filtered by financial assignments.
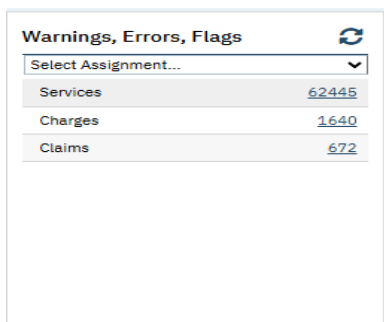
Many Widgets (depending on the kind of information they display) draw their information from and link to List Pages.

NOTE: Click the reload icon   (to refresh the widget. The data in the widget is refreshed/recalculated based upon an auto refresh.

#5: List Pages

Selecting a page will typically take you to a list page where information is summarized. Key information in SmartCare is stored or displayed via List Pages, and entered via Detail Pages and Documents referenced by a specific List Page.

List Pages serve an important role in the management of information. Aside from being the location where information is stored and displayed, List Pages are also filterable to search and sort specific types of needed information.

Data appears in the List. Most columns are sortable, and several fields give basic information on the entry. Click hyperlinks in the entries to navigate to detail pages related to that entry. (For example, clicking the date of service takes you to the Service Detail page, while clicking the Charge link takes you to a Charge Detail page.)

They are also able to be 'Favorited', which allows you to set commonly-used Filters and immediately apply them.

- The <u>My Office tab</u> contains list pages to help you organize your caseload and quickly access information.
- The <u>Client tab</u> contains list pages for services, documents, disclosures and other information.

1. Use the Filters at the top of the List Pages to search for specific information in a list.
   NOTE: If you are not seeing the results you expect, look at your filter criteria.

2. Click on the column headings to sort the list by the selected column.
   - Click the same column heading again to reverse the order of the list based on the selected column.

3. Lists with multiple pages will display page numbers on the bottom.
   - To navigate the pages, there are multiple options: You can select the Page Number, Next/Last, or use the drop-down to navigate through the pages.

#6: SmartLinks

SmartLinks are displayed in the Left Navigation Menu for the staff. SmartLinks are system generated links located in the Navigation sidebar under the QuickLinks. The SmartCare system learns which screens you typically navigate to from the current screen and creates SmartLinks to enable you to navigate there directly.

To help minimize the number of clicks required to get to the screens you frequently use, SmartCare creates SmartLinks to screens, reports, actions, or favorites that you visit regularly. The links in the SmartLinks section change over time depending on your system usage.

#7: Client Flags

Flags are icons used throughout the SC system to point out or mark important information about a client. Permissions can be set on a flag to allow or limit staff from viewing a client's flag(s). To use flags in SmartCare, you can access "Client Flags" in two ways:

1. Go to Client and choose the Client Flags Option.
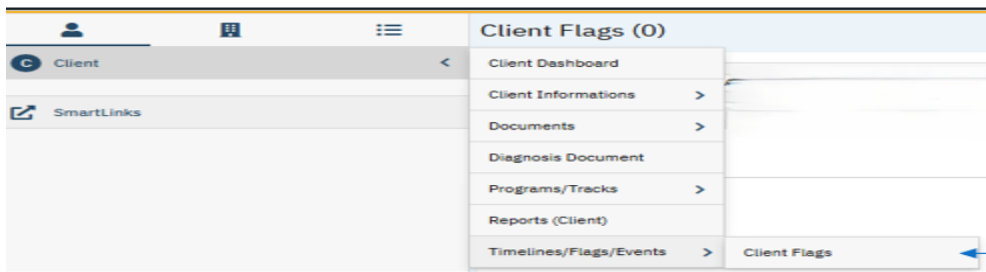
-or-
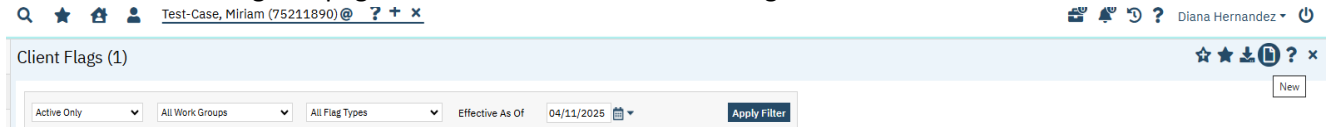
2. Complete a search, by typing in "flag":
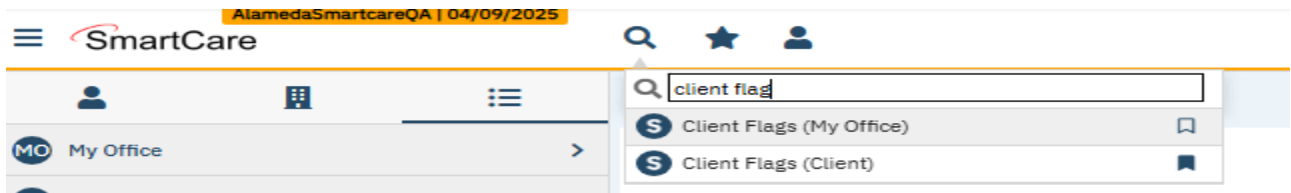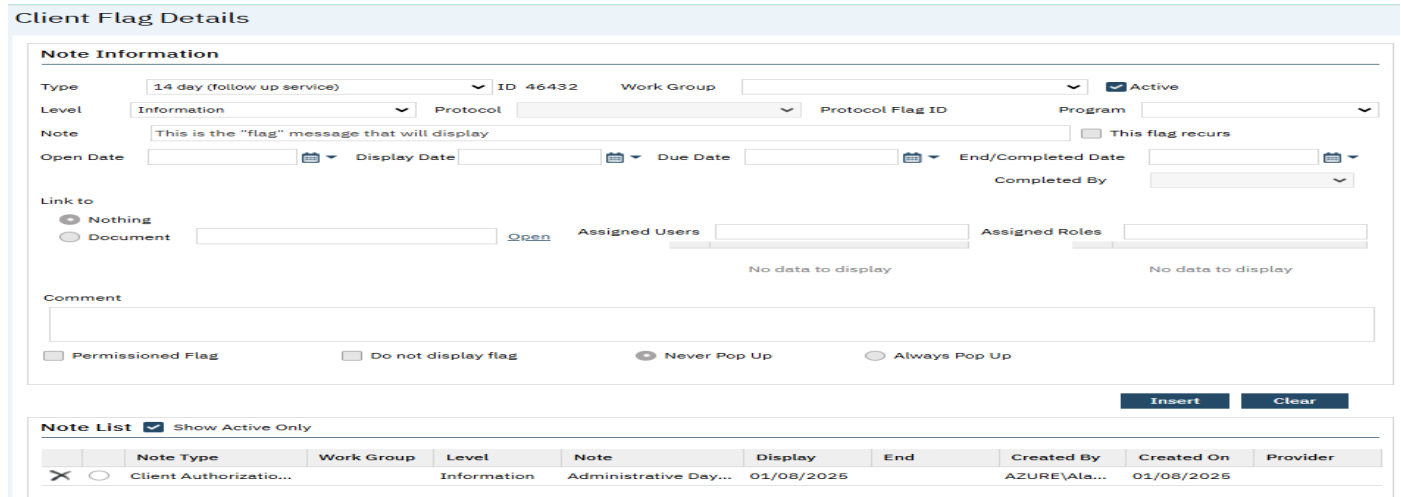
In SmartCare, an event is referred to as a "flag". Each flag can have a due date that can then be tracked and, as the due date nears, can be completed.

Creating a New Flag

1. On the Client Flags list page click on new button to add a flag.
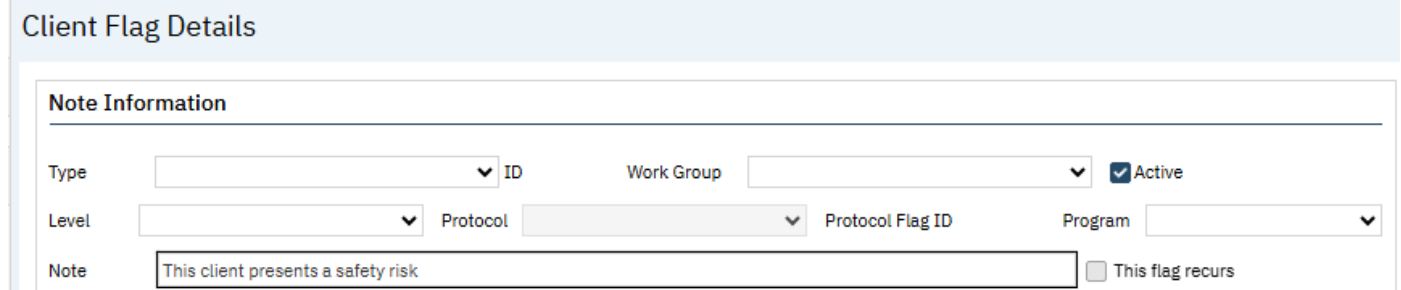
2. Select the "Type" field and a dropdown will appear.

3. The required fields to add a flag are:
   - Type: **Required.**
   - Level: **Required.**
     NOTE: Flags with a "Warning" level will appear on the Client Facesheet.
   - Program: **Required.**
   - Note: **Required.**
   - Open Date: **Required.**
   - Display Date: **Required.**
   - Complete Date: **Required.** This is to be populated when the flag is "Completed".
   - Completed By: **Required.**
   - Due Date: **Optional.**

4. Click on Insert Button

5. Click on Save Button and the flag will be generated.

6. When you hover over the flag you can see the notes.

Testing, Oliver (424) @ ✋ 🔥 + ✕

Self-Harm : Mr Olver Testing is have self-harm issues - Please monitor him closely for the next 72 hours

ails
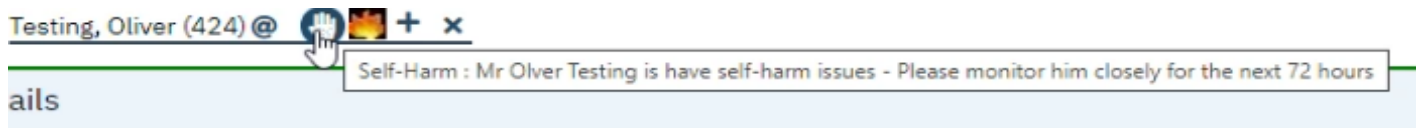
TIP: You can click on the add button to add additional flags.

Testing, Oliver (424) @ ⚠ ✋ 🔥 ➕ ✕

NOTE: When you open up a client record that has a flag associated with it, you will receive a "Flag Alert".

Flags	Start Date	End Date	Flag Type	Notes	Linked Document
?	01/08/2025	No End Date	Client Authorization Changed	Administrative Day DMH, and 12811	

My Office Quick link

My Office quick link contains overall information on all client's records assigned to you based on your security permissions; different roles may view different information.
NOTE: You will have searched for and selected a client prior to looking at the information contained in this section.
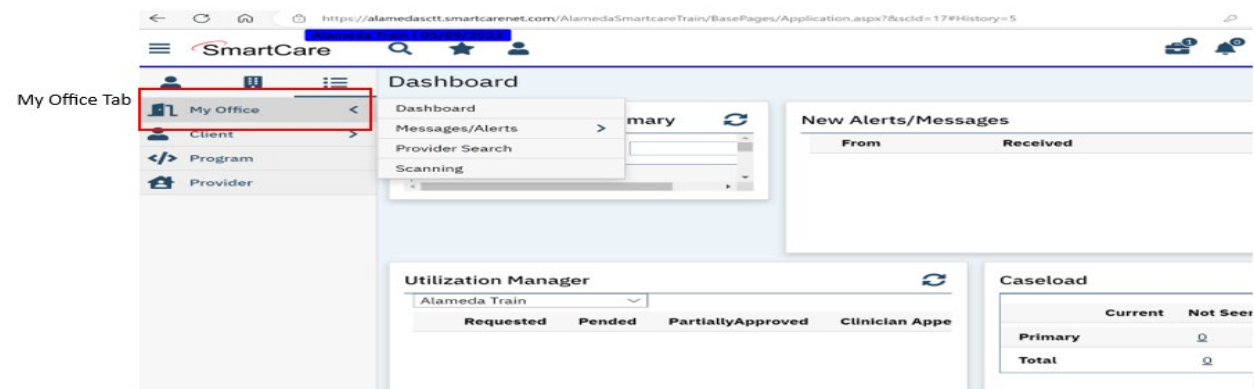
Client Quick link
Client quick link contains information in a client's individual record and will display sub-menus.

Tool Tip: By hovering over client's name, while on Client tab, a Tool Tip will be displayed. This Tool Tip will display information related to the client.
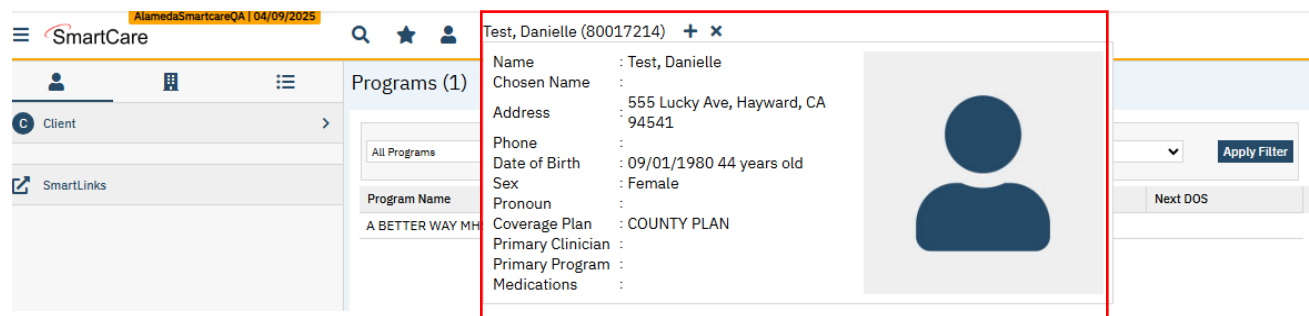
What is displayed can vary by role, depending on your security permissions.
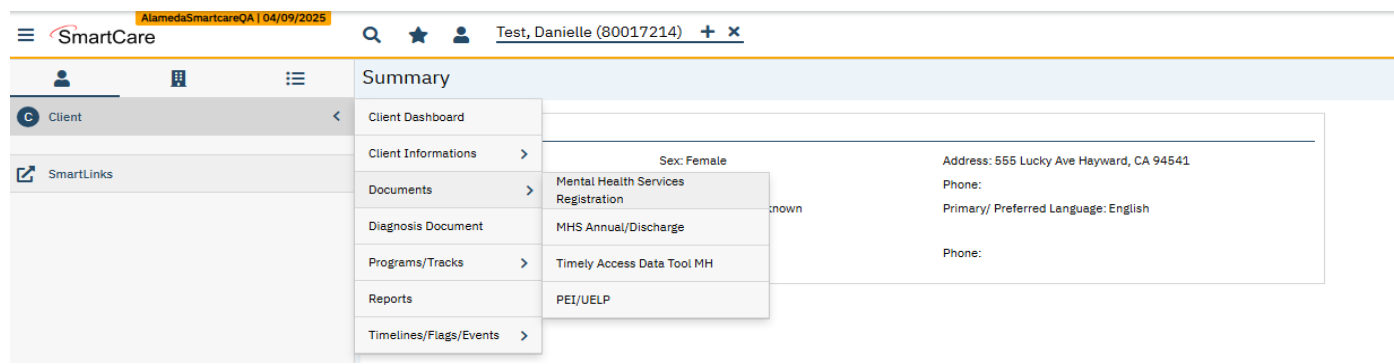
NOTE: This section allows you to see all the Programs and Documents that a client has in one place.

System Quick Tips

1. Use the tab or mouse to move through pages, especially detail screens with multiple fields.
   TIP: Depending on the screen, pressing the tab may be faster and on other screens using your mouse is sometimes faster.

2. Make sure that you select the Save button before moving off a screen.

Commonly Used SmartCare Tools & Icons

| Icon	Name	Description
	New	Will allow you to create a new entry based on the page that is displayed. For example, if the Authorizations page is displayed, clicking this icon displays the Client Search screen so you can create a new authorization for a client, or a new document or list page.
	Search	Enter in a key work and when clicked it will initiate a search for information or content.
	Client Search	Will allow you to search on a specific client name.
	Save	Will allow you to save what you are working on. Click this icon to save your work without closing the page.

Icon	Name	Description
		NOTE: Saving the form is different from signing, as saving does not require all validations to be fulfilled.
	Close	Will close the screen you are currently on and take you to the previous screen.
	Delete	Displayed on certain pages, such as the Inpatient Activity Details page. Click this icon to delete the action displayed on the page. You will not able to retrieve what you delete.
	Spell Check	Displayed on any page throughout SmartCare where there is a free-form Comment field. Use to check the spelling of any text entered in free-form comment fields you completed on the page.
	Export	Click this icon to export the data in the body of a list page into an Excel spreadsheet.
	Favorite(s)	Click this icon to display a hyperlinked list of favorite pages and windows you marked as favorites. Click the link to display the page or window. Use the New Favorite icon to save a favorite page. ▪ Filters are specific to a user. ▪ Filters are not specific to clients. ▪ To create a filter, enter all filter parameters in the list page and click Apply Filter, click on New Favorite(s). This will save the filter that is currently displayed on the list page, enter a filter name, click OK button to complete.
	Information	Provides information about screen/document (who and when created and modified).
	Copy Service	When selected this will open a calendar. Once date and time have been selected, Procedure and Location will copy from original service. ▪ This icon is meant to be used with services.
	Schedule Follow-Up	When selected will open calendar. Once date and time have been selected, Procedure and Location will copy from original service. ▪ This is meant to be used with services.
	Reschedule	When selected it will open a calendar. Once date and time have been selected New Entry Type pop-up will appear, unlike other times this will have a Reschedule option. Select Reschedule and enter cancel reason, then click OK. Service will then open with selected Date and time, Procedure and Location will copy from original service. ▪ This can only be used with Scheduled services.
	Messaging	Allows you to send a message and automatically attach client document to message. ▪ Utilized with Documents.
	Unsaved Changes Briefcase	This briefcase contains items that have not been saved. If you have left pages where you entered or changed data and did not save the page, SmartCare holds onto the changes for a certain amount of time. The information on these pages is held to give you an opportunity to save your work. 1. You can discard these changes by clicking "Discard All" or leave the changes unsaved by clicking the "Review Later" button or you may click "Cancel".

Icon	Name	Description
		2. Unsaved changes should NOT be used to track items user needs to work on, widgets can accomplish this. 3. These changes only remain in your suitcase for 48 hours **BEST PRACTICE:** Try not to have many unsaved changes or keep a document under unsaved changes for too long as items can become corrupted and can no longer be accessed.
	Notification	The Bell icon lists active messages and notifications. Select each from the dropdown to read and resolve it.
	History	Allows you to quickly access the last screens or clients within a logged in session. Use to view all the pages you have accessed in this session in the sequence accessed. Click the tool to return to a specific page. 1. It will also list client records that have been opened within a logged in session. 2. When you log out of the session, your history will be erased. 3. The history window displays the last 13 QuickLinks and/or clients you have accessed in your current SmartCare session.
	Logout	Displayed on the Title bar. Click the icon when you are ready to sign off and close your session in SC.
	Help	Displayed on all SC pages. Use this to display help on the specific SC module. **NOTE:** Not all Help sections contain current SC application information and currently does not contain ACBH work processes.
	Validate	After completing a section, you can hit the validate button and the system will specifically highlight what fields are required, that you might not have chosen or any issues that it is finding while it is validating. The validation button in SmartCare serves as a helpful tool to ensure that all necessary data is provided and that any errors or discrepancies are identified. **NOTE:** SmartCare currently does not indicate what fields are required with an asterisk (*). Until this is implemented, use this feature to identify required fields.
	Edit	When clicked, it opens a form or document where the user can modify the selected information.

Based off of the R6.4 Navigation User Guide

Additionally, there is a drop list next to your logon name on the top right corner of the screen, which provides a few options for your account.
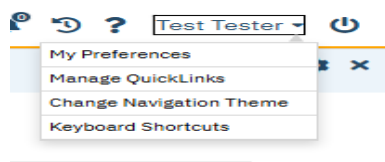
Chapter 3: Use of Documents Within SmartCare

Documents

Information is not entered through dashboards or list pages, instead most information is entered into SmartCare by use of documents and detail pages. Documents are individual iterations of a template, and many List Pages are lists of Documents.
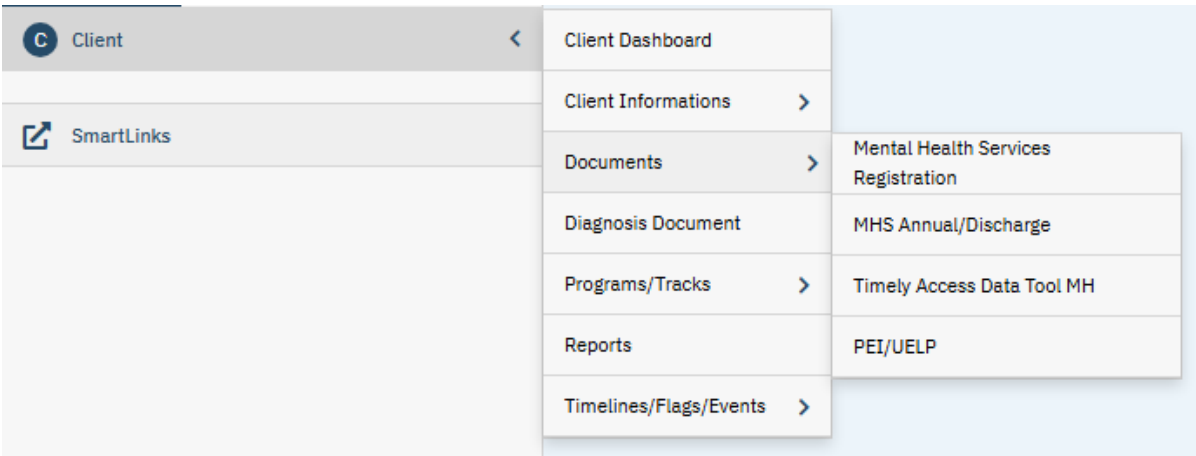
Modifying Documents

SmartCare does not have the functionality to delete a specific version of the document.
NOTE: The action of <u>Erroring a document 'deletes'</u> the whole document including all versions.

When searching the SmartCare system for certain documents, list pages, or reports the system will automatically assign "S" for screen or "R" for report to identify which type of module you are working in.

SmartCare Documents are pages that allow you to enter data into specific fields and you have the ability to save the overall document to its associated client or to a system record. Most Documents are informational – they record MHS Registration, Program Enrollment, Admissions, Discharges, and Annual data.

NOTE: You cannot bill Services from Documents alone, and a MHS Program Enrollment is required to complete Service Entry. Use of documents allows information to be pulled for Reporting, State Reporting, etc. and used for initializations, or checked against validations.

Example of a Discharge Document:

Example of a Discharge pdf:

Detail Pages

Detail pages are specific to certain types of data entry, they are not typically signable and do not generate pdf. They contain a great deal of information about a specific action, event, or record, e.g. Service Entry.

This Detail page lists all applicable data related to a single Service on a specific date for a specific client. Completed Detail pages are locked for recordkeeping purposes, while new or active Detail pages are editable.

Information is entered directly into each tab and field, while actions related to the Detail page as a whole can be taken via icons on the toolbar. Detail pages are not typically signable and do not generate a PDF.

Completed documents and detail page entries will be accessible through the appropriate list page.

Client Records

The Client Record contains client information, entered into SmartCare concerning a client.

➢ The Client Search feature allows you to search from a pool of clients and select a client record or create a new record.
➢ Having a Client Record selected does a number of things in the system: it allows you to take actions that impacts registration, it allows you to run reports on the client, and it configures all client data-focused Widgets to display information on that Client via the Client Dashboard.

Scan and Upload Documents

SmartCare has the ability to scan and upload documents and it is currently not in use. This functionality will enable users to upload and scan various medical documents such as Medi-Cal cards, Authorization documentation, Driver's Licenses, and much more.

Chapter 4: Client Search

Before you can work with any client information in SmartCare, the client must have a SmartCare Client ID. If a client is new to your program, you must determine whether the client has a Client ID in SmartCare, by using the Client search screen, described below. If you cannot find an assigned Client ID, a new Client ID is needed, see Chapter 5 for instructions.

NOTE: It is possible that a client could have multiple last names, multiple first names and aliases, etc. To prevent creating a duplicate client and before registering a new client be sure you have tried all possible spellings of the client's name and aliases.

Preventing Duplicate Client Registration

- If there is a Social Security Number (SSN) in the system that is the same as the SSN you are searching for, the system displays an error message and does not let you continue.
    - You ***cannot*** override a Social Security Number match.
    - If you are sure that the SSN you entered is correct, reach out to the eligibilityhelpdesk@acgov.org.

- If there is a client in the system with the same name and same birth date you are searching for, you will need to review the client list to prevent creating a duplicate client.

- If two different clients have the exact same name and same birth date, they may be a duplicate.

The following fields are part of Client Search, which will provide more details for the search output. You must carefully review each individual client information field to prevent creating a duplicate client. Review the following to determine if this is the same client.

- Address
- Phone number
- SSN
- Sex
- Race
- Ethnicity
- Marital Status
- Primary Language
- Alias
- Primary Insure Id
- Primary Plan

NOTE: If they have the same/similar names, same birthday, check with the client to determine if they have a twin.

NOTE: For updates to the Client Name, Date of Birth (DOB) or Social Security Number (SSN) please reach out to the eligibilityhelpdesk@acgov.org.

[Begin Client Search](#)

1. Click on the Client Icon at the top of the SmartCare window to activate the client search option.

2. Click on the <Client Search> button to activate the Client Search screen as shown below:

NOTE: This screen supports bidirectional scrolling to explore additional search details.

Additional fields have been added to Client Search to provide more details for the search output: Sex, Race, Marital Status, Primary Language, Alias, Primary Insured ID, and Primary Plan.

BEST PRACTICE: To optimize the Client Search enhancement:
  ➢ Please be sure to complete all fields when entering client data.
  ➢ These additional field data should significantly help identify clients when searching for a client.
  ➢ This will help reduce the number of duplicate clients in the system and improve data integrity.

[Client Search Field Definitions](#)
  i.   Client Name: **Required.** If unknown enter Jane or John Doe with DOB 1/1/1900.

  ii. Social Security Number (SSN): **Required.** The Social Security Number is the fastest way to find the client. If you have the client's SSN (not all 9's), enter the SSN in the SSN Search field, and click the SSN Search button.

iii.   Date of Birth (DOB): **Required.** Enter date of birth, if unknown use 1/1/1900.

iv.   Master Client ID Search: **Optional.** Use this field to search by the Clients SmartCare ID.

 v.   Client ID Search: **Optional.** Use this field to search by the Clients SmartCare ID.

vi.   Insured ID Search: **Optional.** Use this field to search by the Client's coverage plan # i.e. Medi-Cal ID, BIC #, CIN Etc.

There are two types of searches available:
> **Broad Search** looks for names containing the letters represented in the search field, but also may have additional characters.

> **Narrow Search** is for looking to find exact matches to the name in the field.

3.   Enter the Client's last name and first name and Click the "Broad Search" button
NOTE: There is a minimum of 3 characters required to search.   Broad Search

If the Client's name search results in: ❌ No Search Records Found

4.   Enter the Client's SSN and click the SSN Search button   SSN Search

If the Client name search and the SSN search results in ❌ No Search Records Found

5.   Enter the Client's DOB and click the DOB Search button   DOB Search

These three combinations will most likely provide results – the search results are found on the Records Found section of the Client Search screen:

	ID	Master ID	Client Name	△	Chosen Name	SSN/EIN	DOB	Status	City	Primary Clinician
⦿	243	243	Testing, Zee			9999	01/01/19...	Active	Oakland	

Records Found

6. Carefully review the Records Found results to determine if the client you are searching for is listed, once you find your client **select your client using the radio button as shown above and click on the Select button**

Create New Potential Client | Select | Cancel
Registration | Inquiry (Selected Client) | Inquiry (New Client)

7. At the top of the SmartCare window next to the Client Icon, you will find the Client Name and Client ID.

≡ SmartCare 🔍 ★ 🏠 👤 Testing, Zee (243) + ✕

👤 🏠 🏢 ≔ Client Information
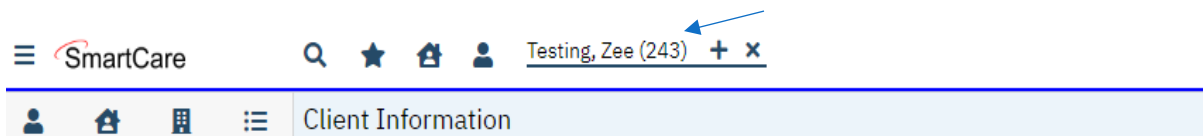
🛑 **Next step requires moving to the Client Information Screen document to capture required data fields**

Chapter 5: Create a new Client ID

Before registering a new client, be **100**% sure you have tried all possible spellings of the client's name and client's alias names to prevent creating a duplicate Client ID. If you cannot find a client using the Client Search Screen, you must activate the *Create New Potential Client* option to generate a Client ID before you can start the Mental Health Services Registration document to Enroll/Admit the client to a Program before entering Services.

NOTE: Follow the ACBH Client Registration & Client Naming Convention Rules below to generate a new Client ID, the Rules can also be found in Appendix.

Client Registration Rules & How to Ask the Right Questions:

1) *What is your name on your CA ID/ID or DL? (Field Name: **First Name, Middle Name & Last Name**.)*
2) *What is your preferred name? (Field Name: **Aliases - Preferred Name;** First, Middle & Last.)*
3) *What is your Gender Identity?* (Field Name: **Gender Identity**.)
4) *What is your sex of record on your Medi-Cal account (Male/Female/Not Listed)?* (Field Name: **Sex,** one selection allowed of M/F/NL. If client does not know-select Not Listed.)
5) *What is your Sexual Orientation?* (Field Name: **Sexual Orientation**, multiple selections allowed.)
6) *What are your Pronouns*? (Field Name: **Preferred Pronoun,** multiple selections allowed.)
7) *W*hat is your Date of Birth listed on *your CA ID/DL or on your birth certificate*? (Field Name: **Date of Birth**)
   NOTE: *If clients name and/or DOB are unknown or unable to obtain:*
   - **Will be listed consistently as: Jane or John Doe with DOB 1/1/1900.**
   - *All other fields above are listed as unknown if client does not answer the questions.*

Client Naming Convention Rules

Because the information entered in the Client Registration screen establishes the client's identity, it is best to ask the client for a form of ID (CA ID, DL, SSN Card or other document) to be used for entering the client demographic data.

Three critical pieces of information must be entered correctly:

1. Client Name
2. Birth Date
3. Social Security Number

Client Last Name:
- Enter a last name as listed on the CA ID/ID, SSN Card or DL
  - LEAVE OUT apostrophes and blank spaces
    - "O'Connor" should be typed "OConnor"
    - "Torres Smith" should be typed "Torres-Smith"
  - DO NOT enter Jr., Sr., etc. in the Last Name field, these are to be entered in the *Suffix* field
  - DO NOT enter spaces in front of name

Client First Name:
- Enter a first name as listed on the CA ID/ID, SSN Card or DL
  - Leave out apostrophes and blank spaces

o   DO NOT enter spaces in front of the name

Client Middle Name (optional):
- Enter a middle name as listed on the CA ID/ID, SSN Care or DL
  - o   Leave out apostrophes, dashes and blank spaces
  - o   DO NOT enter spaces in front of name

Client Suffix:
- Enter the client suffix title that is part of the client's name, such as Jr., Sr., or the Roman Numerals II, III, etc.

NOTE: SmartCare requires three (3) basic searches before the system will activate the *Create New Potential Client* button to create a new Client ID. Ensure that each of the below search buttons are completed.

1. **Broad Search** Enter the client's last name and first name and Click the "Broad Search" button.
   TIP: There is a minimum of 3 characters required to search.

   Broad Search

2. **SSN Search** Enter the client's Social Security Number and Click the "SSN Search" button. The Social Security Number is the fastest way to find the client.
   When SSN is unknown, enter all 9's. e.g. 999-99-9999.

   SSN Search

   NOTE: Crucial SmartCare functionality and reporting will be broken if an incorrect SSN is entered into SC.

3. **DOB Search** Enter the client's date of birth. When DOB is unknown use 1/1/1900.
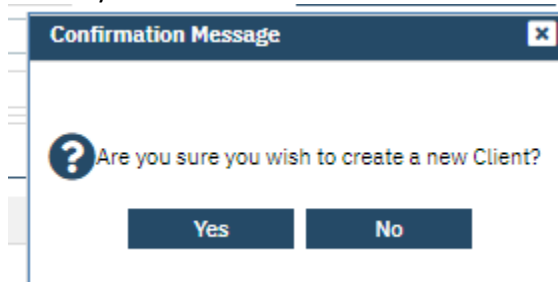
   DOB Search

Enter basically the same information as used for Client Search - **Modify As Needed.**

NOTE: The "Create New Potential Client" button will be grayed out until the 3 basic searches are completed.

Create New Potential Client

4. Click **Yes** when asked to confirm you want to create a new Client.

   Confirmation Message

   ? Are you sure you wish to create a new Client?

   Yes   No

The new Client ID will appear on the top of the SmartCare screen next to the Client Icon
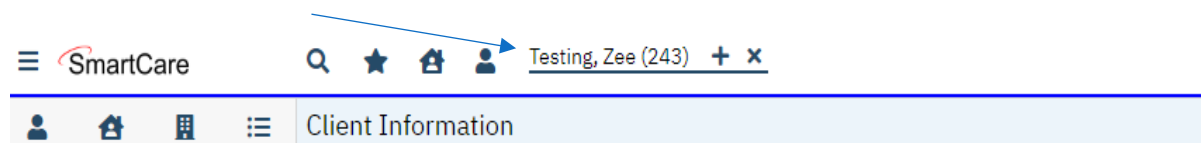
NOTE: **The workflow for completing the Client Information screen is as follows:**

1. General Tab – **Required.**
2. Aliases Tab – **Required.**
3. Demographics Tab - **Required.** Identifying information section is required; other sections are not required.
4. Primary Care Referral Tab **– Not Required.**
5. Release of Information Log **Tab – Not Required.**
6. Contacts Tab (Client) – **Optional.**
7. Client Episodes Tab - **Not Used.**
8. Family Tab – **Not Used.**
9. Custom Fields Tab - **Not Used.**

#1: General Tab

The general tab contains general information about the client such as name, e-mail address, phone number, address, etc. If an Inquiry was performed and/or Client Information was updated, some fields are already populated on this tab.

Data fields on the "General Tab" should be initialized from the client search screen, enter in the remaining required fields and click save.

General Information Section: **Required.**

1. Type of Client: **System Informational Field Only**.
2. Client ID: **This information will auto be populated**.
3. SSN: **This information will auto be populated**.
4. Primary Clinician: **Not Used.**
5. Primary Physician: **Not Used.**
6. Prefix: **Optional**.
7. First Name: **Required**.
8. Middle Name: **If Applicable.**
9. Last Name: **Required**
10. Suffix: **If Applicable**.
11. Email: **Optional.**
12. Medi-Cal ID: **This information will auto be populated**.
13. Active: System **Informational Field Only**.
14. **Professional Suffix: N**ot Used.**
15. **Medical Beneficiary ID: Not Required.**
16. **Patient Portal ID: N**ot Used.**
17. **Addresses: Required.**

Phone Numbers Section

Collection of client phone numbers is **optional**. Should you collect a telephone number and want to input it into a client record select the phone number field applicable and enter the 10-digit phone number.

o   Do not call (DNC): **Not Used.**
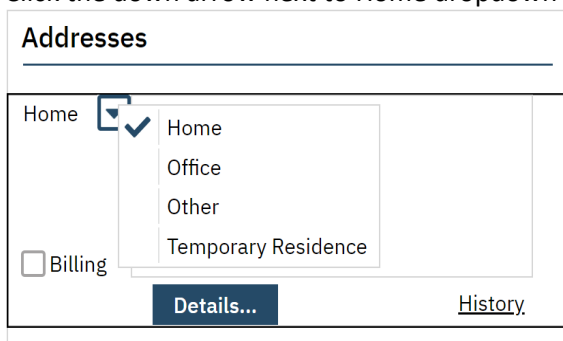o   Do not leave message (DNLM): **Not Used.**

Any of the Phone Number fields can be redefined to the values shown in the pop-up window below. Click the down arrow next to the field whose title you wish to change and select the new title from the pop-up list.

Addresses Section Required.

A client address is **Required.** To enter a client address, complete the following.

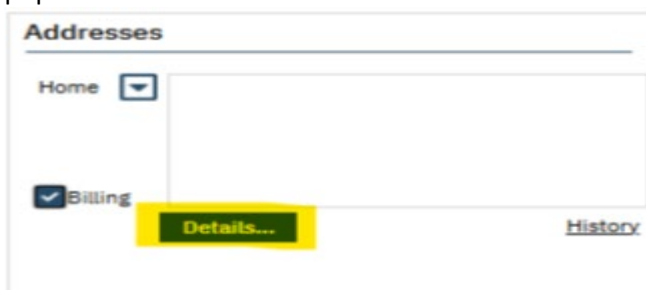1. Click the down arrow next to Home dropdown to add additional address types.

> **NOTE:** The address option is required to be "Home". This is required for claiming purposes and can cause services to be rejected if not. Please do not select any other option.
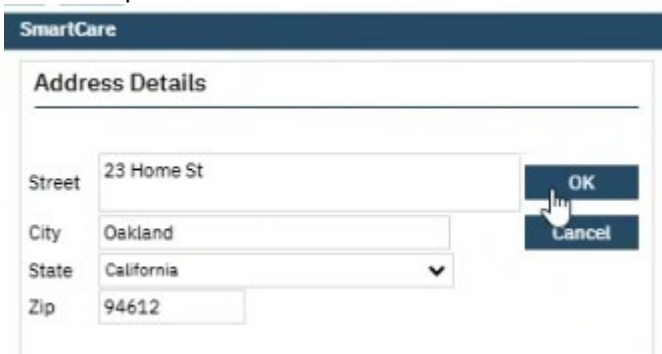
2. Click the Details button and a data entry pop-up window will display the specific fields that need to be populated.

> **NOTE: DO NOT copy/paste the address to the Addresses field**, as any formatting discrepancies will cause issues when claiming and will cause the claim file to be rejected.

3. Once complete select "OK".

4. **Billing Checkbox: Required.**

NOTE: The <u>Billing Checkbox must be checked</u>, this is required for claiming.

NOTE: Due to the increased number of SmartCare system issues related to client address, please remember to add or update the client address by using the address **"Details…" button**. Adding or updating a client address **without** using the "Details…" button will generate system and claiming issues.

    i.   <u>Do not copy and paste</u> the address into the address text field, any formatting discrepancies will cause issues when claiming.

    ii.   The client address must be added to the individual Street, City, State, and Zip fields displayed once the "Details…" button is selected

    iii.   When entering in suffixes, please <u>do not use Punctuation</u> when entering these into the SC System. A list of Address suffixes can be found in the Appendix.

NOTE: When the **service is rendered at the location code of Home**, the client must have a <u>valid "home address"</u>.

    i.   <u>No Homeless, no Unknown, no PO Box can be used,</u> as the service will be denied by DHCS <u>without</u> a home valid address. A valid address is required to render a service at home.

NOTE: The address type is "Home", even if they are Homeless.

    i.   If the client is Homeless enter **"Homeless"** for Street and 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).

    ii.   Please see the SmartCare Appendix A: Global Code Tables for the City Hall Codes use for Homeless Client Address table.

    iii.   To claim the service, the address must be either **"Homeless" or "Unknown",** <u>these are the only two values that are accepted by the State</u>. Wording such as transient, under the bridge, unable to identify, all these types of content are not acceptable by the State and will cause the claim to be rejected.

• **Zip Field:** When the user selects State without entering the Zip code, then upon saving, a validation message is displayed as below:

    Validation Message:
    General - Please enter the Zip
    Contacts - Please enter the Zip
    NOTE: Use this postal services tool to look for a Zip Code to verify that the Zip Code is correct.
    https://tools.usps.com/zip-code-lookup.htm?byaddress

    NOTE: You are **no longer required** to enter the +4 in the zip code

• **State Field:** When the user enters only the Zip code without selecting State, then upon save, a validation message is displayed as below:

    Validation Message:
        General - Please enter the State

Contacts - Please enter the State

• When the **combination of State with Zip code** is mismatched or Zip code is missing in the database, then upon save, a warning message is displayed as below:

> ***Warning Message:***
> > *General - Zip code and State combination do not exist*
> > *Contacts - Zip code and State combination do not exist*

IMPORTANT: SC System does not validate 'City' resides within 'State' or 'Zip Code'. Users must ensure that City is valid within the State and Zip Code.

NOTE: *To verify that the Address information is correct use this Postal Services tool -* https://tools.usps.com/zip-code-lookup.htm?byaddress

TIP: If you click on the "History" link, you will find a list of all the previous addresses that have been entered.

Comments Section: **Not Required.**
You may make any additional comments about client special needs or other items important to note in the textbox.

#2: Alias Tab – **Optional.**

Once you have entered client's general information, if the client has an alias use the Aliases Tab to enter the alias information.

The purpose of gathering alias information is to provide an additional means of searching for a person's name. By including aliases or alternate names that an individual may be known by, the search capabilities of the system are enhanced. This allows for a more comprehensive and accurate retrieval of information when conducting searches or generating reports.

In many cases, individuals may have multiple names they are known by, such as nicknames, maiden name, or previous legal name. By capturing and storing this alias information within SmartCare, the system can broaden its search parameters and increase the likelihood of finding relevant records associated with the client.

Enter this information when registering a client.

1. If the client has ever used an alias, enter them under the "Alias Tab". You may enter as many aliases as needed via the Client Information Screen.

2. Enter Alias information, e.g. First name, Middle Name, Last Name.

3. Assign "Alias Type" by selecting Dropdown Menu.

4. "Allow Search" check box is auto populated with a check, which enables the search criteria.

5. If the Alias is what they would like to use as their primary name, please click the "Chosen Name" checkbox.

6. Select "Insert" and then "Save". If you don't save it, it will appear in your suitcase or can be lost.

7. Once an Alias is generated and inserted to a client record the Alias will appear on the "List of Alias" table and will appear in searches if you select the allow search box.

The above shows a list of the aliases for this client.

#3: Demographics Tab – **Required.**

Identifying Information Section: **Required.** Complete the required fields.

- Date of Birth: **Prepopulated data.** Date was entered during the detail client search.

- Age: **Prepopulated data.** Age was calculated based on Date of Birth.

- Sex**: Required.**

- Marital Status: **Required.**

- Gender Identity: **Required.** Click on the drop-down list and select the Gender Identity.

- Sexual Orientation: **Required.** Click on the drop-down list and select the Sexual Orientation.

- Deceased On: Completed by ACBH Staff. **If this field is available, please <u>do not</u> complete.**

- Cause of Death: Completed by ACBH Staff. **If this field is available, please <u>do not</u> complete.**

- Pronoun: **Required.** Click on the drop-down list and select the Pronoun.

- Ethnicity: **Required.** Check all appropriate checkboxes.

- Race: **Required**. Check all appropriate checkboxes.

- Client declined to provide: **Not Used.**

Primary Care Physician Section: **Not Required.**

Financial Information Section: **Not Required.**

Living Arrangement Section: **Not Required.** This section is completed using the Mental Health Services Registration document.

Educational/Employment Section: **Not Required.** This section is completed using the Mental Health Services Registration document.

Language Section: **Not Required.** This section is completed using the Mental Health Services Registration document.

Transportation Information Section: **Not Required.**

Preferences Section: **Not Required.**

#4: Primary Care Referral Tab – **Not Required.**

#5: Release of Information Log Tab – **Not Required.**

#6: Contacts Tab – Client Information Screen.

NOTE: This tab is **"Optional"** at time of registration, but if you choose to utilize it, there is required minimum information.

This tab is used to add records indicating additional individuals that are important to the client's care. When you navigate to the tab the first time, the "List of Contacts" grid is empty if there are not already any contacts listed in the client's record.

The Registration form must be saved before you are able to add a new contact.

NOTE: Saving the form is different from signing, as saving does not require all validations to be fulfilled.

Client Information Contacts Tab Required Fields:

- Relation: **Required**. Select the relationship the contact has with the client.
- First Name: **Required**. Enter the contact's first name.
- Last Name: **Required**. Enter the contact's last name.
- Select what the Contact relationship is to the Client. **Required**.

Add a new contact or modify an existing contact by following the steps below.
1. Click the Add/Edit Contacts button. The Client Information screen opens to the Contacts tab.
2. Complete the areas on the tab and click the Insert button. Refer to Client Information Contacts Tab Field Definitions for information about each field.

#7: Client Episodes Tab - **Not Used.**

#8: Family Tab – **Not Used.**

#9: Custom Fields Tab - **Not Used.**

Once complete click **"Save"** to finish capturing all data.

Chapter 6: InPatient Mental Health Services Registration document

CSI Periodic Reporting Data

The CSI Periodic data is no longer captured on a separate screen.

A Periodic record describes the current education, employment, conservatorship/court status, living arrangement and caregiver status for a person. The information in the Periodic record is used to measure the effectiveness of services.
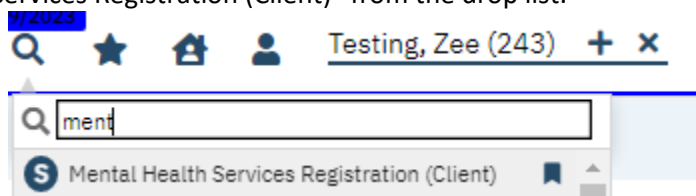
The data is reported at time of Program Enrollment, Annually and at formal Discharge. Completing the Mental Health Services Registration document, captures the Periodic data at time of Program Enrollment. Annual and Discharge data will be captured on the MHS Update/Discharge Document.

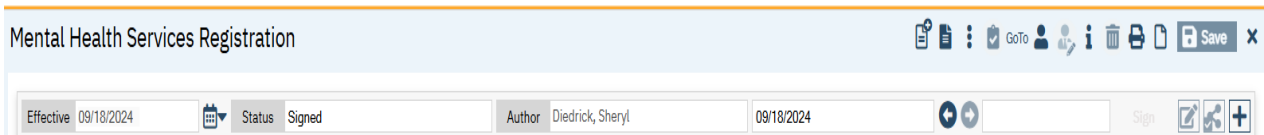## Mental Health Services Registration Document

The Mental Health Services Registration is used to capture required data fields for **Client Information/Demographic** and opening an **Admission using the Program Enrollment**. A new Mental Health Services Registration document will need to be created for each program enrollment.

A new Mental Health Services Registration document is created by completing the following steps:

1. Click on the Magnifying Glass and enter the search term "Mental".

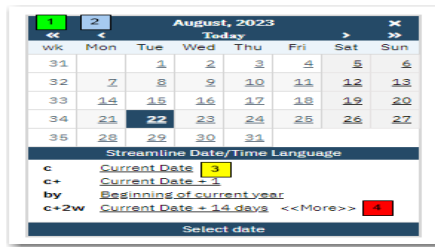2. Select "Mental Health Services Registration (Client)" from the drop list.

3. SC Document Navigation Bar: The first item at the top of the resulting page is the Document Navigation Bar which represents data for the Effective Date of Registration, the Status of the document completion, the Author, and the creation date.

You will want to make sure you periodically check the status of your documents, e.g. New, In Progress, especially following saving any information, as moving onto other processes before completing registration will cause errors.

TIP: Clicking the double angle brackets (<< or >>)(1) in the calendar navigates you backward or forward by one year. Clicking the single angle bracket (< or >)(2) navigates you backward or forward by one month. For pre-set dates, click the applicable hyperlink (3) in the Streamline Date/Time Language section at the bottom of the pop-up calendar. Additionally, using keystroke shortcuts, you can populate the date field with information. There are additional shortcuts listed when you click the <<More>> link (4).

4. Tabs act like separate pages or sections on a document, typically containing different categories of information. The tabs <u>required</u> to complete/sign the Mental Health Services Registration document are noted in **red** font below, the other tabs are available but not required at this time:

Tabs:

  #1: Program Tab – **Required.**
  #2: Episode Tab – **Required.**
  #3: General Tab – **Required.**
  #4: Demographic and Client Information Tab – **Required.**
  ~~#5: Client Contacts Tab~~ – **Optional.**
  ~~#6: Insurance Tab~~ – **Not Used.**
  ~~#7: Forms and Agreements Tab~~ – **Not Used.**

Mental Health Services Registration Screen

TIP: Since you have the newly created client number still selected on your screen, the Registration Document automatically uses that client name and number for the new registration.

#1: Program Tab

Program Enrollment is a period of treatment for a client at a Program. Before you can enter services for a client, there must be an open Program Enrollment to that Program.

NOTE: The system is designed to only allow one Open Program Enrollment for the same Program. The following message appears when tempting to "add" a new Program Enrollment when the Program is already "opened":

To Enroll the client to a Program complete the required fields in bold below:

1. **Primary Program: Required.** This will display a list of programs the user has permission to.

   NOTE: If you do not see the Program needed to Enroll the client, please contact your manager or the Help Desk. You cannot proceed without this required information.

2. **Status: Required.** This is a dropdown list that allows you to Enroll the client in the Program.

3. **Assigned Staff – Required (to capture case load information for the program enrollment)**. Assigned Staff is a typeable search text box. Enter the first few letters of the staff's last or first name to select them.

4. **Requested Date: Not required. Not in use.**

5. **Enrolled Date**: **Required.** Enter the start date for the Program Enrollment.

   NOTE: The Enrollment date must match the Effective Date.

6. **Assigned as CDAG: Required.** After entering your Primary Program, the Status as "Enrolled", the Assigned Staff, and the Enrolled Date the Assigned as CDAG checkbox is enabled. This box must be checked.

7. **Primary Program:** <u>Do NOT Complete</u>, this feature is not used by ACBHD, please leave unchecked.

8. **Comment: Not Required.**

9. Once the data fields above have been completed, click on the "**Add Program Details**" button to insert the Program.

#2: Episode Tab

The Episode in SmartCare is a functionality called the overarching Episode. ACBH <u>is not using this overarching</u> <u>Episode</u> functionality. However, the Registration Date for the overarching Episode is required.

Case Information Section: **Required**

On the first initial Program Enrollment, populate the Registration Date using the same Effective Date as the Program Enrollment date. After the initial Program Enrollment, this data field will be prepopulated and cannot be changed.

1. Registration Date: **Required.**

Case Information

Initial Referral/Screening Date [   ] 📅 ▾

Registration Date [05/22/2024] 📅 ▾

Information	Registration Comment
Episode Number: 1 Registration: 05/22/24 Discharged:	

CSI Episode Information Section: **Required**

CSI Episode Information

Transaction Type [Admission ▾]

Discharge Date [   ] 📅 ▾   Patient Status [Still a patient or expected t ▾]   Legal Class at Admission [W60000:Voluntary ▾]

Legal Class at Discharge [▾]   Admission Necessity [Emergency ▾]

1. Transaction Type: **Required.** Indicate "Admission".
   NOTE: Once the Admission value is selected, click the **Save button**. Once you save it, it will invoke the InPatient Data fields.

2. Patient Status: **Required**. You will need to select "Still a patient or expected to return".

3. Admission Necessity: **Required**.

4. Legal Class of Admission: **Required**.

Referral Resource & Reason Section: **Not Required.**

Referral Resource

Referral Date [   ] 📅 ▾   Referral Type [▾]   Referral Subtype [▾]

Type of Provider [▾]   Provider Name [▾]

Organization Name [   ]   Phone [   ]

First Name [   ]   Last Name [   ]

Address Line 1 [   ]   Address Line 2 [   ]

City [   ]   State [▾]   ZIP [   ]   Email [   ]

Comments
[   ]

Referral Reason

Reason for Referral 1 [▾]   Reason for Referral 2 [▾]

Reason for Referral 3 [▾]

Comment
[   ]

#3: General Tab

The General tab contains general information about the client such as name, e-mail address, phone number, address, etc. If an Inquiry was performed and/or Client Information was updated, some fields are already populated on this tab.

Data fields should be initialized from the client information or a previous Mental Health Registration document. If not, then complete the following required fields:

- First Name at Birth: **Required.**

- Middle Name at Birth: **If Applicable.**

- Last Name at Birth: **Required.**

- Suffix at Birth: **If Applicable.**

- Phone Number: **If Available.**

- Addresses: **Required.**

- Billing Checkbox: **Required.**
  NOTE: The Billing Checkbox must be checked, this is required for claiming.

    o When the **service is rendered at the location code of Home**, the client must have a valid "home address". Do not use Homeless, do not use Unknown, and do not use a PO Box if the service was rendered at Home, as the service will be denied by DHCS without a valid address. A valid address is required to render a service at home.

    o If the address type is "Home", **if the the client is Homeless** enter "Homeless" for Street and 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).
        i. Please see the SmartCare Appendix A: Global Code Tables for the City Hall Codes use for Homeless Client Address table.
        ii. To claim the service, the address must be either **"Homeless" or "Unknown",** these are the only two values that are accepted by the State. Wording such as transient, under the bridge,

unable to identify, all these types of content are not acceptable by the State and will cause the claim to be rejected.

Waitlist Priority: Not Required.

#4: Demographic and Client Information Tab:

Some of this data will initialize from the inquiry and registration document. Much of the information is used in other areas of the client record.

Identifying Information Section: Required.

The Identify Information Section should initialize from the client information or a previous Mental Health Registration, if not complete the required fields.

- Sex: **Required.**
- Marital Status: **Required.**
- Gender Identity: **Required.**
- Sexual Orientation: **Required.**
- Deceased On: Completed by ACBH Staff. **If this field is available, please do not complete.**
- Cause of Death: **If this field is available, please do not complete.**
- Preferred Pronoun: **Required.**

- Ethnicity: **Required.**
- Race: **Required.**
- Client declined to provide: **Not Used.**

Additional Identifying Information Section: Required.

- **Place of Birth – Country: Required.** This displays the Birth Place Country of the client. If the client was not born in the United States, then the Birth State and Birth County are not required.
  - If born in the United State, then birth state is required.

- **Place of Birth – State: Required.** This displays the birth place state of the client. If the client was not born in California, then the County is not required.
  - If they were born in California, then the birth place County is required.

- **Place of Birth – County: Required.** This displays the birth County of the client.

- **Special Population: This field should be disabled**. If not disabled, please do not complete it. It is not applicable at this time.

- **Conservatorship or Juvenile Court Status: Required.** Identifies whether or not the client has a conservatorship or juvenile court status.

- **Has the client experienced a traumatic event?: Required.** Purpose: Identifies clients that have experienced traumatic events including experiences such as having witnessed violence, having been a victim of crime or violence, having lived through a natural disaster, having been a combatant or civilian in a war zone, having witnessed or having been a victim of a severe accident, or having been the victim of physical, emotional, or sexual abuse.

- **General Medical Conditions Fields: Required.**
  - If you select "No General Medical Condition" in number 1, then #2 and #3 are not applicable.
  - If a Medical Condition is indicated in #1, such as Asthma, the General Medical Condition in #2 is required.
  - If no additional Medical Condition is identified, indicate "No General Medical Condition" in 2.
  - Duplicates are not allowed.

- **Does the client have a Substance Abuse/Dependence Issue: Required.** Select "yes" or "no". If yes, is collected then you will need to complete the next field which is the diagnosis.

- **Substance Abuse/Dependence Diagnosis: Conditional.** Select a diagnosis. e.g. Type in F10.x and it will provide a dropdown list to choose from.

Does the client have a Substance Abuse/Dependence issue?   Yes, the client has a substance abuse / c ⌄

Substance Abuse/Dependence Diagnosis   F10.14 - Alcohol abuse with alcohol-induced mood

- **What type of disability/disabilities does the client have, if any?: Required.** This is a multi-select drop down, select the client's disabilities if applicable.

Primary Care Physician Section: **Optional.**

Optional means that if you are able to get the information from the beneficiary, then collect and record it; otherwise, it is not required information.

Primary Care Physician

Primary Care Physician   ⌄   Organization:
☐ Client does not have PCP   Phone #:
                                               PCP Email:

Financial Information Section: **Not Required.**

Financial Information

Financially
Responsible   ⦿ Yes ◯ No   Annual Household
                            Income   [   ]   # of Dependents   [   ]

Family Information Section: **Required.**

Family Information

Pregnancy Status   [⌄]   Mother's First Name   [   ]
# of Dependents under the age of 18   [   ]   # of Dependents over the age of 17   [   ]

- Pregnancy Status: **Required.** Indicate if the client is pregnant.

- Mother's First Name: **Required.** Indicate the client's mother's name. If **unknown**, it is required to enter the full word Unknown in this field.

- # of Dependents under the age of 18: **Required. (If the answer is unknown, enter 99 for the response).**

- # of Dependents over the age of 17: **Required. (If the answer is unknown, enter 99 for the response).**

Family Information

Pregnancy Status	No	Mother's First Name	Unknown
# of Dependents under the age of 18	99	# of Dependents over the age of 17	99

Living Arrangement Section: **Required.**

Living Arrangement

Living	House or apartment(includes trailers)
County of Residence	Alameda - CA County of Financial Responsibility Search here

- Living: **Required.** Select the environment in which the client is living from the dropdown list.
- County of Residence: **Required.** Start typing the name of the CA County and then select the desired county from the drop-down list.
- County of Financial Responsibility: **Required.** Enter the CA County who is financially responsible.

NOTE: Refer to the Appendix section for additional information.

Educational/Employment Section: **Required.**

Educational/Employment

Educational Status		Veteran Status		Military Status	
Employment Status					
Employment Information					

- Educational Status: **Required.** Identify the highest grade level completed by the client.
- Veteran Status: **Required.**
- Military Status: **Required.**
- Employment Status: **Required.**
- Employment Information: **Optional.**

Refer to the appendix for additional information.

Language Section: **Required.**

Language

Primary Language		Preferred Language		☐ Client does not speak English	Hispanic Origin	No
☐ Interpreter Services Needed						

- Primary Language: **Required.** Select the client's primary language in which to receive services.

- Preferred Language: **Required.** Select the client's preferred language in which to receive services.

- Client does not speak English check box: **Not Required.**

- Hispanic Origin: **Required.** Select details about client's Hispanic origin.

- Interpreter Services Needed: **Not Required.** Select this check box if applicable.

Transportation Information Section, Preferences Section, and Picture Sections: These three sections are **Not Required** at this time. There is no need to complete this section.

#5: Insurance Tab: **Not Required.**

This tab should be grayed out and inaccessible, as it is Not Required.

#6: Forms & Agreement Tab: **Not Required.**

This tab should be grayed out and inaccessible, as it is Not Required.

#7: ClientReferredFromTo: **Not Required.**
This tab should be grayed out and inaccessible, as it is Not Required.

MH Registration Document: The final step is to **Sign** this registration. Once registration is complete, a pdf. document will be created. Attached is an example of the MHS Registration pdf:

TIP: Following the creation of the PDF, navigate to the quick link for Clients, then select Programs, and verify that the status is "enrolled" for the program you just entered.

NOTE:

➢ There is **only one program enrollment per Mental Health Services Registration document per program**.
➢ Do **not edit the MHS Registration** to add a new program enrollment.
➢ **Do not use the Edit icon** to create a new program enrollment.

New Mental Health Services Registration Document (New Program Enrollment)

1. Create a new Mental Health Services Registration document instead when you enroll a client into a new program**.**

2. Select New button on the Mental Health Registration screen.

Program						
Program	**Status**	**Assigned Staff**	**Requested Date**	**Enrolled Date**	**Assign As CDAG**	**Primary Program**
A BETTER WAY MHS CHILD (81941)	Enrolled			07/02/2024	N	N
FELTON INSTITUTE EPP TAY (01NE1)	Enrolled	Simmons, Vanessa		07/15/2024	N	N
SECOND CHANCE HAYWRDRC 2.1 IOS (01ABL0)	Enrolled			07/02/2024	N	N
SECOND CHANCE HAYWARD RC OS (01ABK0)	Enrolled			07/02/2024	N	N

3. The Mental Health Services Registration screen is displayed, and Status is New.

****

Edit Mental Health Services Registration Document

NOTE: There is **only one program enrollment per Mental Health Services Registration document per program**. Do not edit the MHS Registration to add a new program enrollment. **Do not use the Edit** icon to create a new program enrollment.

1. Select edit from the Mental Services Registration screen.

2. Effective: Same as Program Enrollment date
    NOTE: If Effective date have been changed, the Program enrollment date will need to be changed.

3. **Status:** in Progress

4. **Author:** Name of the author

To Edit Program

5. Select Program Tab

6. Select radio button of the Program you want to update.

7. Make the changes that are required.

    NOTE: Program Enrollment Date must be the same as the Effective Date.

8. Select Modify to save changes to the Program.

9. Sign the Mental Health Services Registration document.

Edit Mental Health Services Registration document signed by the "same" author

1. Make the updates.

2. **Sign** Mental Health Services Registration document.

Edit Mental Health Services Registration document signed by a "different" author

1. Change name of the author: Select **your** name from drop down.

   i.
2. Make update.

3. **Sign** the Mental Health Services document.

NOTE: Check version of the signed Mental Health Services Registration document by selecting **"+"**.

The version information is displayed along with the signed PDF of the latest version.

Chapter 7: InPatient Diagnosis Document

The Diagnosis document is used to add, update or remove diagnosis information.

A Program enrollment must be completed, and the Program Status must be "**Enrolled**" before you can create and sign a diagnosis document. Prior to completing the MHS Annual/Discharge document, the diagnosis document are to be completed, when applicable. The <u>diagnosis document effective date would be the date of the discharge</u>.

1. To access the diagnosis document begin typing Diagnosis in the search bar and the Diagnosis Document will appear on the list.

2. Select the Diagnosis Document:

3. Select Program in the CDAG Program Enrollment popup.

4. Diagnosis Document will be displayed.

To complete the Diagnosis Document:

1. The Effective Date is the Program Enrollment date.

   NOTE: To prevent a rejected Medi-Cal claim there needs to be a new diagnosis document for every Program enrollment and the effective date must match the program enrollment date.

2. In the "Code" field, begin typing the first letter of the code, e.g. "F" (the list contains ICD10/DSM 5 codes). Code F

3. Click on the Magnifying Glass (🔍) and enter the search term "Diagnosis".

4. Select a diagnosis from the dropdown list, below is an example of the drop down with ICD-10 codes:

NOTE: Use code with an * (* indicate DSM 5 description) for ICD-10 description

5. The Diagnosis Code and description fields will populate with the diagnosis information. (2)

6. Select the code and press the "Insert" button.

TIP: Click on the favorite button if this is a diagnosis code that you use often. That way there is no need to go through all the codes.

Diagnosis Entry Section:

1. Type: **Required.** This is required for Primary diagnosis. It indicates the type of diagnosis; Primary, Additional, or Provisional.

2. Severity: **Not Required.** Low, Medium or High.

3. Remission: **Not Required.** Partial, Full, Early Full, Early Partial, Sustained Full, Sustained Partial.

4. Comments: **Not Required.**

5. Specifier: **Not Required.**

6. Source: **Optional.** Enter the name of the clinician providing the diagnosis if different than the document author.

7. Billable: **Required** To prevent Medi-Cal claims rejections, please ensure that the systems prepopulated Billable radio button reflects **Yes**.

NOTE: The **Billing radio button must be clicked**, this is required for claiming.

When the diagnosis is selected and if **Yes** is not indicated, you should not be choosing that diagnosis.

NOTE: You must only use the diagnosis code UM has allowed, as those codes are billable. In the "Order" column you can change the diagnosis order if they need to be updated.

8. Primary diagnosis needs to have Order set to 1. You will need to reorder the diagnoses list if you need to add a new primary diagnosis.

9. Select the radio button to select the current primary in the Diagnosis list.

10. Change the order to the next number after the last Order number in the Diagnosis list.

11. Change the Type to Additional or Provisional

12. Select the Modify button to save the change.

Create new Primary diagnosis.

1. Set the diagnosis Order to 1.
2. Select **Insert.**

3. Repeat Steps 1 – 4 to change the order of the Additional diagnosis.

Deleting diagnosis from the Diagnosis List

1. Check on the delete icon next to the diagnosis to be deleted.

2. Confirm deletion

NOTE: The Diagnosis list will contain diagnoses from previous program enrollments. Delete all diagnoses that do not apply to the current program enrollment.

Diagnosis List Section

If multiple diagnoses are listed in the Diagnosis List section, use the radio button (2) to select the one you wish to add notes in the "Screening Tools" or "Other General Medical Conditions" fields of the Diagnosis list section.

1. Select the Modify Button

2. Screening Tools Used: **Not Required.** Enter screening tools utilized for data collection.

3. Other General Medical Conditions: **Not Required.** Enter other medical conditions here.

4. Click the insert button to create the entry on the diagnosis list. (1)

5. **Sign** Diagnosis document.

Edit Diagnosis document

1. Select edit icon.

2. Confirm edit.

Edit Diagnosis document signed by the same Author

1. Effective date must be the same as the program enrollment date.

2. Make the updates in the document.

3. **Sign** the Diagnosis document.

Edit Diagnosis document signed by a different Author

1. Effective date must be the same as the program enrollment date.

2. Change name of the author: Select **your** name from drop down.

3. Make the updates in the document.

4. **Sign** the Diagnosis document.

Diagnosis Changed During Program Enrollment

If the diagnosis changes when the client is enrolled in the program, a **new** Diagnosis Document is created.

Please follow the workflow below anytime a client's diagnosis code changes throughout the period of the unique Program Enrollment:

NOTE: You must only use the diagnosis code UM has allowed, as those codes are billable. In the "Order" column you can change the diagnosis order if they need to be updated.

To enter client diagnosis changes for the Program Enrollment period, select the "**NEW**" Icon in the upper right-hand of the document's status bar.

1. Because the Diagnosis Document is linked to the clients individual Program Enrollments the CDAG Program Enrollment popup blocker will prompt the user to select the applicable Program Enrollment from the drop-down menu – as shown on the screenshot below:

2. **Enter the date the client's diagnosis changed** for the Program Enrollment by using the "Effective date" on the new Diagnosis Document. The client diagnosis change could align with the service treatment period. However, keep in mind a Diagnosis Document is required for the service entry period, and can be unique to the individual treatment service period – as shown in the example below:

NOTE: Changing the documents effective date may affect Service Entry and Claiming.

3. To update the **primary diagnosis** code, select the applicable radio button next to the diagnosis in the Diagnosis list area. This will populate the information in the Diagnosis section of the document to be changed/modified. Update the "Type" from "Primary" to "Additional" update the order sort – as shown on the screenshot below:

NOTE: The effective date of the diagnosis document will determine which diagnosis document will be referenced during service entry. The service date will use the effective date of the diagnosis document. This date is critical and can impact a service from being claimed successfully if they do not align.

When updating the diagnosis information there MUST be a primary diagnosis code on the document to save and sign the diagnosis document. Delete the ICD-10 diagnosis code by selecting the ✕ next to the applicable diagnosis in the Diagnosis List area.

Select **Modify**, to update the Diagnosis information in the Diagnosis list area.

			Order	DSM 5/ ICD 10	SNOMED	R/O	ICD/ DSM Description	SNOMED Description	Type	Severity	Source	Comments
✕	○	ⓘ	4	F41.0*	231502...		Panic disorder	Situational panic at...	Additional			
✕	○	ⓘ	2	F43.0*	192037...		Acute stress disorder	Acute panic state d...	Additional			
✕	○	ⓘ	3	F44.0	225040...		Dissociative amnesia	Localized dissociati...	Additional			

Diagnosis List — Insert — Clear

4. To add the new **Primary Diagnosis** code, Enter the applicable ICD code, update the "Type" to "Primary", change the order to "1" and select **Insert** to add the new Primary Diagnosis code to the Diagnosis List area – as shown on the screenshot below:

5. The Diagnosis list will be updated with the new ***primary diagnosis*** code – as shown on the screenshot below:

6. Once the diagnosis information is complete. Select the [Sign] button on the document status bar to sign and complete the NEW "Diagnosis Document" with the NEW "Effective date".

A PDF diagnosis document will be displayed on the screen informing the user the signed Diagnosis Document has been completed for the client Program Enrollment that may also cover the service entry period.

Chapter 8: InPatient Annual/Discharge Document

CSI Periodic Data

The CSI Periodic data is no longer captured on a separate screen.

A Periodic record describes the current education, employment, conservatorship/court status, living arrangement and caregiver status for a person. The information in the Periodic record is used to measure the effectiveness of services.

The data is reported at time of Admission, Annually and at formal Discharge. Completing the Mental Health Services Registration document, captures the Periodic data at time of Program Enrollment/Admissions. The Annual and Discharge data will be captured on the MHS Annual/Discharge Document.

Inpatient - Discharge Client

1. To access the MHS Annual/Discharge document, begin typing "annual/discharge" in the search bar and the MHS Annual/Discharge will appear on the list.

2. Select Program in the CDAG Program Enrollment popup.

3. MHS Annual/Discharge document is displayed.

4. The **Effective Date** is the **Program discharge date**.

#1 General Tab

CSI Episode Information Section : **Required**

Complete these fields in order to discharge a client.

1. Update Reason: **Required**. Select **Discharge**
2. Admission Date: **Required.** Prepopulated data.
3. Discharge Date: **Required.**
   NOTE: This is the same as the "effective date".
4. Legal Class at Discharge: **Required.**
5. Program: **Required**. Select the Program associated with your client.
6. First Date of Service: **Required.** Prepopulated data.

7. Patient Status: **Required.** Select one of the Discharge options.
8. Admission Necessity: **Required.** Prepopulated data.
9. Last Date of Service: **Not Required.**
10. Legal Class at Admission: **Required.** Prepopulated data.

General Information Section: Required

Confirm prepopulated fields.

First Name: **Required** –prepopulated data.

Last Name: **Required** –prepopulated data.

Middle Name: **If Applicable** –prepopulated data.

Suffix: **If Applicable** –prepopulated data.

SSN: **Required –**prepopulated data.

Date of Birth: **Required** –prepopulated data.

Medi-Cal ID: **If Applicable** –prepopulated data.

Current Client Status Information Section: Required

All the fields in this section are Required. Some of the fields are prepopulated and you are required to update the data if it has changed.

1. Employment Status: **Required.**

2. Living Arrangement: **Required.**

3. Has the client experienced a traumatic event?: **Required.**

   Purpose: Identifies clients that have experienced traumatic events including experiences such as having witnessed violence, having been a victim of crime or violence, having lived through a natural disaster, having been a combatant or civilian in a war zone, having witnessed or having been a victim of a severe accident, or having been the victim of physical, emotional, or sexual abuse.

4. # of Dependents over the age of 17: **Required.**

5. General Medical Conditions Fields: **Required.**

   o If a Medical Condition is indicated in #1, such as Asthma, the General Medical Condition in #2 is required.

   o If no additional Medication Condition is identified, indicate "No General Medical Condition" in #2.

   o Duplicates are not allowed.

6. Does the client have a Substance Abuse/Dependence Issue: **Required.** Select "yes" or "no".

   If "yes", is selected then you will need to complete the next field which is the diagnosis.
   Substance Abuse/Dependence Diagnosis: Conditional. Required. Select a diagnosis. Type in F10.x and it will provide a drop down list to choose from.

7. Education Status: **Required.**

8. Conservatorship or Juvenile Court Status: **Required.** Identifies whether or not the client has a conservatorship or juvenile court status.

9. # of Dependents under the age of 18: **Required.**

#2 Diagnosis Tab – **Required.**

A closing diagnosis is required.

NOTE: Create a new Diagnosis document if the closing diagnosis is different than the current diagnosis.

#3 Client ReferredFromTo Tab - **Not Used.**

Now the discharge is ready to be signed. Click on the Sign button.

Below is an example of the Discharge document in a pdf format.

Once completed you can go to the Programs Client and you can see that they have a program enrollment, that is now discharged.

Annual Updates:

Required. This is required once a year.

NOTE: You are <u>seeing the same screens</u>, but <u>you need to go through and update/verify</u> that all the information is current.

You will use the MHS Annual/Discharge Document and will follow the same process as outlined in Discharge Document, with the following changes:

1. CSI Episode Information: Select Annual as the option.

General Information Section

This should have initialize the client information.

You will be required to complete the below fields. These are known as the CSI Periodic Data Fields:

The Diagnosis Tab

Contains the client's diagnosis and if there is already a signed diagnosis document for the client, that diagnosis will initiate when you open the Diagnosis Document.

1. The Add Diagnosis button will redirect the user to the Diagnosis Document Screen. The user may add or update diagnosis information. Refer to the Diagnosis Document section for additional details.
   NOTE: Only the new Registration Document will have the signed document listed in the below grid.

2. The final step is to **Sign** this Annual/Discharge Document.

3. Once this is complete, a pdf. document will be created.

Chapter 9: OutPatient Mental Health Services Registration document
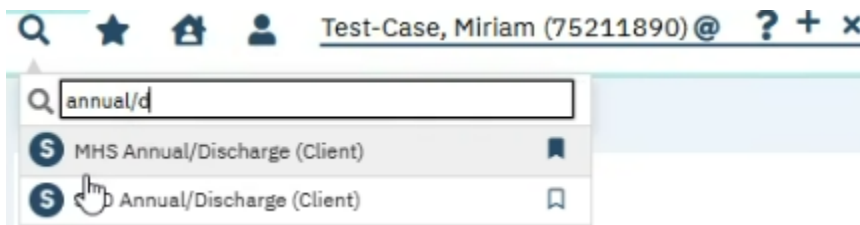
CSI Periodic Reporting Data

The CSI Periodic data is no longer captured on a separate screen.

A Periodic record describes the current education, employment, conservatorship/court status, living arrangement and caregiver status for a person. The information in the Periodic record is used to measure the effectiveness of services.
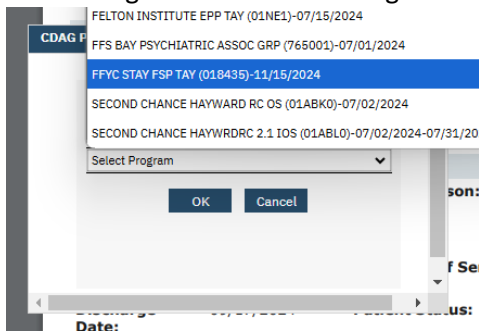
The data is reported at time of Program Enrollment, Annually and at formal Discharge. Completing the Mental Health Services Registration document, captures the Periodic data at time of Program Enrollment. Annual and Discharge data will be captured on the MHS Update/Discharge Document.

Mental Health Services Registration Document

The Mental Health Services Registration document is used to capture required data fields for **Client Information/Demographic** and opening an **Admission using the Program Enrollment**. A new Mental Health Services Registration document will need to be created for each program enrollment.

1. Click on the Magnifying Glass and enter the search term "Mental".

2. Select "Mental Health Services Registration (Client)" from the drop list.

3. SC Document Navigation Bar: The first item at the top of the resulting page is the Document Navigation Bar which represents data for the Effective Date of Registration, the Status of the document completion, the Author, and the creation date.

You will want to make sure you periodically check the status of your documents, e.g. New, In Progress, especially following saving any information, as moving onto other processes before completing registration will cause errors.

TIP: Clicking the double angle brackets (<< or >>)(**1**) in the calendar navigates you backward or forward by one year. Clicking the single angle bracket (< or >)(**2**) navigates you backward or forward by one

month. For pre-set dates, click the applicable hyperlink (<mark>3</mark>) in the Streamline Date/Time Language section at the bottom of the pop-up calendar. Additionally, using keystroke shortcuts, you can populate the date field with information. There are additional shortcuts listed when you click the <<More>> link (<mark>4</mark>).

4. Tabs act like separate pages or sections on a document, typically containing different categories of information. The tabs <u>required</u> to complete/sign the Mental Health Services Registration document are noted in **red** font below, the other tabs are available but not required at this time:

Tabs:

#1: Program Tab – **Required.**

#2: Episode Tab – **Required.**

#3: General Tab – **Required.**

#4: Demographic and Client Information Tab – **Required.**

~~#5: Client Contacts Tab~~ – **Optional.**

~~#6: Insurance Tab~~ – **Not Used.**

~~#7: Forms and Agreements Tab~~ – **Not Used.**

Mental Health Services Registration Screen

TIP: Since you have the newly created client number still selected on your screen, the Registration Document automatically uses that client name and number for the new registration.

Program Enrollment is a period of treatment for a client at a Program. Before you can enter services for a client, there must be an open Program Enrollment to that Program.

NOTE: The system is de Mental Health Services Registration Document Tabs:
ed to only <u>allow one Open Program Enrollment for the same Program</u>. The following message appears when tempting to "add" a new Program Enrollment when the Program is already "opened":

To Enroll the client to a Program complete the required fields in bold below:

1. Primary Program: **Required.** This will display a list of programs the user has permission to.

   NOTE: If you do not see the Program needed to Enroll the client, please contact your manager or the Help Desk. You cannot proceed without this required information.

2. Status: **Required.** This is a dropdown list that allows you to Enroll the client in the Program.

3. Assigned Staff: **Required (to capture case load information for the program enrollment)**. Assigned Staff is a typeable search text box. Enter the first few letters of the staff's last or first name to select them.

4. Requested Date: **Not Used.**

5. Enrolled Date: **Required.** Enter the start date for the Program Enrollment.

   NOTE: The Enrollment date must match the Effective Date.

6. Assigned as CDAG: **Required.** After entering your Primary Program, the Status as "Enrolled", the Assigned Staff, and the Enrolled Date the Assigned as CDAG checkbox is enabled. This box must be checked.

7. Primary Program: **Not Used.** <u>Do NOT Complete</u>, this feature is not used by ACBHD, please leave unchecked.

8. Comment: **Not Required.**

9. Once the data fields above have been completed, click on the "**Add Program Details**" button to insert the Program.
   NOTE: There can be multiple Program Enrollments displayed on this page, as shown below.

#2: Episode Tab

The Episode in SmartCare is a functionality called the overarching Episode. ACBH is not using this overarching Episode functionality. However, the Registration Date for the overarching Episode is required.

Case Information Section:

Registration Date: **Required.**
On the first initial Program Enrollment, populate the Registration Date using the same Effective Date as the Program Enrollment date. After the initial Program Enrollment, this data field will be prepopulated and cannot be changed.

Case Information

Initial Referral/Screening Date [   ] 📅 ▾

Registration Date [05/22/2024] 📅 ▾

Information

Episode Number: 1
Registration: 05/22/24   Discharged:

Registration Comment
[   ]

If you are completing **OutPatient** enrollment, the CSI Episode Information Transaction Type fields <u>is **not** required</u>.

CSI Episode Information Section: **Not Required.**

Referral Resource & Reason Section: **Not Required.**

#3: General Tab

The General tab contains general information about the client such as name, e-mail address, phone number, address, etc. If an Inquiry was performed and/or Client Information was updated, some fields are already populated on this tab.

Data fields should be initialized from the client information or a previous Mental Health Registration document. If not, then complete the following required fields:

- First Name at Birth: **Required.**

- Middle Name at Birth: **If Applicable.**

- Last Name at Birth: **Required.**

- Suffix at Birth: **If Applicable.**

- Phone Number: **If Available.**

- Addresses: **Required.**

- Billing Checkbox: **Required.**
  NOTE: The <u>Billing Checkbox must be checked</u>, this is required for claiming.

  o When the **service is rendered at the location code of Home**, the client must have a <u>valid "home address"</u>. <u>No Homeless, no Unknown, no PO Box can be used</u> if the service was rendered at Home, as the service will be denied by DHCS <u>without</u> a valid address. A valid address is required to render a service at home.

  o If the address type is "Home", **if the the client is Homeless** enter "Homeless" for Street and 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).

     iii. Please see the SmartCare Appendix A: Global Code Tables for the City Hall Codes use for Homeless Client Address table.
     iv. To claim the service, the address must be either **"Homeless" or "Unknown",** <u>these are the only two values that are accepted by the State</u>. Wording such as transient, under the bridge, unable to identify, all these types of content are not acceptable by the State and will cause the claim to be rejected.

Waitlist Priority: Not Required.

#4: Demographic and Client Information Tab:
Some of this data will initialize from the inquiry and registration document. Much of the information is used in other areas of the client record.

Identifying Information Section: **Required.**

The Identify Information Section <u>should initialize</u> from the Client Information or a previous Mental Health Registration, if not complete the required fields.

1. Sex: **Required**
2. Marital Status: **Required**
3. Gender Identity: **Required**
4. Sexual Orientation: **Required**
5. Preferred Pronoun: **Required**
6. Ethnicity: **Required**
7. Race: **Required**
8. Deceased On: Completed by ACBH Staff. **If this field is available, please do not complete.**
9. Client declined to provide: **Not Applicable/Not Required**

Additional Identifying Information Section: **Required.**

- Place of Birth – Country: **Required.** This displays the Birth Place Country of the client. If the client was not born in the United States, then the Birth State and Birth County are not required.
  - If born in the United State, then birth state is required.

- Place of Birth – State: **Required.** This displays the birth place state of the client. If the client was not born in California, then the County is not required.
  - If they were born in California, then the birth place County is required.

- Place of Birth – County: **Required.** This displays the birth County of the client.

- Special Population: **Do Not Use.** This field should be disabled. If not disabled, please do not complete it. It is not applicable at this time.

- Conservatorship or Juvenile Court Status: **Required.** Identifies whether or not the client has a conservatorship or juvenile court status.

- Has the client experienced a traumatic event?: **Required.** Purpose: Identifies clients that have experienced traumatic events including experiences such as having witnessed violence, having been a victim of crime or violence, having lived through a natural disaster, having been a combatant or civilian in a war zone, having witnessed or having been a victim of a severe accident, or having been the victim of physical, emotional, or sexual abuse.

- General Medical Conditions Fields: **Required.**

  - If you select "No General Medical Condition" in number 1, then #2 and #3 are not applicable.
  - If a Medical Condition is indicated in #1, such as Asthma, the General Medical Condition in #2 is required.
  - If no additional Medical Condition is identified, indicate "No General Medical Condition" in 2.
  - Duplicates are not allowed.

    General Medical Condition(s)
    1. No General Medical Cor ⌄   2. No General Medical Cor ⌄   3. No General Medical Cor ⌄

- Does the client have a Substance Abuse/Dependence Issue: **Required.** Select "yes" or "no". If yes, is collected then you will need to complete the next field which is the diagnosis.

- Substance Abuse/Dependence Diagnosis: **Conditional.** Select a diagnosis. e.g. Type in F10.x and it will provide a dropdown list to choose from.

    Does the client have a Substance Abuse/Dependence issue?   Yes, the client has a substance abuse / c ⌄
    Substance Abuse/Dependence Diagnosis   F10.14 - Alcohol abuse with alcohol-induced mood (

- What type of disability/disabilities does the client have, if any?: **Required.** This is a multi-select drop down, select the client's disabilities if applicable.

Primary Care Physician Section: Optional.

Optional means that if you are able to get the information from the beneficiary, then collect and record it; otherwise, it is not required information.

    Primary Care Physician
    Primary Care Physician   ⌄   Organization:
    ☐ Client does not have PCP   Phone #:
                                         PCP Email:

Financial Information Section: Not Required.

Financial Information

| Financially Responsible | ● Yes ○ No | Annual Household Income | | # of Dependents | |

Family Information Section: Required.

1. Pregnancy Status: **Required.** Indicate if the client is pregnant.

2. Mother's First Name: **Required.** Indicate the client's mother's name. If **unknown**, it is required to enter the full word Unknown in this field.

3. # of Dependents under the age of 18: **Required. (If the answer is unknown, enter 99 for the response).**

4. # of Dependents over the age of 17: **Required. (If the answer is unknown, enter 99 for the response).**

Family Information

| Pregnancy Status | No ⌄ | Mother's First Name | Unknown |
| # of Dependents under the age of 18 | 99 | # of Dependents over the age of 17 | 99 |

Living Arrangement Section: Required.

Living Arrangement

| Living | House or apartment(includes trailers) ⌄ |
| County of Residence | Alameda - CA ⬥ | County of Financial Responsibility | Search here ⬥ |

5. Living: **Required.** Select the environment in which the client is living from the dropdown list.

6. County of Residence: **Required.** Start typing the name of the CA County and then select the desired county from the drop-down list.

7. County of Financial Responsibility: **Required.** Enter the CA County who is financially responsible.

Refer to the appendix for additional information.

Educational/Employment Section: Required.

Educational/Employment

Educational Status	⌄	Veteran Status	⌄	Military Status	⌄
Employment Status	⌄
Employment Information	

1. Educational Status: **Required.** Identify the highest grade level completed by the client.

2. Veteran Status: **Required.**

3. Military Status: **Required.**

4. Employment Status**: Required.**

5. Employment Information: **Optional**

Refer to the appendix for additional information.

Language Section: **Required.**

1. Primary Language: **Required.** Select the client's primary language in which to receive services.

2. Preferred Language: **Required.** Select the client's preferred language in which to receive services.

3. Client does not speak English check box: **Not Required.**

4. Hispanic Origin: **Required.** Select details about client's Hispanic origin.

5. Interpreter Services Needed: **Not Required.** Select this check box if applicable.

Transportation Information Section, Preferences Section, and Picture Sections: These three sections are Not Required at this time. There is no need to complete this section.

#5: Insurance Tab: **Not Required.**

This tab should be grayed out and inaccessible, as it is not required.

#6: Forms & Agreement Tab: **Not Required.**

MH Registration Document: The final step is to **Sign** this registration. Once registration is complete, a pdf. document will be created.

Attached is an example of the MHS Registration pdf:

Following the creation of the PDF, navigate to the quick link for Clients, then select Programs, and verify that the status is "enrolled" for the program you just entered.

NOTE:

➢ There is **only one program enrollment per Mental Health Services Registration document per program**.
➢ Do not edit the MHS Registration to add a new program enrollment.
➢ **Do not use the Edit icon** to create a new program enrollment.

New Mental Health Services Registration Document (New Program Enrollment)

1. Create a new Mental Health Services Registration document instead when you enroll a client into a new program.

2. Select New button on the Mental Health Registration screen.

3. The Mental Health Services Registration screen is displayed, and Status is New.

****

Edit Mental Health Services Registration Document

NOTE: There is **only one program enrollment per Mental Health Services Registration** document per program. Do not edit the MHS Registration to add a new program enrollment. **Do not use the Edit** icon to create a new program enrollment.

1. Select edit from the Mental Services Registration screen.

2. Effective: Same as Program Enrollment date

NOTE: If Effective date has been changed, the Program enrollment date will need to be changed.

3. **Status:** in Progress

4. **Author:** Name of the author

Edit Program

1. Select Program Tab

2. Select radio button of the Program you want to update.

3. Make the changes that are required.
   NOTE: Program Enrollment Date must be the same as the Effective Date.

4. Select Modify to save changes to the Program.

5. Sign the Mental Health Services Registration document.

Edit Mental Health Services Registration document signed by the "same" author

1. Make the updates.

2. **Sign** Mental Health Services Registration document.

Edit Mental Health Services Registration document signed by a "different" author

1. Change name of the author: Select **your** name from drop down.

   i.
2. Make update.

3. **Sign** the Mental Health Services document.

NOTE: Check version of the signed Mental Health Services Registration document by selecting **"+"**.

The version information is displayed along with the signed PDF of the latest version.

Mental Health Services Registration

| Effective | 08/12/2023 | Status | Signed | Author | Rao, Poornashree | 07/17/2023 | ← → | | Sign | | |

Other Versions
- ● 3. 08/11/2023, Poornas... ⟳
- ○ 2. 08/11/2023, Poornas... ⟳
- ○ 1. 08/11/2023, Poornas... ⟳

Signed By
1. Poornashree Rao ON 08/11/2023 (1)
2. Poornashree Rao ON 08/11/2023 (2)

Signer
Add Signer(s)...

[Co-Sign] [Decline]

Program
ADULT FORENSIC BEHAV

Document

| ☰ | 🖊 ∨ | ▽ Draw ∨ | ✎ | ⊤ | ⋯ | − + | ⬚ | 1 | of 4 | ↻ | ⊡ | 🔍 | 🖨 | 💾 | ⚙ |

Client ID: 80000073 | Page 1

Alameda QA | 08/01/2023
Mental Health Services Registration Document

Program

Program	Status	Assigned Staff	Requested Date	Enrolled Date
TELECARE MORTON BAKAR SNF (00621)	Enrolled			08/01/2023
FFS BLAUSTEIN MEL MD (761174)	Enrolled			08/02/2023
SUBSTITUTE PAYEE (01001)	Enrolled			08/01/2023

Chapter 10: OutPatient Diagnosis Document

The Diagnosis document is used to add, update or remove diagnosis information.

A Program enrollment must be completed, and the Program Status must be "**Enrolled**" before you can create and sign a diagnosis document. Prior to completing the MHS Annual/Discharge document, the diagnosis document are to be completed, when applicable. The <u>diagnosis document effective date would be the date of the discharge</u>.

5. To access the diagnosis document begin typing Diagnosis in the search bar and the Diagnosis Document will appear on the list.
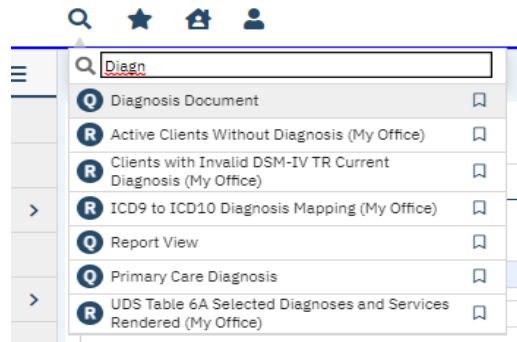
6. Select the Diagnosis Document:

7. Select Program in the CDAG Program Enrollment popup.

8. Diagnosis Document will be displayed.

To complete the Diagnosis Document:

1. The Effective Date is the Program Enrollment date.

   a. **NOTE:** To prevent a rejected Medi-Cal claim there needs to be a new diagnosis document for every Program enrollment and the effective date must match the program enrollment date.

2. In the "Code" field, begin typing the first letter of the code, e.g. "F" (the list contains ICD10/DSM 5 codes).

3. Click on the Magnifying Glass ()a] 🔍 d enter the search term "Diagnosis".

4. Select a diagnosis from the dropdown list, below is an example of the drop down with ICD-10 codes:

NOTE: Use code with an * (* indicate DSM 5 description) for ICD-10 description

5. The Diagnosis Code and description fields will populate with the diagnosis information. (2)

6. Select the code and press the "Insert" button.

    TIP: Click on the favorite button if this is a diagnosis code that you use often. That way there is no need to go through all the codes.

Diagnosis Entry Section:

1. Type: **Required.** This is required for Primary diagnosis. It indicates the type of diagnosis; Primary, Additional, or Provisional.

2. Severity: **Not Required.** Low, Medium or High.

3. Remission: **Not Required.** Partial, Full, Early Full, Early Partial, Sustained Full, Sustained Partial.

4. Comments: **Not Required.**

5. Specifier: **Not Required.**

6. Source: **Optional.** Enter the name of the clinician providing the diagnosis if different than the document author.

7. Billable: **Required** To prevent Medi-Cal claims rejections, please ensure that the systems prepopulated Billable radio button reflects **Yes**.

    NOTE: The **Billing radio button must be clicked**, this is required for claiming.
    NOTE: When the diagnosis is selected and if **Yes** is not indicated, you should not be choosing that diagnosis.

8. Primary diagnosis needs to have Order set to 1. You will need to reorder the diagnoses list if you need to add a new primary diagnosis.

			Order	DSM 5/ ICD 10	R/O	ICD/ DSM Description	Type	Severity	Source	Comments
✕	○	ℹ	1	F50.810		Binge eating disorder, m...	Primary			
✕	○	ℹ	2	F23		Brief psychotic disorder	Additional			

Diagnosis List — Insert | Clear

9. Select the radio button to select the current primary in the Diagnosis list.

10. Change the order to the next number after the last Order number in the Diagnosis list.

11. Change the Type to Additional or Provisional

12. Select the Modify button to save the change.

Diagnosis

☐ No Diagnosis

Diagnosis

★ [_____] ⌄

Code F50.810 ℹ   Description Binge eating disorder, mild   🔍 ☆

☐ Rule Out   Type [Additional ⌄]   Specifier [_____]

Severity [_____ ⌄]   Source [_____]

Remission [_____ ⌄]   Order [3]   Billable ● Yes ○ No

Comments [_____]

Diagnosis List — Modify | Clear

			Order	DSM 5/ ICD 10	R/O	ICD/ DSM Description	Type	Severity	Source	Comments
✕	●	ℹ	1	F50.810		Binge eating disorder, m...	Primary			
✕	○	ℹ	2	F23		Brief psychotic disorder	Additional			

Create new Primary diagnosis.

1. Set the diagnosis Order to 1.

2. Select **Insert.**

3. Repeat Steps 1 – 4 to change the order of the Additional diagnosis.

Deleting diagnosis from the Diagnosis list

1. Check on the delete icon next to the diagnosis to be deleted.

2. Confirm deletion

NOTE: The Diagnosis list will contain diagnoses from previous program enrollments. Delete all diagnoses that do not apply to the current program enrollment.

Diagnosis List Section

If multiple diagnoses are listed in the Diagnosis List section, use the radio button (2) to select the one you wish to add notes in the "Screening Tools" or "Other General Medical Conditions" fields of the Diagnosis list section.

1. Select the Modify Button

2. Screening Tools Used: **Not Required.** Enter screening tools utilized for data collection.

3. Other General Medical Conditions: **Not Required.** Enter other medical conditions here.

4. Click the insert button to create the entry on the diagnosis list. (1)

5. **Sign** Diagnosis document.

Edit Diagnosis document

1. Select edit icon.

2. Confirm edit.

Edit Diagnosis document signed <u>by the same</u> Author

> 1. Effective date must be the same as the program enrollment date.

2. Make the updates in the document.

3. **Sign** the Diagnosis document.

Edit Diagnosis document signed <u>by a different</u> Author

3. Effective date must be the same as the program enrollment date.

4. Change name of the author: Select **your** name from drop down.

4. Make the updates in the document.

5. **Sign** the Diagnosis document.

Diagnosis Changed During Program Enrollment

If the diagnosis changes when the client is enrolled in the program, a **new** Diagnosis Document is created.

Please follow the workflow below anytime a client's diagnosis code changes throughout the period of the unique Program Enrollment:

NOTE: You must only use the diagnosis code UM has allowed, as those codes are billable. In the "Order" column you can change the diagnosis order if they need to be updated.

To enter client diagnosis changes for the Program Enrollment period, select the "**NEW**" Icon in the upper right-hand of the document's status bar.

1. Because the Diagnosis Document is linked to the clients individual Program Enrollments the CDAG Program Enrollment popup blocker will prompt the user to select the applicable Program Enrollment from the drop-down menu – as shown on the screenshot below:

   a.

2. **Enter the date the client's diagnosis changed** for the Program Enrollment by using the "Effective date" on the new Diagnosis Document. The client diagnosis change could align with the service treatment period. However, keep in mind a Diagnosis Document is required for the service entry period, and can be unique to the individual treatment service period – as shown in the example below:

NOTE: Changing the documents effective date may affect Service Entry and Claiming.

3. To update the ***primary diagnosis*** code, select the applicable radio button next to the diagnosis in the Diagnosis list area. This will populate the information in the Diagnosis section of the document to be changed/modified. Update the "Type" from "Primary" to "Additional" update the order sort – as shown on the screenshot below:

NOTE: The effective date of the diagnosis document will determine which diagnosis document will be referenced during service entry. The service date will use the effective date of the diagnosis document. This date is critical and can impact a service from being claimed successfully if they do not align.

When updating the diagnosis information there MUST be a primary diagnosis code on the document to save and sign the diagnosis document. Delete the ICD-10 diagnosis code by selecting the ✕ next to the applicable diagnosis in the Diagnosis List area.

Select **Modify**, to update the Diagnosis information in the Diagnosis list area.

			Order	DSM 5/ ICD 10	SNOMED	R/O	ICD/ DSM Description	SNOMED Description	Type	Severity	Source	Comments
✕	○	ⓘ	4	F41.0*	231502...		Panic disorder	Situational panic at...	Additional			
✕	○	ⓘ	2	F43.0*	192037...		Acute stress disorder	Acute panic state d...	Additional			
✕	○	ⓘ	3	F44.0	225040...		Dissociative amnesia	Localized dissociati...	Additional			

Diagnosis List — with Insert and Clear buttons

4. To add the new **Primary Diagnosis** code, Enter the applicable ICD code, update the "Type" to "Primary", change the order to "1" and select **Insert** to add the new Primary Diagnosis code to the Diagnosis List area – as shown on the screenshot below:

5. The Diagnosis list will be updated with the new *primary diagnosis* code – as shown on the screenshot below:

6. Once the diagnosis information is complete. Select the [Sign] button on the document status bar to sign and complete the NEW "Diagnosis Document" with the NEW "Effective date".

A PDF diagnosis document will be displayed on the screen informing the user the signed Diagnosis Document has been completed for the client Program Enrollment that may also cover the service entry period.

Chapter 11: OutPatient Annual /Discharge Document

CSI Periodic Data

The CSI Periodic data is no longer captured on a separate screen.

A Periodic record describes the current education, employment, conservatorship/court status, living arrangement and caregiver status for a person. The information in the Periodic record is used to measure the effectiveness of services.

The data is reported at time of Admission, Annually and at formal Discharge. Completing the Mental Health Services Registration document, captures the Periodic data at time of Program Enrollment/Admissions. The Annual and Discharge data will be captured on the MHS Annual/Discharge Document.

Outpatient - Discharge Client

1. To access the MHS Annual/Discharge document, begin typing "annual/discharge" in the search bar and the MHS Annual/Discharge will appear on the list.

2. Select Program in the CDAG Program Enrollment popup.

3. MHS Annual/Discharge document is displayed.

MHS Annual/Discharge

Effective [ ] **Status** New **Author** Chu, Willie 05

General | Diagnosis | ClientReferredFromTo

CSI Episode Information

Update Reason	[ ]	Program	[ ]
Admission Date	[ ]	First Date of Service	[ ]	Last Date of Service	[ ]
Discharge Date	[ ]	Patient Status	[ ]	Legal Class at Admission	[ ]
Legal Class at Discharge	[ ]	Admission Necessity	[ ]	

General Information

First Name	Miriam	Last Name	Test-Case	Middle Name	[ ]
Suffix	[ ]	SSN	108225432		
Date of Birth	07/01/1953	Medi-Cal ID	[ ]		

Current Client Status Information

Employment Status	[ ]	Education Status	[ ]
Living Arrangement	[ ]	Conservatorship or Juvenile Court Status	[ ]
Has the client experienced a traumatic event?	[ ]	# of Dependents under the age of 18	[ ]
# of Dependents over the age of 17	[ ]		

General Medical Condition(s)

1. Allergies   2. No General Medical Condition   3. [ ]

Does the client have a Substance Abuse/Dependence issue?   Yes, the client has a substance abuse / c

Substance Abuse/Dependence Diagnosis   F14.11 Cocaine abuse, in remission

4. The **Effective Date** is the **Program discharge date**.

MHS Annual/Discharge

Effective 04/17/2025 **Status** New **Author** Chu, Willie 04/17/2025 Sign

CSI Episode Information Section: Required

Complete these fields in order to discharge a client.

1. Update Reason: Choose **Discharge**
2. Program: **Required**. Select the Program associated with your client.
3. Admission Date: **Required** – confirm prepopulated data.

General Information Section: Required

Confirm prepopulated fields.

First Name: **Required** –prepopulated data.

Last Name: **Required** –prepopulated data.

Middle Name: **If Applicable** –prepopulated data.

Suffix: **If Applicable** –prepopulated data.

SSN: **Required** –prepopulated data.

Date of Birth: **Required** –prepopulated data.

Medi-Cal ID: **If Applicable** –prepopulated data.

Current Client Status Information Section: Required

All the fields in this section are Required. Some of the fields are prepopulated and you are required to update the data if it has changed.

1. Employment Status: **Required.**

2. Living Arrangement: **Required.**

3. Has the client experienced a traumatic event?: **Required.**

   Purpose: Identifies clients that have experienced traumatic events including experiences such as having witnessed violence, having been a victim of crime or violence, having lived through a natural disaster, having been a combatant or civilian in a war zone, having witnessed or having been a victim of a severe accident, or having been the victim of physical, emotional, or sexual abuse.

4. # of Dependents over the age of 17: **Required.**

5. General Medical Conditions Fields: **Required.**

   If you select "No General Medical Condition" in number 1, then #2 and #3 are not applicable. **Required.**

   o   If a Medical Condition is indicated in #1, such as Asthma, the General Medical Condition in #2 is required.

   o   If no additional Medication Condition is identified, indicate "No General Medical Condition" in #2.

   o   Duplicates are not allowed.

5. Does the client have a Substance Abuse/Dependence Issue: **Required.** Select "yes" or "no".

   If "yes", is selected then you will need to complete the next field which is the diagnosis.

Substance Abuse/Dependence Diagnosis: Conditional. Required. Select a diagnosis. Type in F10.x and it will provide a drop down list to choose from.

6. Education Status: **Required.**

7. Conservatorship or Juvenile Court Status: **Required.** Identifies whether or not the client has a conservatorship or juvenile court status.

8. # of Dependents under the age of 18: **Required.**

#2 Diagnosis Tab –

A "closing" Diagnosis is **Required**.

NOTE: Create a new Diagnosis document if the closing diagnosis is different than the current diagnosis.

#3 Client ReferredFromTo Tab - **Not Used.**

Now the discharge is ready to be signed. Click on the **Sign** button

Below is an example of the Discharge document that is generated in a pdf format.

MHS Annual/Discharge

Client Information

Client Name: Test-Case,Miriam		DOB: 07/01/1953
Client ID: 75211890		Effective Date: 04/16/2025

CSI Episode Information

	Update Reason:	Discharge	Program:	A BETTER WAY MHS CHILD (81941)
Admission Date:	07/02/2024			

General Information

First Name:	Miriam	Last Name: Test-Case	Middle Name:
Suffix:			
Date of Birth:	07/01/1953	Medi-Cal ID:	

Current Client Status Information

Employment Status:	Competitive job market, 20 hours/less	Education Status:	Grade 11

Once this is completed you can go to the Programs (Client) and you can see that they have a program enrollment, that is now discharged.

Programs (16)

Program Name	△ Status	Enrolled	Discharged	Assigned Staff	Primary	Last DOS	Next DOS
A BETTER WAY ALAME...	Enrolled	07/01/2023			No		
A BETTER WAY MHS C...	Discharged	07/02/2024	04/16/2025		No		
ADULT FORENSIC BEH...	Discharged	09/18/2024	09/18/2024	04/16/2025	ni...	No	
ADULT FORENSIC BEH...	Enrolled	09/18/2024		Moore, Lisa	No		

Annual Updates:

Required. This is required once a year.

NOTE: You are seeing the same screens, but you need to go through and update/verify that all the information is current.

You will use the MHS Annual/Discharge Document and will follow the same process as outlined in Discharge Document, with the following changes:

1. CSI Episode Information: Select Annual as the option.

General Information Section

This should have initialize the client information.

You will be required to complete the below fields. These are known as the CSI Periodic Data Fields:

The Diagnosis Tab

Contains the client's diagnosis and if there is already a signed diagnosis document for the client, that diagnosis will initiate when you open the Diagnosis Document.

1. The Add Diagnosis button will redirect the user to the Diagnosis Document Screen. The user may add or update diagnosis information. Refer to the Diagnosis Document section for additional details.

NOTE: Only the new Registration Document will have the signed document listed in the below grid.

2. The final step is to **Sign** this Annual/Discharge Document.

3. Once this is complete, a pdf. document will be created.

Chapter 12: Timeliness Overview

Please use the Timeliness eForm to submit timeliness information.

You need to be logged into the ACBHD Network to access the Timeliness e-form. If you are with an agency, you will need to be logged into Citrix first using the Citrix Portal. Once you are logged in, click this link to take you directly to the eForm: eforms3.acbhcs.org/lincdoc/doc/run/alameda/CSI_Timeliness

The Timeliness e-form can also be located under the ACBH Forms section. ACBH Forms

Timely Access Data Tool

This data is for New/New Returning Clients.

- Timely Access Data Tool (TADT) Reporting Form

  Use this online form to enter your Timely Access Data.

Chapter 13: Clinicians Gateway

NOTE: A Program Enrollment must be opened before the clinician can create a Progress Note in the Clinicians Gateway (CG) application.

- **Timeliness** in opening an Program Enrollment is extremely important for the clinical staff to complete a Progress Note in CG.

- **New** Client Information and Program Enrollment data is transferred from the SmartCare system to the CG application in 5-minute intervals.

- **Updates** to existing Client Information and Program Enrollment data is transferred nightly from the SmartCare system to the CG application.

Chapter 14: SmartCare Reports

Reports are valuable and essential documents that provide important and useful insights to help guide decision making. ACBHD's priority is to provide "actionable" SmartCare data for our users through operational, performance and financial reports.

Report Rollout Approach:

Reporting has been split into two phases to ensure that SmartCare Reports reach users as quickly as possible.

> **Phase 1** – Introduces a self-service model, where users can log into SmartCare and access reports based on their security permissions (CDAG). We are currently in this phase.

> **Phase 2** – We will explore ways to distribute reports directly to users in an automated fashion.

How To Access SmartCare Reports:

1. On the left-hand side of your screen, go to your Quick links to navigate to "All Reports".
2. Click on Reports (Open) to view a comprehensive list of all SmartCare reports published to date.
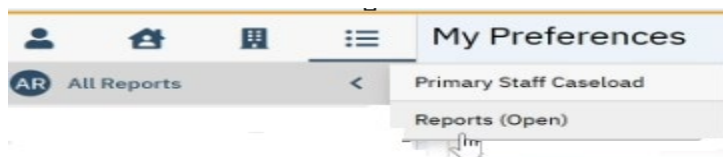
Report Prioritization: Reports will continue to be prioritized and published on an ongoing basis. Please check the ACBHD Providers Website - SmartCare section for detailed information, or log into SmartCare system directly to see which reports are currently available.

Report Structure: Each report will have a user guide and will provide the following information:

- **Purpose of the Report:** A brief description of the report.
- **Scope of Report:** The data parameters used to develop the report.
- **Instructions:** Guidance on how to access and use each report.

User & Testing Feedback: Prior to any SmartCare report being published, a group of SmartCare end users from various CBO Agencies and Service Areas have tested these reports. The reports that are being rolled out, were approved by these end users.

Report Improvement Areas: If you encounter any issues with the reports, please contact the IS Helpdesk.

When submitting a request, be sure to include:

- Report Number
- Screen Shots (if applicable)
- A clear explanation of the issue, including enough details to help us investigate.

Also, please suggest immediate steps we can take to address the issue you identified. Your feedback will be reviewed and prioritized along with the other report development tasks.

Appendix A:

SmartCare Global Codes

This document lists SmartCare Global codes for: Mental Health Services Registration, which includes Client General/Demographic Information, Program Enrollment, Service Entry, and MHS Update/Discharge.

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).

City Hall Codes use for Homeless Client Address			
Alameda	94501	Newark	94560
Albany	94706	Oakland	94612
Berkeley	94704	Piedmont	94611
Castro Valley	94546	Pleasanton	94566
Dublin	94568	San Leandro	94577
Emeryville	94608	San Lorenzo	94580
Fremont	94538	Sunol	94586
Hayward	94541	Union City	94587
Livermore	94550		

ADDRESS SUFFIXES

The following table contains primary street suffix names, common street suffixes or suffix abbreviations and recommended by the Postal Services.

NOTE: When entering in suffixes, please <u>do not use Punctuation</u> and <u>use all CAPS</u> when entering these into the SC System.

Primary Street Suffix Name	Postal Service Standard Suffix Abbreviation	Primary Street Suffix Name	Postal Service Standard Suffix Abbreviation	Primary Street Suffix Name	Postal Service Standard Suffix Abbreviation
ALLEY	ALY	GROVE	GRV	PLAIN	PLN
ANEX	ANX	GROVES	GRVS	PLAZA	PLZ
ARCADE	ARC	HARBOR	HBR	POINT	PT
AVENUE	AVE	HARBORS	HBRS	PORT	PRT
BEACH	BCH	HAVEN	HVN	PRAIRIE	PR
BLUFFS	BLFS	HEIGHTS	HTS	RADIAL	RADL
BOTTOM	BTM	HIGHWAY	HWY	RAMP	RAMP
BOULEVARD	BLVD	HILL	HL	RANCH	RNCH
BRANCH	BR	HILLS	HLS	RAPID	RPD
BRIDGE	BRG	HOLLOW	HOLW	REST	RST
BROOK	BRK	INLET	INLT	RIDGE	RDG
BYPASS	BYP	ISLAND	IS	RIVER	RIV
CAMP	CP	ISLE	ISLE	ROAD	RD
CANYON	CYN	JUNCTION	JCT	ROUTE	RTE
CAPE	CPE	KEY	KY	ROW	ROW
CAUSEWAY	CSWY	KEYS	KYS	RUE	RUE
CENTER	CTR	KNOLL	KNL	RUN	RUN
CIRCLE	CIR	LAKE	LK	SHOAL	SHL
CLIFF	CLF	LAND	LAND	SHORE	SHR
CLUB	CLB	LANDING	LNDG	SHORES	SHRS
COMMON	CMN	LANE	LN	SKYWAY	SKWY
CORNER	COR	LIGHT	LGT	SPRING	SPG
COURSE	CRSE	LIGHTS	LGTS	SPUR	SPUR
COURT	CT	LOAF	LF	SQUARE	SQ
COVE	CV	LOCK	LCK	STATION	STA
CREEK	CRK	LODGE	LDG	STRAVENUE	STRA
CRESCENT	CRES	LOOP	LOOP	STREAM	STRM
CROSSING	XING	MALL	MALL	STREET	ST
DRIVES	DRS	MANOR	MNR	SUMMIT	SMT
ESTATE	EST	MEADOW	MDW	TERRACE	TER

Primary Street Suffix Name	Postal Service Standard Suffix Abbreviation	Primary Street Suffix Name	Postal Service Standard Suffix Abbreviation	Primary Street Suffix Name	Postal Service Standard Suffix Abbreviation
ESTATES	ESTS	MEWS	MEWS	THROUGHWAY	TRWY
EXPRESSWAY	EXPY	MILL	ML	TRACE	TRCE
FALLS	FLS	MISSION	MSN	TRACK	TRAK
FIELD	FLD	MOTORWAY	MTWY	TRAFFICWAY	TRFY
FIELDS	FLDS	MOUNT	MT	TRAIL	TRL
FLAT	FLT	MOUNTAIN	MTN	TRAILER	TRLR
FORD	FRD	MOUNTAINS	MTNS	TUNNEL	TUNL
FOREST	FRST	NECK	NCK	TURNPIKE	TPKE
FORGE	FRG	ORCHARD	ORCH	UNDERPASS	UPAS
FORK	FRK	OVAL	OVAL	UNION	UN
FORT	FT	OVERPASS	OPAS	VALLEY	VLY
FREEWAY	FWY	PARK	PARK	VIADUCT	VIA
GARDEN	GDN	PARKWAY	PKWY	VIEW	VW
GARDENS	GDNS	PASS	PASS	VILLAGE	VLG
GATEWAY	GTWY	PASSAGE	PSGE	VILLE	VL
GLEN	GLN	PATH	PATH	VISTA	VIS
GLENS	GLNS	PIKE	PIKE	WALK	WALK
GREEN	GRN	PINE	PNE	WALL	WALL
GREENS	GRNS	PLACE	PL	WAY	WAY
				WELL	WL

Helpful Links:

1. The best way to format an Address is enter the address into this Postal Services tool:

https://tools.usps.com/zip-code-lookup.htm?byaddress

2. The list of Postal Services Street Suffix Abbreviation can be found here:
https://pe.usps.com/text/pub28/28apc_002.htm

COUNTY CODES

Alameda	Placer
Alpine	Plumas
Amador	Riverside
Butte	Sacramento
Calaveras	San Benito
Colusa	San Bernardino
Contra Costa	San Diego
Del Norte	San Francisco
El Dorado	San Joaquin
Fresno	San Luis Obispo
Glenn	San Mateo
Humboldt	Santa Barbara
Imperial	Santa Clara
Inyo	Santa Cruz
Kern	Shasta
Kings	Sierra
Lake	Siskiyou
Lassen	Solano
Los Angeles	Sonoma
Madera	Stanislaus
Marin	Sutter
Mariposa	Tehama
Mendocino	Trinity
Merced	Tulare
Modoc	Tuolumne
Mono	Ventura
Monterey	Yolo
Napa	Yuba
Nevada	Unknown California County
Orange	Not California County

STATE CODES

Alabama	Nebraska
Alaska	Nevada
Arizona	New Hampshire
Arkansas	New Jersey
California	New Mexico
Colorado	New York
Connecticut	North Carolina
Delaware	North Dakota
District of Columbia	Ohio
Florida	Oklahoma
Georgia	Oregon
Hawaii	Pennsylvania
Idaho	Rhode Island
Illinois	South Carolina
Indiana	South Dakota
Iowa	Tennessee
Kansas	Texas
Kentucky	Utah
Louisiana	Vermont
Maine	Virginia
Maryland	Washington
Massachusetts	West Virginia
Michigan	Wisconsin
Minnesota	Wyoming
Mississippi	
Missouri	Unknown State
Montana	Not US State

COUNTRY CODES

AFGHANISTAN	CAMBODIA
ALBANIA	CAMEROON
ALGERIA	CANADA
AMERICAN SAMOA	CAPE VERDE
ANDORRA	CAYMAN ISLANDS
ANGOLA	CENTRAL AFRICAN REPUBLIC
ANGUILLA	CHAD
ANTARCTICA	CHILE
ANTIGUA AND BARBUDA	CHINA
ARGENTINA	CHRISTMAS ISLAND
ARMENIA	CLIPPERTON
ARUBA ISLANDS	COCOS (KEELING) ISLANDS
ASHMORE/CARTIER ISLANDS	COLOMBIA
AUSTRALIA	COMOROS
AUSTRIA	CONGO
AZERBAIJAN	COOK ISLANDS
BAHAMAS	CORAL SEA ISLANDS
BAHRAIN	COSTA RICA
BAKER ISLAND	COTE D'IVOIRE
BANGLADESH	COUNTRY NOT LISTED
BARBADOS	CROATIA
BASSAS DA INDIA	CUBA
BELARUS	CYPRUS
BELGIUM	CZECH REPUBLIC
BELIZE	DENMARK
BENIN	DJIBOUTI
BERMUDA	DOMINICA
BHUTAN	DOMINICAN REPUBLIC
BOLIVIA	ECUADOR
BOSNIA/HERZEGOVINA	EGYPT
BOTSWANA	EL SALVADOR
BOUVET ISLAND	EQUATORIAL GUINEA
BRAZIL	ERITREA
BRITISH INDIAN OCEAN TERRITORY	ESTONIA
BRITISH VIRGIN ISLANDS	ETHIOPIA
BRUNEI	EUROPA ISLAND
BULGARIA	FALKLAND ISLANDS/MALVINAS
BURKINA	FAROE ISLANDS
BURMA	FEDERATED STATES OF MICRONESIA
BURUNDI	FIJI
FINLAND	JARVIS ISLAND
FRANCE	JERSEY

FRENCH GUIANA	JOHNSTON ATOLL
FRENCH POLYNESIA	JORDAN
FRENCH SOUTHERN/ANTARCTIC	JUAN DE NOVA ISLAND
GABON	KAZAKHSTAN
GAMBIA	KENYA
GAZA STRIP	KINGMAN REEF
GEORGIA	KIRIBATI
GERMANY	KOREA DEMOCRATIC REPUBLIC
GHANA	KOREA, REPUBLIC OF
GIBRALTAR	KUWAIT
GLORIOSO ISLANDS	KYRGYZSTAN
GREECE	LAOS
GREENLAND	LATVIA
GRENADA	LEBANON
GUADELOUPE	LESOTHO
GUAM	LIBERIA
GUATEMALA	LIBYA
GUERNSEY	LIECHTENSTEIN
GUINEA	LITHUANIA
GUINEA-BISSAU	LUXEMBOURG
GUYANA	MACAU
HAITI	MACEDONIA
HEARD ISLAND/MCDONALD ISLANDS	MADAGASCAR
HONDURAS	MALAWI
HONG KONG	MALAYSIA
HOWLAND ISLAND	MALDIVES
HUNGARY	MALI
ICELAND	MALTA
INDIA	MAN,ISLE OF
INDONESIA	MARSHALL ISLANDS
IRAN	MARTINIQUE
IRAQ	MAURITANIA
IRELAND	MAURITIUS
ISRAEL	MAYOTTE
ITALY	MEXICO
JAMAICA	MIDWAY ISLANDS
JAN MAYEN	MOLDOVA
JAPAN	MONACO
MONGOLIA	SPAIN
MONTENEGRO	SPRATLY ISLANDS
MONTSERRAT	SRI LANKA
MOROCCO	ST. HELENA
MOZAMBIQUE	ST. KITTS AND NEVIS
NAMIBIA	ST. LUCIA
NAURU	ST. PIERRE AND MIQUELON
NAVASSA ISLAND	ST. VINCENT/THE GRENADINES
NEPAL	SUDAN
NETHERLANDS	SURINAME

NETHERLANDS	SVALBARD
NEW CALEDONIA	SWAZILAND
NEW ZEALAND	SWEDEN
NICARAGUA	SWITZERLAND
NIGER	SYRIA
NIGERIA	TAIWAN
NIUE	TAJIKISTAN
NORFOLK ISLAND	TANZANIA
NORTHERN MARIANA ISLANDS	THAILAND
NORWAY	TOGO
OMAN	TOKELAU
PAKISTAN	TONGA
PALAU	TRINIDAD AND TOBAGO
PALMYRA ATOLL	TROMELIN ISLAND
PANAMA	TUNISIA
PAPUA NEW GUINEA	TURKEY
PARACEL ISLANDS	TURKMENISTAN
PARAGUAY	TURKS AND CAICOS ISLANDS
PERU	TUVALU
PHILIPPINES	UGANDA
PITCAIRN ISLANDS	UKRAINE
POLAND	UNITED ARAB EMIRATES
PORTUGAL	UNITED KINGDOM
PUERTO RICO	UNITED STATES
QATAR	URUGUAY
REUNION	UZBEKISTAN
ROMANIA	VANUATU
RUSSIA	VATICAN CITY
RWANDA	VENEZUELA
SAN MARINO	VIETNAM
SAO TOME AND PRINCIPE	VIRGIN ISLANDS
SAUDI ARABIA	WAKE ISLAND
SENEGAL	WALLIS AND FUTUNA
SERBIA	WEST BANK
SEYCHELLES	WESTERN SAHARA
SIERRA LEONE	WESTERN SAMOA
SINGAPORE	YEMEN
SLOVAKIASI/SLOVENIA	ZAIRE
SOLOMAN ISLANDS	ZAMBIA
SOMALIA	ZIMBABWE
SOUTH AFRICA	Unknown Country
SOUTH GEORGIA/SANDWICH ISLANDS	

Client General/Demographic Information

Sex/Sex Assigned at Birth – (*) CSI

Female	Male	Unknown

Marital Status

Never married Married Widowed	Divorced Separated Unknown

Gender Identity (current)

Male Female Gender Queer (not exclusively male or female)	Transgender (Trans Woman) Transgender (Trans Man) Gender Non-Conforming Other Additional Gender Category	Prefer Not To Answer/Declined to state Unknown/Not Available

Sexual Orientation

Heterosexual/Straight Gay Lesbian Bisexual	Queer Questioning Other Additional Sexual Orientation	Prefer Not To Answer Unknown

What is your Pronoun (Personal (or preferred) Pronoun)

He/Him She/Her	They/Them Other Pronoun	Prefer Not to Answer Unknown

Ethnicity – (*) CSI

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

Race – (*) CSI

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

Legal Consent (Conservatorship) – (*) CSI (**) Periodic data

This field is normally used to indicate the type of authorization given to treat a minor.

	Unknown
	Not Applicable
	Temporary Conservatorship (W&I Code, Section 5353)
Must be age 14 & over	Lanterman-Petris-Short (W&I Code, Section 5358)
	Murphy (W&I Code, Section 5008)
	Probate (Probate Code, Division 4, Section 1400)
	PC 2974 (Penal Code, Section 2974)
Must be less Than age 25	Representative Payee Without Conservatorship (W&I Code, Section 5686)
	Juvenile Court, Dependent of the Court (W&I Code, Section 300)
	Juvenile Court, Ward - Status Offender (W&I Code, Section 601)
	Juvenile Court, Ward - Juvenile Offender (W&I Code, Section 602)

Trauma – (*) CSI

Identifies clients that have experienced traumatic events including experiences such as having witnessed violence, having been a victim of crime or violence, having lived through a natural disaster, having been a combatant or civilian in a war zone, having witnessed or having been a victim of a severe accident, or having been a victim of physical, emotional, or sexual abuse.

Yes	No	Unknown

GMC (*) CSI

Identifies up to three **General Medical Condition Summary Codes** from the list below that most closely identify the client's general medical condition(s), if any. No Duplicates allowed:

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

Substance Abuse / Dependence Issue – (*) CSI

Identifies whether or not the client has a substance abuse / dependence issue. If Yes , must enter a valid ICD10 Substance Abuse diagnosis code

Yes, Requires ICD-10 Substance Abuse Diagnosis Code	No

Physical Disability/Disabilities – select all that apply

None	Client Declined to State
Visual	Client Unable to Answer due to Disability ONLY
Hearing	Severe Visual Impairment
Speech	Severe Hearing Impairment
Mobility	Speech Impairment
Mental	Physical Impairment/Mobility
Developmentally Disabled	Other Physical Impairment
Other Disability	Unknown

Care Giver - (*) CSI # of Dependents over the age 17

Enter the number of persons the client cares for, or is responsible for, at least 50% of the time, for the age categories of under the age of 18 and over the age of 18.

00 = None	01-98 Number of Persons	99 = Unknown

Living Situation (*)CSI(**)Periodic Data

NOTE: Please see ACBH Housing Definitions

Adult Residential Facility, Social Rehabilitation Facility	House or apt & requiring some support with daily living activities (adult only)	State Hospital
Alcohol Abuse Facility	Housing or apt & requiring daily support and supervision (adults only)	Supporting Housing
Community Treatment Facility	Hotel	Temporary Arrangement
Crisis Residential Facility	Justice Related	VA Hospital
CRTS long-term or transitional housing	Large Board & Care (7 beds or more)	Other
Drug Abuse Facility	Mental Health Rehabilitation Center (24 hour)	Unknown
Foster Family Home (for children)	PHF/Inpatient Psych	
General Hospital	Residential Treatment Center (includes Level 13-14 for children)	
Group Home(includes Levels 1-12 for children)	Satellite housing (adults only)	
Group quarters (dorm, migrant barracks)	Single room (motel, rooming hours)	
Homeless, in transit	Small Board & Care (6 beds or less)	
Homeless, no identifiable county residence	SNF/ICF/IMD, for Psychiatric reasons	
Housing or apartment (includes trailers)	SNF/ICG/Nursing Home for Physical health reasons	

Education – (*) CSI (**) CSI Periodic

NOTE: Identifies the highest grade level completed by the client.

If the highest grade is greater than Grade 20, select Grade 20	Other, includes vocational education and training
Use Grade 12 if the client completed High School	If Unknown, select Unknown
Use Grade 12 for GED	

Veteran Status

Is a Veteran	Declined to State
Is Not a Veteran	Unable to Answer due to disability ONLY

Military Status

Yes	No

Employment Status (*)CSI (**) Periodic data

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

Primary Language/ Preferred Language – (*) CSI

English	Farsi	Japanese	Pashto	Turkish
Spanish	French	Korean	Polish	Vietnamese
Sign ASL	German	Lao	Portuguese	Unknown/Not Reported
Arabic	Hebrew	Mandarin	Punjabi	
Armenian	Hindi	Mien	Russian	
Cambodian	Hmong	Other Chinese Dialects	Samoan	
Cantonese	Ilocano	Other Non-English	Tagalog	
Chinese Dialects	Italian	Other Sign Language	Thai	

Housing Definitions

Code	Term	Current Definition
05	Foster family home (children)	Applies to children only. Living with an approved foster family through child and family services (Social Services Agency).
06	Single room (motel, rooming house)	A facility or residence where the rooms either lack a cooking facility, bathroom, or both. Sometimes the building offers shared bathrooms and cooking facilities. Consumers hold their own lease or rental agreement. There are no on-site service programs or staff members, although external service providers may visit individual tenants.
07	Group quarters (dorm, migrant barracks)	Group living situation sponsored by an institution. Housing is linked with participation in a particular program or institution. Bathrooms and kitchens usually shared.
08	Group Home	Applies to children only. Approved group homes for children licensed by California Department of Community Care licensing. RCL 11 and below.
09	CRTs long-term or transitional housing	Non-institutional residential setting, therapeutic or rehab services, structured program as alternative to hospitalization for someone experiencing an acute psychiatric episode or crisis who do not present medical complications requiring nursing care, 24/7 service. Stays range from 30 days to 24 months. Also applies to individuals living in transitional housing programs specifically designed for serving homeless persons.
10	Satellite housing	Same as house or apt with supervision except housing is associated with exiting a particular treatment program.
13	House/Apartment	A house or apartment with its own cooking facilities and bathroom, shared according to terms established by the consumer in collaboration with other members of the household. Consumers either own the house or hold their own lease or rental agreement. The consumer must pay all or a share of the mortgage or rent. The consumer may live alone, with a spouse, partner, minor children, other dependents, and/or roommate(s). Includes independent or emancipated minors.
14	House or Apt with Support	A house or apartment where the consumer lives with others (family, friends) and receives some support from those living with the person; someone in the household has a signed lease agreement with the landlord or owns the property but the consumer is not part of the lease, rental agreement, or ownership of the building. This category includes the former "living with family/friends" category. Includes minors living with parents or relatives.

Code	Term	Current Definition
15	House or Apt with Supervision	Also known as unlicensed but supervised congregate placement, group living homes, sober living homes. Shared housing with limited to no roommate choice. Shared bathrooms and/or kitchens. Often lack formal lease or rental agreements. May include some meals and on-site supervision and support.
16	Supported Housing	A housing unit located in an apartment complex, an SRO, a single-family residence, or a private building in which consumers hold their own lease or rental agreement or with a not-for-profit organization acting as the master leaser. In some situations, cooking facilities and bathrooms may be shared. Some social/clinical services are formally connected with the building through master leasing arrangement and/or services provided on site in private offices or common areas. Services are VOLUNTARY and not a condition of tenancy.
20	Small Board & Care (6 beds or less)	Licensed adult residential facility (ARF), residential care facility for the elderly (RCFE), or residential care facility for the chronically ill (RCFCI) with 6 beds or less. Admission agreement, no lease, includes meals.
21	Large Board & Care (7+ beds)	Licensed adult residential facility (ARF), residential care facility for the elderly (RCFE), or residential care facility for the chronically ill (RCFCI) with 7 or more beds. Admission agreement, no lease, includes meals.
22	Residential Treatment Center	A residential facility that provides 24/7 services to people with psychiatric disabilities that is NOT a mental health rehabilitation center, SNF, ICF, IMD, CRT, or transitional housing. Includes children & youth in therapeutic RTF that are RCL 12-14.
23	Community Treatment Facility	A residential facility that provides mental health treatment services to children in a group setting and that has the capacity to provide secure containment.
24	Adult Residential/Social Rehab	A Social Rehabilitation Facility is any facility that provides 24-hour-a-day non-medical care and supervision in a group setting to adults recovering from mental illnesses, that temporarily need assistance, guidance, or counseling. Alameda County = Casa Phoenix, Casa de la Vida, Bonita House, and Woodroe place. Admission agreement, no lease, includes meals.
31	State Hospital	NAPA state psychiatric hospital
32	VA Hospital	General or psychiatric Veterans Administration Hospital
33	SNF/ICF/IMD for Psychiatric Reasons	Licensed residential, short-term treatment facilities focused primarily on psychiatric rehabilitation, 24/7 care. May have medical issues as well but primarily staying at facility for psychiatric reasons. Ex. Garfield Neurobehavioral Center, Morton Bakar Center, etc.
34	SNF/ICF/Nursing home for Physical Reasons	Licensed residential, short-term treatment facilities focused on physical rehabilitation, 24/7 care. May have psychiatric issues as well but primarily staying at facility for physical reasons. Ex. Medical Hill Rehabilitation Center, Fairmount, etc.

Code	Term	Current Definition
35	General Hospital	Hospital for medical illness - Alta Bates, Highland, Kaiser, etc.
36	Mental Health Rehabilitation Center	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. 24/7 staffing, focusing on rehabilitation. Ex. Villa Fairmont, Gladman, etc.
37	PHF/Inpatient Psych	Inpatient psychiatric unit - John George, Fremont, Herrick, Willow Rock, etc.
40	Drug abuse facility	Licensed residential drug abuse treatment facility. Note: Select this option if the consumer's primary reason for participating in the program is related to an addictive substance other than alcohol.
41	Alcohol abuse facility	Licensed residential alcohol abuse treatment facility. Note: Select this option if the consumer's primary reason for participating in the program is related to an addiction to alcohol.
42	Justice Related	Prison, jail, community-based justice facility, or temporarily detained in Juvenile Justice Center.
50	Temporary Arrangement	Consumer is living in a facility that provides short-term housing (e.g., Single Room Occupancy Motel, Safe Haven, living with friends and paying no rent). The consumer does not hold a lease and is staying on a day-to-day, week-to-week, or month-to-month basis. This category includes individuals temporarily housed through a public program, e.g., social services emergency housing voucher. Also refers to a short-term housing arrangement in which the individual is temporarily staying with friends, family, or others with a willingness to house the person for a limited time (less than 30 days). Includes youth "couch surfing" with friends or family due to homelessness.
51	Homeless, no identifiable county residence	Includes living on the streets, place not meant for human habitation, or an emergency shelter for homeless persons. Also includes persons fleeing a domestic violence situation and individuals with an eviction within a week from a private dwelling unit and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing. Person typically resides in or plans to reside in Alameda County.
52	Homeless, in transit	Includes living on the streets, place not meant for human habitation, or an emergency shelter for homeless persons. Also includes persons fleeing a domestic violence situation and individuals with an eviction within a week from a private dwelling unit and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing. Generally assumed that person lives outside of Alameda County.
98	Other	Type of housing not listed above, should be rarely used.

Code	Term	Current Definition
99	Unknown	Current housing status unknown by staff.

Referral Codes (data field TBD)

Referral Codes—Source and Destination—can be any program Reporting Unit number in your system. In addition there are number of generic codes. These codes are to be used only when there is no specific mental health reporting unit, or when there is no specific local agency code.

01 = Self	17 = Jail	43 = Dept. Social Services
02 = Family	20 = Acute Day Treatment	44 = Criminal Justice
03 = Friends	21 = Habilitative Day Treatment	45 = Drug Abuse Program
04 = Employer	30 = Emergency Psychiatric	46 = Alcohol Abuse Program
05 = Other	31 = Suicide & Crisis	47 = School/College
06 = County Resident	32 = Outpatient Clinic	48 = Vocational Rehab Program
10 = State Hospital MH	33 = Private MH Practice	49 = Veterans Administration
11 = State Hospital DD	37 = Case Management	50 = Clergy or Religious Org.
12 = Other Psychiatric Hosp	38 = Homeless Program	51 = Other Human Service Org.
13 = Psychiatric SNF	40 = Medical Inpatient	
14 = Alternative to Hospitalization	41 = Medical Outpatient	
15 = CRTS Program	42 = Convalescent Hosp	

Discharge Fields:

Reason for Discharge (data field TBD)	
Mutual Agreement/Treatment Goals Reached	Client Moved Out of Service Area
Mutual Agreement/Treatment Goals Partially Reached	Client Discharged/Program Unilateral Decision
Mutual Agreement/Treatment Goals Not Reached	Client Incarcerated
Client Withdrew: AWOL, AMA, Treatment Partially Completed	Discharge/Administrative Reasons
Client Withdrew: AWOL, AMA No Improvement	Other
Client Died	

Service Entry

This document lists Standard codes for the Direct and Indirect Service Screens

Service Location Entry Codes		
Office (Primary)	Inpatient (Non-Psych) Hosp	Public Health Clinic
Office (Satellite)	Inpatient (Psych) Hosp	Residential Substance Abuse Fac
Field	Licensed Care	School
Comm Mental Health Center	Opioid (Non-Res) Tx Facility	Skilled Nursing Facility
Crisis Field	Outpt Substance Abuse Tx Fac	Telehealth (Patient in home)
Crisis Mobile Unit-Service	Patient's home	Telehealth (Patient not home)
Court	Patient's Work Site	Temporary Lodging
Custodial Care Facility	Other Community Loc	Urgent Care Facility
Emergency Room (Hospital)	Pharmacy	Location Unknown/Other
Faith Based	Phone (Patient in home)	
FQHC	Phone (Patient not home)	
Group/Board and Care Home	Prison/Correction Facility	
Health/Primary Care	Psych Facility (Partial Hosp)	
Homeless/ER Shelter	Psych Residential Tx Ctr (adult)	
Hospice	Psych Residential Tx Ctr (child)	

The following data fields are for 24 Hour Facility Only:

The SmartCare Global Codes are only collected from 24 Hour Facility Programs.

Legal Status – (*) CSI
W60000 = Voluntary W51500 = 72 Hour Hold
W55850 = 72 Hour Hold for Minor
W52500 = First 14 Day Hold
W52600 = Second 14 Day Hold
W52700 = Thirty Day Extension for Grave Disability
W53000 = 180 Day Post Certification
W53520 = Temporary Conservatorship
W53521 = Temporary Conservatorship Extension
W53550 = Permanent Conservatorship
W53551 = Permanent Conservatorship Extension
P10260 = Not Guilty by Reason of Insanity

P13680 = Incompetent To Stand Trial