

**Uniform Record Manual
For Alcohol and Drug Treatment
Providers
(June 2014)**

CLIENT FILE ORDER

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***Medi-Cal Providers Only**

Section 1 Intake/Financial

| | |
|---------|---|
| F101 | DMC Tracking Form * |
| F101a | Non-Drug Medi-Cal Clients Tracking Form |
| F102a,b | QAR Review Worksheets * |
| F103 | DMC Eligibility Printout * |
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| F104a | Minor Children Information Form |
| F105 | Client Fee Collection Form |
| F106 | Copy of ID/Social Security Card |
| F107 | Copy of Medi-Cal Card* |
| F108 | Financial Responsibility & Information Form |
| F109 | CalOMS Admission |
| F110 | CalOMS Annual Update |
| | Additional Intake/Financial |

*Medi-Cal providers

DMC Client Tracking Form

REQUIRED FORM:

This form is a required document in client file for Medi-Cal providers only

WHEN:

At client's first DMC billable service and every billable visit thereafter

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- **ODF/DCH:** Check appropriate box for Outpatient Drug Free (ODF) or Day Care Habilitative (DCH).
- **Client Name:** Complete with client's full name.
- **Client ID#:** Complete the client ID number as determined by agency guidelines.
- **Admit Date:** Complete the date of admission.
- **Date D/MC Billing Began:** Complete the date of client's first face-to-face billable service.
- **M/C (BIC#):** Complete client's Medi-Cal, Benefit Identification Card (BIC) number.
- **Birth Date:** Complete client's month/day/year of birth.
- **DSM-IV Dx Code:** Complete client's substance abuse diagnostic code extracted from DSM-IV.
- **Gender:** Complete with appropriate answer.
- **Race:** Complete with appropriate answer.
- **Tracking Chart:**
 - (1) **Service Date:** Complete each date of client's DMC billable services.
 - (2) **Service Type & Counselor (CO):** Complete the type of service client received from County billing activity codes. (e.g., Code 2-Individual Counseling/Intake, Code 3-Individual Counseling/Planning, Code 4-Individual Counseling/Crisis/Intervention, Code 6-Group Counseling, Code 19-Day Treatment.)
 - (3) **Date Billed:** Complete the date Medi-Cal billing was submitted to the County.
- **Review Date:** The date tracking form is reviewed at Quality Assurance Review (QAR).
- **QA Reviewer Signature:** QAR representative must sign after reviewing tracking form.
- **QAR Determination:** QAR representative must select and check the appropriate box according to the review determination.
- **Upcoming Review Dates:** QAR representative must check the box for "no more review dates" or select upcoming review dates.

NOTES:

Must be reviewed by QAR for an initial, stay, extension, and discharge.

D/MC CLIENT TRACKING FORM

ODF DCH

Client Name: _____

Client ID#: _____

Admit Date: _____

Date D/MC Billing Began: _____

M/C (BIC#): _____ Birth date _____

DSM IV Dx Code _____

Gender: _____ Race: _____

| Service Date | Service Type & CO | Date Billed | Service Date | Service Type & CO | Date Billed | Service Date | Service Type & CO | Date Billed |
|--------------|-------------------|-------------|--------------|-------------------|-------------|--------------|-------------------|-------------|
| 1. | | | 21. | | | 41. | | |
| 2. | | | 22. | | | 42. | | |
| 3. | | | 23. | | | 43. | | |
| 4. | | | 24. | | | 44. | | |
| 5. | | | 25. | | | 45. | | |
| 6. | | | 26. | | | 46. | | |
| 7. | | | 27. | | | 47. | | |
| 8. | | | 28. | | | 48. | | |
| 9. | | | 29. | | | 49. | | |
| 10. | | | 30. | | | 50. | | |
| 11. | | | 31. | | | 51. | | |
| 12. | | | 32. | | | 52. | | |
| 13. | | | 33. | | | 53. | | |
| 14. | | | 34. | | | 54. | | |
| 15. | | | 35. | | | 55. | | |
| 16. | | | 36. | | | 56. | | |
| 17. | | | 37. | | | 57. | | |
| 18. | | | 38. | | | 58. | | |
| 19. | | | 39. | | | 59. | | |
| 20. | | | 40. | | | 60. | | |

| | | | |
|---|---|---|--|
| <p>Review Date: _____</p> <hr style="border: 0.5px solid black;"/> <p>QA Reviewer Signature</p> | <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><u>QAR Determination</u></p> <p><input type="checkbox"/> Client file in full compliance</p> <p><input type="checkbox"/> Corrective Action Required</p> <p><input type="checkbox"/> Approved Discharge</p> <p><input type="checkbox"/> Please note denials were noted on QAR Worksheet</p> </td> <td style="width: 50%; vertical-align: top;"> <p><u>Upcoming Review Dates</u></p> <p>No more Review Dates <input type="checkbox"/></p> <p>Extension Review due by: _____</p> <p>Stay Review due by: _____</p> </td> </tr> </table> | <p><u>QAR Determination</u></p> <p><input type="checkbox"/> Client file in full compliance</p> <p><input type="checkbox"/> Corrective Action Required</p> <p><input type="checkbox"/> Approved Discharge</p> <p><input type="checkbox"/> Please note denials were noted on QAR Worksheet</p> | <p><u>Upcoming Review Dates</u></p> <p>No more Review Dates <input type="checkbox"/></p> <p>Extension Review due by: _____</p> <p>Stay Review due by: _____</p> |
| <p><u>QAR Determination</u></p> <p><input type="checkbox"/> Client file in full compliance</p> <p><input type="checkbox"/> Corrective Action Required</p> <p><input type="checkbox"/> Approved Discharge</p> <p><input type="checkbox"/> Please note denials were noted on QAR Worksheet</p> | <p><u>Upcoming Review Dates</u></p> <p>No more Review Dates <input type="checkbox"/></p> <p>Extension Review due by: _____</p> <p>Stay Review due by: _____</p> | | |

Non Medi-Cal Tracking Form

This is not a standardized form. If your agency is currently using this form, place it in this section.

QAR Review Worksheet

INITIAL REVIEW

REQUIRED FORM:

This form is a required document in client file for Medi-Cal providers only

WHEN:

All Medi-Cal client files will be reviewed at QAR (Quality Assessment Review). These Medi-Cal client files will be taken to the QAR for an Initial Review (within sixty days from admit)

COMPLETED BY:

Authorized agency representative will complete top section of this form. QA Reviewer attending the QAR will review the file and complete remaining sections of this form

REQUIRED ELEMENTS:

The top part of all QAR forms should be completed by staff prior to QAR.

- **Program:** Complete the name of program.
- **Admission Date:** Complete client's date of admission.
- **D/MC Eligible Date:** Complete the date client's Drug Medi-Cal billing started.
- **Date of Review:** Complete the date file will be reviewed at QAR.
- **ODF/DCH:** Check appropriate treatment modality.
- **Check the appropriate type of QAR review:** Initial Review, Re-admission or D/C, or Transfer out.
- **Client I.D.:** Complete the Client ID number as determined by agency guidelines.
- **Primary Counselor's Name:** Complete primary counselor's name responsible for file.

NOTES:

The file will be reviewed at the QAR and the remainder of form will be completed by QAR reviewer.

INITIAL REVIEW

| | | |
|--|--|--|
| Program _____ Admission Date _____ D/MC Billing began Date _____ Date of Review _____ | ___ ODF ___ DCH ___ Initial Review ___ Re-admission ___ D/C or Transfer out | CLIENT I.D. _____ Primary Counselor's Name: _____ |
|--|--|--|

NOTE: All items must have a \checkmark or N/A. If an item is missing, circle the line and identify corrective action in bottom section.

| | |
|---|--|
| <p style="text-align: center;"><u>INTAKE</u></p> ___ Medical Necessity present (M.D. Signature) Date MD signed Med. Nec. _____ (Within 30 days) ___ • Perinatal / EPSDT Eligibility ___ Intake Screening Form ___ Drug History or ASI ___ Client Assessment or ASI ___ SanWITS completed (Medi-Cal beneficiary?) ___ Financial Form <p style="text-align: center;"><u>CONSENT FORMS</u></p> ___ Release of Information ___ Treatment consent ___ Program Rules & Regulations ___ Follow-up Consent ___ Client Rights (including Fair Hearing Rights) <p style="text-align: center;"><u>PHYSICAL</u></p> ___ Health Questionnaire Complete ___ MD Reviewed; Date MD signed Physical Waiver _____ ___ MD Reviewed within 30 days of admission (If not see disallowances below) Exam/Lab work: () ordered () waived () recommended ___ Follow-up on Medical orders &/or recommendations in file (Letter to client) ___ Medical problems adequately addressed on TX plan/notes (e.g.: dual dx, TB medication, Hep follow-up, pregnancy, etc) | <p style="text-align: center;"><u>TREATMENT PLAN(S) TIMELINE</u></p> Initial Treatment Plan Development Date _____ *** ___ Initial Plan developed within 30 days of admission? Date physician signed Initial TX Plan _____ ___ MD signature within 15 days? (If either date is late, see disallowances below) ___ DSM IV DX Code(s) on plan: # _____ <p style="text-align: center;"><u>TREATMENT PLAN(S)</u></p> ___ TX Goals appropriate to client's stage in treatment ___ Long/Short Term Goals & Target dates identified ___ Action Steps measurable & attainable ___ Type of counseling identified in Action Steps ___ Frequency of Counseling is identified in Action Steps (Minimum = 2 times monthly) <p style="text-align: center;"><u>DISCHARGE</u></p> Date of last contact (SanWITS D/C date) _____ Discharge Summary date (counselor signed) _____ ___ Discharge SanWITS completed ___ 10 Day Notice <p style="text-align: center;"><u>PROGRESS NOTES</u></p> ___ Monthly DMC Eligibility Reports in file ___ Progress Notes address ALL problems on TX Plan ___ P Notes document Ct. progress toward TX Plan goals ___ Each billing has acceptable documentation ___ Multiple 2nd Service Billings in File ___ ADP 7700 Present |
|---|--|

| | |
|---|--|
| <p><u>QAR DETERMINATION</u></p> ___ Client file in full compliance ___ Corrective action required - See Below ___ Approved Discharge | <p><u>UPCOMING REVIEW DATES</u></p> _____ Next Extension Review Date (3 months from now) _____ Next Stay Review Date (6 months from admit date) _____ Check this line if Discharge Review completed today |
|---|--|

D/MC DENIALS No Denials noted in this chart
 A State auditor would probably deny D/MC funding from _____ through _____. # Visits denied _____
 List the dates of visits that would be denied in a State audit: _____
 List reason(s) for denied visits _____

CORRECTIVE ACTION REQUIRED (Title 22 related)

Please give letter to client w/MD orders/recommendations

QAR COMMENTS & RECOMMENDATIONS:

Please follow up with client regarding medical tests (letter has already been given to client & is in file)

QA Reviewer Signature _____ Date _____ Second QA Reviewer Signature _____ Date _____

QAR Review Worksheet

EXTENSION/STAY/DISCHARGE REVIEW

REQUIRED FORM:

This form is a required document in client file for Medi-Cal providers only

WHEN:

All Medi-Cal client files will be reviewed at QAR (Quality Assessment Review). These Medi-Cal client files will be taken to the QAR for Extension Review (ninety days from Initial Review), Stay Review (six months from admit date), and at discharge (sixty days from client's discharge)

COMPLETED BY:

Authorized agency representative will complete top section of this form. QA Reviewer attending the QAR (Quality Assurance Review) will review the file and complete remaining sections of this form

REQUIRED ELEMENTS:

The top part of all QAR forms should be completed by staff prior to QAR.

- **Program:** Complete the name of program.
- **Admission Date:** Complete client's admission date.
- **D/MC Billing began date:** Complete the date client's Drug Medi-Cal billing started.
- **Date of Review:** Complete the date file will be reviewed at QAR.
- **Date of Last Review:** Complete the last date the file was reviewed at QAR.
- **Date MD signed last Stay Review:** Complete the date the Medical Director signed last Stay Review.
- **Stay Review Due Date:** Complete the date the Stay Review is due for completion.
- **ODF/DCH:** Check appropriate treatment modality.
- **Check the appropriate type of QAR review:** Extension Review, Stay Review, D/C or Transfer out, or Last Corrective Action completed.
- **Client I.D.:** Complete the Client ID number determined by agency guidelines
- **Primary Counselor's Name:** Complete primary counselor's name responsible for file.

NOTES:

The file will be reviewed at the QAR and the remainder of form will be completed by QAR reviewer.

**QUALITY ASSESSMENT REVIEW WORKSHEET
EXTENSION/STAY/DISCHARGE REVIEW**

| | | |
|--|---|---|
| Program _____ Admission Date _____ D/MC Billing began Date _____ Date of Review _____ Date of Last Review _____ Date MD signed last Stay Review: _____ Stay Review Due Date: _____ | ___ ODF ___ DCH ___ Extension Review ___ Stay Review ___ D/C or Transfer out ___ Last Corrective Action complete | CLIENT I.D. _____ Primary Counselor's Name _____ |
|--|---|---|

NOTE: All items must have a \checkmark or N/A. If an item is missing, circle the line and identify corrective action in bottom section.

| | |
|--|--|
| <p align="center"><u>MEDICAL/HEALTH REVIEW</u></p> Follow-up on MD Orders & Recommendations in chart? (Client notified) <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a Client cleared for participation? <input type="checkbox"/> yes <input type="checkbox"/> no Annual Health Questionnaire needed? <input type="checkbox"/> yes <input type="checkbox"/> no <p align="center"><u>STAY REVIEW</u></p> Has QAR reviewed latest Stay Review? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a (check previous Review forms for accurate dates) Stay Review Justification present & signed by MD? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a Date MD Signed latest Stay Review _____ (See disallowances below if MD signed later than 6 months) <p align="center"><u>DISCHARGE</u></p> Date of last contact (SanWITS D/C date) _____ Discharge Summary date (counselor signed) _____ ___ Discharge SanWITS completed ___ 10 Day Notice <p align="center"><u>LAST QAR FORM</u></p> Corrective Action complete: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a Comments/Recommendations incorporated in charting? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a <i>Note: Corrective Action must be completed, however, not all comments or recommendations must be adhered to. Check with QAR Chair if you have questions.</i> | <p align="center"><u>TREATMENT PLAN(S) TIMELINE</u></p> Development Date of last TX Plan reviewed (See last QAR Review Form for this date): 1) _____ TX Plan due date(s) (90 days from last TX Plan(s)) 2) _____ & 4) _____ Review of TX Plan(s) needed? <input type="checkbox"/> yes <input type="checkbox"/> no (if no, skip to Progress Note section) TX Plan Development date(s): 3) _____ & 5) _____ New TX plan(s) developed in timely manner? <input type="checkbox"/> yes <input type="checkbox"/> no Date MD signed TX Plan(s) _____ & _____ MD signature within 15 days? yes <input type="checkbox"/> no <input type="checkbox"/> & <input type="checkbox"/> yes <input type="checkbox"/> no (If either date is late, see disallowances below) DSM IV DX Code(s) on all tx plan(s): # _____ TX Goals appropriate to client's stage in TX: () & () Long/Short Term Goals & Target dates identified: () & () Action Steps measurable & attainable: () & () Type of counseling identified in Action Steps () & () Frequency of Counseling is identified in Action Steps (minimum = 2 times monthly) () & () <p align="center"><u>PROGRESS NOTES</u></p> ___ Monthly DMC Eligibility Reports in file ___ Progress Notes address ALL problems on TX Plan ___ PNotes document Clt. progress toward TX Plan goals ___ Each billing has acceptable documentation (if not, see disallowances below) ___ Multiple 2nd Service Billings in File ___ ADP 7700 Present |
|--|--|

| | |
|---|---|
| <p><u>QAR DETERMINATION</u></p> ___ Client file in full compliance ___ Corrective action required - See Below ___ Approved Discharge | <p align="center"><u>UPCOMING REVIEW DATES</u></p> _____ Next Extension Review Date (3 months from now) _____ Next Stay Review Date (6 months from admit date or last MD signature on Stay Review) _____ Check this line if D/C review completed today |
|---|---|

D/MC DENIALS No Denials noted in this chart
 A State auditor would probably deny D/MC funding from _____ through _____. # Visits denied _____
 List the dates of visits that would be denied in a State audit: _____
 List reason(s) for denied visits _____

CORRECTIVE ACTION REQUIRED (Title 22 related)

Please give letter to client w/MD orders/recommendations

QAR COMMENTS & RECOMMENDATIONS:

Please follow up with client regarding medical tests (letter has already been given to client & is in file)

QA Reviewer Signature _____ Date _____ Second QA Reviewer Signature _____ Date _____

DMC Eligibility Printout

REQUIRED FORM:

This form is a required document in the client file for Medi-Cal providers only

WHEN:

Completed at Intake/Admission or when client becomes Medi-Cal eligible

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- **Subscriber ID:** This is the client's Medi-Cal subscriber number. You may also use the client's social security number.
- **Client's Birth Date:** This is the client's date of birth. The format is as follows: 00/00/0000
- **Service Date:** This is the date of service you will be billing to Medi-Cal
- **Issue Date:** This is the date that Medi-Cal was issued to the client. If you do not have the issue date, you may use today's date in the following format: 00/00/0000

NOTES:

Providers may verify Medi-Cal eligibility in one of three ways:

1. POS (Point of Service) Machine – See the POS User Guide for instructions
2. Online using the Eligibility Verification System (EVS) – See Medi-Cal Program and Eligibility Manual for instructions
3. Automated Eligibility Verification System (AEVS) – See Medi-Cal Program and Eligibility Manual for instructions

All clients who are eligible for Medi-Cal must have a verification of eligibility in their file. **It is suggested that all program participants should be checked for Medi-Cal eligibility on a monthly basis regardless of their current Medi-Cal status.**

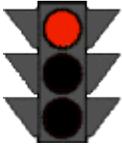
Programs using POS or EVS must have the Eligibility Printout in the file. **POS or EVS must be done monthly and placed in the client file for the duration of the clients treatment episode or until the client becomes ineligible for Medi-Cal.**

Programs using the AEVS by phone must have documentation of AEVS eligibility in the client file. **AEVS phone verification must be done monthly and documentation placed in the client file for the duration of the client's treatment episode or until the client becomes ineligible for Medi-Cal.**

-----Refer to the following three samples of Medi-Cal eligibility documentation-----

Eligibility Response

Eligibility transaction performed by provider:



| | | |
|--|------------------------|-------------------------|
| Subscriber ID: | | |
| Service Date: | Subscriber Birth Date: | Issue Date: |
| Primary Aid Code: | | First Special Aid Code: |
| Second Special Aid Code: | | Third Special Aid Code: |
| Subscriber County: | | HIC Number: |
| Primary Care Physician Phone #: | | Service Type: |
| Trace Number (Eligibility Verification Confirmation (EVC) Number): | | |
| Eligibility Message: | | |

Initial Screening/Intake Form

REQUIRED FORM:

This form is a required document in the client file

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Authorized agency representative with client

REQUIRED ELEMENTS:

- **Client ID#:** Complete the client's ID number as determined by agency guidelines.
- **Staff Completing the Form:** Complete the name of staff conducting the screening/intake.
- **Date of Screening/Intake:** Complete the date screening/intake was conducted.
- **Place of Screening/Intake:** Complete the location of screening/intake such as jail, program site, trolley station, etc.
- **Referral source:** Complete client's referral source name and phone number (e.g., Probation, CWS, Parole, etc.)

PERSONAL INFORMATION

- **Name:** Complete client's first name, middle initial, and last name.
- **Social Security Number:** Complete client's social security number. If client has no social security number, follow agency guidelines.
- **Birth date/Age:** Complete client's month/day/year of birth and age.
- **Address:** Complete client's physical address. If client is homeless, document "homeless" in this space.
- **Phone Number:** Complete client's phone number. Circle if the phone number is personal or message.
- **Homeless:** Circle appropriate yes or no answer.
- **Gender:** Circle appropriate answer.
- **Preferred language:** Complete client's preferred language.
- **Veteran Status:** Circle appropriate yes or no answer.
- **Pregnant /Due date:** Complete client's pregnancy status. If pregnant, complete due date. Inform client that they may be required to provide documentation such as proof of pregnancy.

- **Number of Children Under 18:** Complete client's number of children under the age of 18. Programs requiring additional information may refer to "Supplemental A: Minor Children Information Form."
- **Do you have Medi-Cal:** Circle appropriate yes or no answer. If yes, complete Medi-Cal card number. Inform client that they may be required to provide documentation of Medi-Cal eligibility. Follow agency guidelines for Medi-Cal eligibility.
- **Health Insurance:** Circle appropriate yes or no answer. If yes, complete Insurance Company's name. Inform client that they may be required to provide documentation of insurance information. Follow agency guidelines for health insurance eligibility.
- **Are you on Medically Assisted Treatment (MAT) (I.E. Methadone, Vivitrol, Suboxone):** If YES, list the type of medication. **Where do you obtain this medication:** Indicate the type of clinic prescribing or if primary care physician is prescribing.

EMERGENCY CONTACT

- **Emergency Contact:** Complete name, relationship, and phone number of person to contact in case of emergency. The second emergency contact information is optional.

PARENT/GUARDIAN INFORMATION

(Adolescent Programs Only)

- **Parent/Guardian Information:** Complete name, relationship, and phone number of person responsible for minor entering treatment.

MENTAL HEALTH

- **Have you ever been diagnosed with mental health conditions:** Circle appropriate yes or no answer. If yes, specify diagnosis.
- **Prescription Medications:** List all medications the client is taking for mental health condition(s).

ALCOHOL AND DRUG

- **Date Last Used:** Complete the date client last used any drugs, including alcohol.
- **Days in a Row:** Complete the number of days in a row the client has been using alcohol or other drugs, up to the last date used.
- **Problem Length:** Complete the length of time the client reports having problem(s) with alcohol or drugs.

- **Primary Drug:** List the client's primary drug of use. Complete the number of days the client used the primary drug in the last 30 days. Complete the route of administration (e.g., oral, inhalation, smoking, I.V.) Complete the date the client last used the primary drug.
- **Secondary Drug:** List the client's secondary drug of use. Complete the number of days the client used the secondary drug in the last 30 days. Complete the route of administration (e.g., oral, inhalation, smoking, I.V.) Complete the date the client last used the secondary drug.
- **Tertiary Drug:** List the client's tertiary drug of use. Complete the number of days the client used the tertiary drug in the last 30 days. Complete the route of administration (e.g., oral, inhalation, smoking, I.V.) Complete the date the client last used the tertiary drug.
- **Have You Used Needles in the Past 12 Months:** Circle the appropriate yes or no answer.

DETOX CLIENTS ONLY

(This section should be completed by programs screening clients for residential detox)

- **History of seizures or DT's:** Circle appropriate yes or no answer. If yes, specify whether the client experiences seizures, DT's or both.
- **Staff Follow Up:** Use this space to document appropriate follow up per agency guidelines.

LEGAL

- **Are you on Probation/Parole/Both:** Circle appropriate answer
- **PO Contact Name and Phone Number:** List Probation or Parole Officer's name and phone number.
- **Pending Court date(s):** Circle appropriate yes or no answer. If yes, complete reasons, and court dates.
- **Arrests/charged/convicted/registered for arson:** Circle appropriate yes or no answer. If yes, follow agency guidelines.
- **Arrests/charged/convicted/registered for sex crime(s):** Circle appropriate yes or no answer. If yes, follow agency guidelines.

POTENTIAL RISK ASSESSMENT

Purpose of this section is to evaluate the client's physical safety and concerns for the safety of others in relationship with the client.

- **Current Thoughts of Harm:** Circle appropriate yes or no answer.
- **Safety Concerns:** Circle appropriate yes or no answer
- **Action Taken:** If client answered "Yes" to any of the above questions, describe the action taken. Refer to your agency guidelines for potential risk guidelines.

OUTCOME

- **Accepted to Treatment:** Circle appropriate yes or no answer.
- **Modality:** Complete modality of treatment the client is accepted (i.e. Outpatient, Residential, Detox, ect.)
- **Waiting List:** Circle appropriate yes or no answer. If “Yes,” complete items regarding obtaining releases of information (if indicated), and priority admission criteria. If waitlist services are offered to client, track date of service, type of service and fees paid in the section indicated. When removed from waitlist, record date of removal and indicate the reason removed.
- **Informed of Voter Registration:** Circle appropriate yes or no answer.
- **Referred To:** List all appropriate referrals given to the client whether they are accepted for treatment at your program or not (e.g. Shelter, mental health assessment, other treatment providers, etc.)
- **Staff Summary/Comments:** Use this space to summarize the overall assessment of the client as they presented in the screening/intake. This space may also be used for any additional client information not asked in the screening/intake form.

CERTIFICATION

- **Client Signature:** Client is required to sign and date this form to certify that all information given is true and correct.
- **Staff Signature:** The staff member who conducted the screening/intake is required to sign.

NOTE:

This a required form for all San Diego County funded alcohol and drug programs. This form may be used as a screening tool or intake admission form depending on your program guidelines.

Initial Screening/Intake Form

Client ID # _____

Staff completing the form: _____ Date of screening: _____

Place of interview: _____ Referral source (Name & Phone #) _____

PERSONAL INFORMATION

First Name: _____ M.I. _____ Last Name: _____

Social Security Number: _____ Birth Date: ____/____/____ Age: _____

Address: _____
Street City State Zip Code

Phone Number: (____) _____ Personal Message Are you homeless (Circle one)? YES NO

Gender Male Female Other Preferred Language: _____

Are you a veteran? YES NO

Are you pregnant? YES NO Due Date: _____ # of Children under 18: _____

Do you have Medi-Cal? YES NO Medi-Cal Card #: _____

Health Insurance? YES NO Insurance Company: _____

Are you on Medically Assisted Treatment (MAT) (i.e. Methadone, Vivitrol, Suboxone)? YES NO

If YES, List: _____ Where do you obtain this medication? _____

FIRST EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone # (____) _____

SECOND EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone # (____) _____

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship: _____ Phone # (____) _____

Client Name: _____

LEGAL

Are you on (circle one): Probation Parole Both None

PO Contact Name & Phone Number: _____

Pending court date(s)? YES NO

If yes, state reason(s) and date(s): _____

Have you ever been arrested/charged/convicted/registered for arson? YES NO

Have you ever been arrested/charged/convicted/registered for sex crime(s)? YES NO

POTENTIAL RISK ASSESSMENT

Do you have any current thoughts of hurting yourself or others? YES NO

Do you have any concerns for the safety of yourself or your immediate family? YES NO

If client answered "YES" to any of the above questions, describe the action(s) taken:

For Staff use only

OUTCOME

A. Accepted into treatment: YES NO Modality: _____

B. Placed on waiting list: YES NO (If "No," skip to item "C" below).

Releases of information required/obtained:

Priority Admission Criteria (check one):

- 1. Pregnant Injection Drug User
- 2. Pregnant Substance User
- 3. Parenting Injection Drug User
- 4. Other Injection Drug User
- 5. Parenting Substance Users
- 6. Other Referral _____

| Date of Service | Type of Service | Fee Paid | Date of Service | Type of Service | Fee Paid |
|-----------------|-----------------|----------|-----------------|-----------------|----------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Date of Removal from Waitlist: _____

Reason for Removal (check one):

Noncompliance+

Acceptance into Treatment Program

Name of program: _____

+ Noncompliance = 2 consecutive weeks of failing to contact the program or 2 consecutive weeks of non-payment, or serious violation of program policies

Note: At a minimum, interim services should include counseling and education about HIV and tuberculosis (TB), about the risks of needle-sharing, the risks of transmission to sexual partners and infants, and about steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV or TB treatment services if necessary. For pregnant women, interim services also include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care.

C. Informed of Voter Registration: YES NO

D. Referred to: _____

E. **Staff Summary/Comments:** _____

I certify that all information I have furnished on this form is true and correct.

Client Signature

Staff Signature

Date

Minor Children Information Form

Client's Name: _____

Date of Admission: _____

| Child's Name | Gender | Age | With whom do they live? | Will they be entering the program? Y/N |
|--------------|--------|-----|-------------------------|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |
| | | | | |

Client Fee Collection Form

This is not a standardized form. If your agency is currently using this form, place it in this section.

Copies of Identification / Social Security Cards

REQUIRED FORM

This form is optional and not a required document in the client file

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Agency authorized representative

REQUIRED ELEMENTS:

None

Copy of Identification and Social Security Card

This section is optional. If your agency is requiring copy of ID and SS card from clients, place it in this section.

Copy of Medi-Cal Card

REQUIRED FORM:

This form is optional and not a required document in the client file

WHEN:

Completed at Screening/Intake Admission or when the client becomes Medi-Cal eligible

COMPLETED BY:

Agency authorized representative

REQUIRED ELEMENTS:

None

Copy of Medi-Cal Card

This section is optional. If your agency is requiring copy of Medi-Cal card from clients, place it in this section.

Financial Responsibility and Information Form

REQUIRED FORM:

This form is a required document in the client file

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Authorized agency representative or client

REQUIRED ELEMENTS:

- **Client's name:** Complete client's first and last name.
- **Parent or authorized representative's name:** If minor, complete name of parent or authorized representative.
- **Do you and/or your family have health coverage:** Circle appropriate yes, no, or N/A answer. If client does not have health coverage, client must be provided a referral to 2-1-1 and Covered California website.
- **Medical Eligible:** Circle appropriate yes or no answer.
- **Currently have Medi-Cal:** Circle appropriate yes or no answer.
- **Cal-Works recipient:** Circle appropriate yes or no answer.
- **Number dependent on income (including self):** Complete the number of people, dependent on the income of the client including self.
- **Gross Family Income (before taxes):** Complete the client's gross family income earned before taxes.
- **Court-ordered revenue and recovery expenses:** Complete total deductions taken for court ordered revenue and recovery expenses. Client may be asked to provide proof of payments.
- **Adjusted Income:** This is gross family income minus court-ordered revenue and recovery expenses.
- **Fee based on sliding scale:** Use the County Sliding Fee Scale to determine the fee.
- **Adjusted Fee:** This is the final fee based on client's ability to pay or funding source (e.g., indigent, Medi-Cal eligible, CalWorks, third party pay).
- **Reason for fee adjustment:** This is an explanation of why client's fee was adjusted.
- **Client signature:** Client must sign and date affirming all statements are true and correct.
- **Parent or authorized Representative Signature:** If minor, parent or authorized representative must sign and date.
- **Screened by:** The staff screening this form must sign and date.

NOTE: This is a required form for all San Diego County funded alcohol and drug programs.

FINANCIAL RESPONSIBILITY AND INFORMATION

If the client is seeking treatment without the knowledge or consent of a parent or authorized representative, the information given below should be based only on the client's financial information. If the client is seeking treatment with the knowledge and/or consent of a parent or authorized representative, the information given below should be based on the parent or authorized representative's financial information.

Client's Name: _____

Parent or authorized representative's name: _____

Do you and/or your family have health coverage? YES NO N/A

Were you provided a referral to 2-1-1 and Medi-Cal or Covered California? YES NO

Medi-Cal eligible: Yes No Do you currently have Medi-Cal? YES NO

Cal-Works Recipient: Yes No

Number dependent on income (*including self*): _____

Gross Family Income (*before taxes*) \$ _____

Court-ordered revenue and recovery expenses
(*Client may be asked to provide proof of payments*) \$ _____

Adjusted income (*gross minus court expenses*) \$ _____

Fee based on sliding scale \$ _____

Adjusted fee \$ _____

Reason for fee adjustment: _____

Indigent Clients

It has been determined that it is an important treatment tool to require clients to pay a minimum fee even when indigent. This helps clients value and take responsibility for treatment. Although no service will be refused due to client's inability to pay, the fee is owed to the program.

I affirm that the statements made herein are true and correct to the best of my knowledge:

Client Signature: _____ Date: _____

Parent or authorized
Representative Signature: _____ Date: _____

Screened by: _____ Date: _____

CalOMS Admission Form

REQUIRED FORM:

This form is a required document in client file

WHEN:

This form will be completed at Intake Admission

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- For instructions on each specific field, refer to CalOMS Data Collection Guide/CalOMS Treatment Data Dictionary.

| |
|------------------------|
| Data Entry Date: _____ |
| Data Entry Int. _____ |

CalOMS Profile

Provider ID

Use the following codes for answers:

Not Applicable = NA Declined to State = DS Unknown or Don't Know = UNK
 Unable to Answer = UA (*allowed only if type of service is Detox or disability includes developmentally disabled*)

Highlighted fields are required.

| | | | | |
|-----------------------|------------------------------------|------------------------------|----------------------|----------------------|
| Client Profile | | Mid Int <input type="text"/> | (System generated) | <input type="text"/> |
| Current First Name | <input type="text"/> | State Client ID | <input type="text"/> | <input type="text"/> |
| Current Last Name | <input type="text"/> | Provider Client ID | <input type="text"/> | <input type="text"/> |
| Birth First Name | <input type="text"/> | SSN | <input type="text"/> | <input type="text"/> |
| Birth Last Name | <input type="text"/> | Driver's License | State Abbr. | Number |
| Mother's First Name | <input type="text"/> | Medicaid# | <input type="text"/> | |
| Gender | Circle: Male/ Female/ Other | Date of Death | mm / dd / yyyy | |
| Date of Birth | mm / dd / yyyy | Place of Birth | County | State Abbr. |
| No Readmit Until | mm / dd / yyyy | Consent on File | No | |
| | | Has Paper File | Circle: Y / N | |

| | |
|------------------------|----------------------|
| Alternate Names | |
| Last Name | <input type="text"/> |
| First Name | <input type="text"/> |
| Middle Name | <input type="text"/> |

Highlighted fields are required.

Additional Information

Ethnicity Circle one: **1. Not Hispanic** **3. Cuban**
2. Mexican/Mexican American **4. Puerto Rican** **5. Other Hispanic/Latino**

Primary Race/Ethnicity (Circle one):
White Black/African-American Mexican/Latino/Hispanic Asian/Pacific Islander Native American Other

Race (Enter Codes. If multi-racial, may select up to five codes) - - - -

- Select from the following codes:
- | | | | |
|-----------------------------|----------------|-----------------|------------------|
| 01 - White | 06 – Cambodian | 11 – Japanese | 16 – Other Asian |
| 02 - Black/African-American | 07 – Chinese | 12 – Korean | 17 – Other Race |
| 03 – American Indian | 08 – Filipino | 13 – Laotian | 18 – Mixed Race |
| 04 – Alaskan Native | 09 - Guamanian | 14 – Samoan | |
| 05 – Asian Indian | 10 – Hawaiian | 15 – Vietnamese | |

Disabilities

- Circle all that apply:
- 1 - None
 - 2 - Visual
 - 3 - Hearing
 - 4 – Speech
 - 5 – Mobility
 - 6 – Mental
 - 7 - Developmentally Disabled
 - 8 - Other Disability (not Alcohol or Drug)
 - 99900 - Declined to State
 - 99904 - Unable to Answer

General Client Comments: _____

Preferred Language: _____

Interpreter Needed: Y/N

Religious Preference

U.S. Veteran? (Circle):

1 – Yes

2 – No

99900 - Declined to State

99904 - Unable to Answer

Highlighted fields are required.

SanWITS Intake

| |
|------------------------|
| FSN _____ |
| Data Entry Date: _____ |
| Data Entry Int. _____ |
| Client ID _____ |

Client Name: _____

Date of Birth

| | | | | |
|----|---|----|---|------|
| mm | / | dd | / | yyyy |
|----|---|----|---|------|

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---------------------|--|------------------------|--|------------------|--|--|--|-------------------------|--|----------------------|--|------------------------|--|--------------------|--|--|----------------------------|----------------------------|--------------------|--------------------|--------------------|--|-----------------|--|--|----------------------|----------------------------|----------------------|
| <p>Intake</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 20%;">Intake Facility</td> <td></td> </tr> <tr> <td>Intake Staff</td> <td></td> </tr> <tr> <td>Initial Contact</td> <td></td> </tr> <tr> <td>Residence</td> <td></td> </tr> </table> <p>Source of Referral (enter code)</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 70%;"></td> <td style="width: 30%;"></td> </tr> </table> <p>Source of Referral Codes: 1 = Individual, including self-referral 2 = Alcohol/Drug Abuse program 3 = Other Health Care provider 4 = School/Educational 5 = Employer/EAP 6 = 12 Step Mutual Aid 7 = SACPA /Prop36/OTP/Probation or Parole 8 = Post-Release Coummunity Supervision(AB109) 9 = DUI/DWI 10 = Adult Felon Drug Court 11 = Dependency Drug Court 12 = Non SACPA /Criminal Justice 13 = Other Community Referral 14 = Child Protective Services</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 20%;">Referral Contact</td> <td style="background-color: #cccccc;"></td> </tr> <tr> <td>Referral Date</td> <td style="background-color: #cccccc;"></td> </tr> <tr> <td>Assessment Date</td> <td style="background-color: #cccccc;"></td> </tr> <tr> <td>Date Closed</td> <td style="background-color: #cccccc;"></td> </tr> </table> | Intake Facility | | Intake Staff | | Initial Contact | | Residence | | | | Referral Contact | | Referral Date | | Assessment Date | | Date Closed | | <table border="1" style="width: 100%;"> <tr> <td style="width: 50%;"># of Previous Cases</td> <td style="width: 50%;">Populated By System</td> </tr> <tr> <td>Case Status</td> <td>OPEN ACTIVE</td> </tr> <tr> <td>Intake Date</td> <td></td> </tr> <tr> <td>Pregnant</td> <td>Circle: Y / N Due Date <table border="1" style="width: 60px; height: 20px;"></table></td> </tr> <tr> <td>Chronic Life Threatening Illness (CLTI)</td> <td>Circle: Y / N</td> </tr> <tr> <td>Injection Drug User</td> <td>Circle: Y / N</td> </tr> </table> | # of Previous Cases | Populated By System | Case Status | OPEN ACTIVE | Intake Date | | Pregnant | Circle: Y / N Due Date <table border="1" style="width: 60px; height: 20px;"></table> | Chronic Life Threatening Illness (CLTI) | Circle: Y / N | Injection Drug User | Circle: Y / N |
| Intake Facility | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Intake Staff | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Initial Contact | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Residence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referral Contact | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referral Date | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Assessment Date | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date Closed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| # of Previous Cases | Populated By System | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Case Status | OPEN ACTIVE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Intake Date | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pregnant | Circle: Y / N Due Date <table border="1" style="width: 60px; height: 20px;"></table> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chronic Life Threatening Illness (CLTI) | Circle: Y / N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Injection Drug User | Circle: Y / N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| |
|---------------------------|
| Presenting Problem |
|---------------------------|

Highlighted fields are required.

SanWITS Admission Profile

| |
|------------------------|
| FSN _____ |
| Data Entry Date: _____ |
| Data Entry Int. _____ |
| Client ID _____ |

Client Name: _____

Date of Birth

| | | | | |
|----|---|----|---|------|
| mm | / | dd | / | yyyy |
|----|---|----|---|------|

Screening

Potential Client for MH? Circle: **Y / N**

1. Court Ordered Treatment
2. Court Ordered Screening/Assessment
3. Based on Screening
4. Based on Referral
5. Based on Test Result

Potential Client for TBI? Circle: **Y / N**

1. Court Ordered Treatment
2. Court Ordered Screening/Assessment
3. Based on Screening
4. Based on Referral
5. Based on Test Result

Admission Profile

| | | | |
|---|----------------|-------------------------------------|----------------------|
| Admission Date | mm / dd / yyyy | | |
| Admission/Transaction Type <small>1 = Initial Admit 2= Transfer</small> | | Codependent/Collateral? | |
| Type of Treatment Service 1 = Nonresidential/Outpatient/ Recovery 2 = Nonresidential/Outpatient/ Intensive 3 = Nonresidential/Outpatient/ Detox 5 = Residential Detox (non-hospital) 6 = Residential Tx/ Recovery (30 days or less) 7 = Residential Tx/ Recovery (31 days or +) | | CalWORKs Recipient | Circle: Y / N |
| Submit to CalOMS? | YES | SA Tx Under CalWORKs | Circle: Y / N |
| # of Days Waited to Enter Tx | | Special Services Contract ID | |
| # of Prior Episodes | | Special Services Contract County | |

Note: For number of days waited to enter treatment, enter the number of days a client waited for services beginning on the day they were accepted for treatment services and ending on the first day of receiving such services.

Highlighted fields are required.

SanWITS Admission Administration

| |
|------------------------|
| FSN _____ |
| Data Entry Date: _____ |
| Data Entry Int. _____ |
| Client ID _____ |

Client Name: _____

Date of Birth

| | | | | |
|----|---|----|---|------|
| mm | / | dd | / | yyyy |
|----|---|----|---|------|

| | | | |
|-----------------------------|----------------------|-------------------------|--|
| Program Fees: | | Intake Fees: | |
| Drug Testing Participation: | Circle: Y / N | Testing Level Indicator | |
| Baseline UA Completed | Circle: Y / N | Drug Screening Fees | |
| Pictures Taken | Circle: Y / N | Encounters Fees | |

Prop 36 questions must be answered for Drug MediCal billing

| | Start Date | End Date | JURIS # |
|-----------------|------------|----------|---------|
| Prop. 36 | | | |

| | | |
|-----------------------------------|--|--|
| Special Population Program | <ol style="list-style-type: none"> 1. Medi-Cal Participant 2. CalWorks Funded 3. FIT Grant Participant 4. Perinatal Funded/Non DDC/Non DMC 5. HIV Funded Participant 6. Bridge to Recovery Referral 7. Juvenile Drug Court 8. Drug Court Participant | <ol style="list-style-type: none"> 9. ReEntry Court Funded 10. Parolee Partnership Program 11. AB 109 Participant 12. EBSPSP Funded 13. None (County ADS Funded) 14. Fee-For-Service 15. Non ADS Funded Participant |
| How did you hear about us? | <ol style="list-style-type: none"> 1. Get Off Meth Brochure 2. ADS Web Site 3. Help/Info Line (211) 4. Any Criminal Justice ie Probation/Court/Parole/Law Enforcement 5. Other – Please Explain | <ol style="list-style-type: none"> 6. Not Applicable 7. ER/Trauma/Hospital/Health Clinic 8. Homeless Shelter 9. Bridge to Recovery Referral 10. EBSPSP |
| If Other, Specify: | | |

Highlighted fields are required.

SanWITS Admission Substance Abuse

| |
|------------------------|
| FSN _____ |
| Data Entry Date: _____ |
| Data Entry Int. _____ |
| Client ID _____ |

Client Name: _____

Date of Birth

| | | | | |
|----|---|----|---|------|
| mm | / | dd | / | yyyy |
|----|---|----|---|------|

Alcohol and Drug Use

| | |
|--------------------------------|--|
| Primary Drug | |
| Drug Type | |
| Drug Name | |
| # of Days Used in Past 30 Days | |
| Route of Administration | |
| Age of First Use | |

| | |
|--------------------------------|--|
| Secondary Drug | |
| Drug Type | |
| Drug Name | |
| # of Days Used in Past 30 Days | |
| Route of Administration | |
| Age of First Use | |

| | |
|--------------------------------|--|
| Tertiary Drug | |
| Drug Type | |
| # of Days Used in Past 30 Days | |
| Route of Administration | |
| Age of First Use | |

| |
|--|
| Drug Type Codes (must specify name if *): |
| 0 = None |
| 1 = Heroin |
| 2 = Alcohol |
| 3 = Barbiturates* |
| 4 = Other Sedatives or Hypnotics* |
| 5 = Methamphetamine |
| 6 = Other Amphetamines* |
| 7 = Other Stimulants* |
| 8 = Cocaine/Crack |
| 9 = Marijuana/Hashish |
| 10 = PCP |
| 11 = Other Hallucinogens* |
| 12 = Tranquilizers (e.g. Benzodiazepine)* |
| 13 = Other Tranquilizers* |
| 14 = Non-Prescription Methadone |
| 15 = Oxy Codone/ Oxy Contin |
| 16 = Other Opiates or Synthetics* |
| 17 = Inhalants* |
| 18 = Over-the-Counter* |
| 19 = Ecstasy |
| 20 = Other Club Drugs* |
| 99901 = Unknown |
| 99903 = Other* |

| |
|-------------------------------------|
| Route of Administration |
| 1 = Oral |
| 2 = Smoking |
| 3 = Inhalation |
| 4 = Injection (IV or intramuscular) |
| 99902 None or not applicable |
| 99903 Other |

| | |
|---|--|
| # of Days Used Alcohol in Past 30 Days If 1 st or 2nd drug is Alcohol, answer NA) | |
| # of Days Used IV in Past 30 Days | |
| Used Needles in Past 12 Months | |
| Circle: Y/ N | |

Highlighted fields are required.

SanWITS Tobacco / Family Social

| |
|------------------------|
| FSN _____ |
| Data Entry Date: _____ |
| Data Entry Int. _____ |
| Client ID _____ |

Client Name: _____

Date of Birth

| | | | | |
|----|---|----|---|------|
| mm | / | dd | / | yyyy |
|----|---|----|---|------|

| Tobacco / Nicotine | | | |
|--|--|---|--|
| (Circle correct answer) | | | |
| Have you ever used Tobacco/Nicotine products? | Yes No Unknown | In the past 30 days, what tobacco/nicotine product did you use most frequently? | No tobacco Use Cigarettes Cigars or Pipes Smokeless Tobacco Other Nicotine Product Combo/more than 1 |
| Smoker Status | Current Every Day Smoker Current Some Day Smoker Smoker, current status Unk Former Smoker | In the past 30 days, how often did you use tobacco/nicotine product(s)? | 1. 1-3 times last 30 days 2. Once a week 3. 3-6 times a wk 4. Daily 5. 3-6 times a day 6. More than 6 x a day 97 Unknown |
| At what age did you first use tobacco/nicotine products? | 1. Age 10 or younger 2. Between 11 and 14 3. Between 15 and 19 4. Between 20 and 25 5. Between 26 and 30 6. 31 or older 7. Unknown | In the past 30 days, how many cigarettes did you smoke per week? | Enter actual number |

| Family/Social | | | |
|---|--|---|--|
| (Enter number in box next to question) | | | |
| # of Days Social Support in Past 30 | | # of Children Under 18 | |
| Current Living Arrangements 1-Homeless 2-Dependent Living 3-Independent Living | | # of Children Age 5 or less | |
| # of Days Living w/User of Alcohol or Durg in Past 30 | | # of children Living w/Someone Else Because of a Child Protection Order | |
| # of Days Family Conflict in Past 30 | | # of Children Living w/Someone Else for whom Parental Rights have been Terminated | |
| Current Zip Code | | | |

| Abuse Characteristics | | | | |
|--------------------------------------|-------------|--------|----|---------------------|
| (Circle correct answer) | | | | |
| Does episode involve physical abuse? | Perpetrator | Victim | No | Unwilling to Answer |
| Does episode involve sexual abuse? | Perpetrator | Victim | No | Unwilling to Answer |
| Does episode involve domestic abuse? | Perpetrator | Victim | No | Unwilling to Answer |

Highlighted fields are required.

SanWITS Admission Employment/Legal/Health

FSN _____
Data Entry Date: _____
Data Entry Int. _____
Client ID _____

Client Name: _____

Date of Birth

| | | | | |
|----|---|----|---|------|
| mm | / | dd | / | yyyy |
|----|---|----|---|------|

| | | |
|--|---|--|
| Employment | | Employment Status 1 = FT (35 hrs or more) 2 = PT (less than 35 hrs) 3 = Unemployed, looking for work 4 = Unemployed, not in the labor force (not seeking) 5 = Not in the labor force (not seeking) |
| Employment Status (enter code) | <input style="width: 100%;" type="text"/> | |
| Number of Paid Work Days in Past 30 Days | <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> | |
| Enrolled in School? | Circle: Y / N | |
| Enrolled in Job Training? | Circle: Y / N | |
| Graduated from High School? | Circle: Y / N | |
| Highest School Grade Completed | <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> | |

| | | |
|---------------------------------|---|---|
| Legal/Criminal Justice | | Drop down values for Criminal Justice Status 1-No Criminal Justice Involvement 2-Under parole supervision by CDC 3-On parole from any other jurisdiction 4-Post-release Community Service(AB109) or on probation from any federal, state, or local jurisdiction 5-Admitted under other diversion from any court under CA Penal code, Section 1000 6-Incarcerated 7-Awaiting trial, charges or sentencing 99904-Client unable to answer |
| # of Arrests in Last 30 Days | <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> | |
| # of Jail Days in Last 30 | <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> | |
| # of Prison Days in Last 30 | <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> | |
| # of Arrests in Last 6 Months | <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> | |
| Criminal Justice Status | <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> | |
| Type of Sentence | <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> | |
| CDC Number (Enter number or NA) | <input style="width: 60px;" type="text"/> | Drop down values for Type of Sentence 1-Conditional Sentence 2-Formal Probation 3-Parole |
| Parolee Services Network(PSN) | Y / N | |
| FOTP Parolee | Y / N | |
| FOTP Priority Status | 99902 | |

| | | | | | | | | | | |
|--|---|---|---|---|---|-------------------------------------|---|---|----|----|
| Medical/Physical Health | | | | | | | | | | |
| # of Times Emergency Room in Past 30 | <input style="width: 30px;" type="text"/> | Medi-Cal Beneficiary | Y | N | DS | UA |
| # of Hospital Overnights in Past 30 Days | <input style="width: 30px;" type="text"/> | Medication Prescribed as Part of Tx | | | | |
| # of Days Medical Problems in Past 30 | <input style="width: 30px;" type="text"/> | Communicable Diseases: Tuberculosis | Y | N | DS | UA |
| HIV Tested | Y | N | DS | UA | | Communicable Diseases: Hepatitis C | Y | N | DS | UA |
| HIV Test Results Received | Y | N | DS | UA | | Communicable Diseases: STD | Y | N | DS | UA |
| Drop down values for Medication Prescribed 1-None 5-Buprenorphine (Suboxone) | | | | | | Pregnant at Admission | Y | N | DS | UA |

Highlighted fields are required.

| Mental Health | |
|---|--|
| Mental Illness Diagnosed | Circle: Y / N / 99901 (Not Sure/Don't Know) |
| Number of Times Outpatient ER MH Services in Past 30 Days | |
| Number of Days of Psychiatric Facility Stay of more than 24 Hrs in Past 30 Days | |
| Mental Health Medication in Past 30 Days | Circle: Y / N |
| Suicide Attempts | Circle: Y / N |

CalOMS Annual Update Form

REQUIRED FORM:

This form is a required document in client file

WHEN:

Annual updates are required for those program participants that are in treatment for a period of twelve months or more, continuously (no break in services exceeding 30 days). For such individuals, providers must collect the CalOMS treatment data approximately one year from the day the individual was admitted to the program. Annual update information can be collected earlier than twelve months, as early as 60 days prior to the individual's admission date of anniversary

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- For instructions on each specific field, refer to CalOMS Data Collection Guide/CalOMS Treatment Data Dictionary.

CalOMS Annual Update

| |
|------------------------|
| FSN _____ |
| Data Entry Date: _____ |
| Data Entry Int. _____ |

Provider ID

Form Serial Number

W

Use the following codes for answers:

Not Applicable = NA Declined to State = DS Unknown or Don't Know = UNK
 Unable to Answer = UA (*allowed only if type of service is Detox or disability includes developmentally disabled*)
 The answers above are only allowed for questions marked with a corresponding symbol:
 * = NA + = DS ∞ = UNK ^ = UA

| | | | |
|--|--|----------------------|--|
| Client Profile (Enter name and complete other fields if any changes.) | | | |
| *^Client First Name | <input type="text"/> | Mid Int | <input type="text"/> |
| ^Client Last Name | <input type="text"/> | State Client ID | <input type="text"/> |
| *Birth First Name | <input type="text"/> | Provider Client ID | <input type="text"/> |
| Birth Last Name | <input type="text"/> | +*^SSN | <input type="text"/> - <input type="text"/> - <input type="text"/> |
| Mother's First Name | <input type="text"/> | +*^Driver's License | <input type="text"/> |
| Gender | Circle: Male Female Other | +^Current Zip Code | <input type="text"/> |
| Date of Birth | <input type="text"/> / <input type="text"/> / <input type="text"/> | Homeless enter 00000 | <input type="text"/> |
| | | Place of Birth | <input type="text"/> |
| | | Consent on File | Circle: Y / N |

| | |
|--|--|
| Annual Update Profile | |
| Admission Date | <input type="text"/> / <input type="text"/> / <input type="text"/> |
| Annual Update Date | <input type="text"/> / <input type="text"/> / <input type="text"/> |
| Number of the Annual Update Being Reported | <input type="text"/> |

* = NA + = DS ∞ = UNK ^ = UA (UA allowed only if type of service is Detox or disability includes developmentally disabled)

Alcohol and Drug Use

Primary Drug

| | |
|--------------------------------|--|
| Drug Type | |
| If Other, Specify Name | |
| # of Days Used in Past 30 Days | |
| Route of Administration | |
| Age of First Use | |

Drug Type Codes (must specify name if *):

- 0 = None
- 1 = Heroin
- 2 = Alcohol
- 3 = Barbiturates*
- 4 = Other Sedatives or Hypnotics*
- 5 = Methamphetamine
- 6 = Other Amphetamines*
- 7 = Other Stimulants*
- 8 = Cocaine/Crack
- 9 = Marijuana/Hashish
- 10 = PCP
- 11 = Other Hallucinogens*
- 12 = Tranquilizers (e.g. Benzodiazepine)*
- 13 = Other Tranquilizers*
- 14 = Non-Prescription Methadone
- 15 = OxyCodone/OxyContin
- 16 = Other Opiates or Synthetics*
- 17 = Inhalants*
- 18 = Over-the-Counter*
- 19 = Ecstasy
- 20 = Other Club Drugs*
- 99901 = Unknown
- 99903 = Other*

Secondary Drug

| | |
|--------------------------------|--|
| Drug Type | |
| If Other, Specify | |
| # of Days Used in Past 30 Days | |
| Route of Administration | |
| Age of First Use | |

Route of Administration

- 1 = Oral
- 2 = Smoking
- 3 = Inhalation
- 4 = Injection (IV or intramuscular)
- 99902 None or not applicable
- 99903 Other

of Days Used Alcohol in Past 30 Days
 If primary or secondary drug is Alcohol, must answer NA)

| |
|--|
| |
| |

of Days Used IV in Past 30 Days

Family/Social

| | | |
|--|--|--|
| # of Days Social Support Recovery Activities in Past 30 Days | | |
| Current Living Arrangements 1 = Homeless 2 = Dependent Living 3 = Independent Living | | |
| +^ # of Days Living w/ Alcohol or Drug User in Past 30 Days | | |
| +^ # of Days Serious Family Conflict in Past 30 Days | | |

^ Number of Children Under 18

^ Number of Children Age 5 or Less

^ Number of Children Living w/ Someone Else because of a Child Protection Court Order
 ^ Number of Children Living w/ Someone Else for whom Parental Rights have been Terminated

Current Zip Code
 Must be "00000" if homeless, "XXXXX" if declines to state, or "ZZZZZ" if unable to answer.

| | |
|--|--|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

* = NA + = DS ∞ = UNK ^ = UA (UA allowed only if type of service is Detox or disability includes developmentally disabled)

| | | | | | |
|---|--|--|--|--|--|
| Employment | | | | | |
| Employment Status (enter code) | <table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> | | | | |
| | | | | | |
| | | | | | |
| +^ Number of Paid Work Days in Past 30 Days | <table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> | | | | |
| | | | | | |
| | | | | | |
| +^ Enrolled in School | Circle: Y / N | | | | |
| +^ Enrolled in Job Training | Circle: Y / N | | | | |

Employment Status

1 = FT (35 hrs or more)
 2 = PT (less than 35 hrs)
 3 = Unemployed, looking for work
 4 = Unemployed, not in the labor force (not seeking)
 5 = Not in the labor force (not seeking)

| | | | | | |
|-------------------------------|--|--|--|--|--|
| Criminal Justice | | | | | |
| ^ # of Arrests in Last 30 | <table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> | | | | |
| | | | | | |
| | | | | | |
| ^ # of Jail Days in Last 30 | <table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> | | | | |
| | | | | | |
| | | | | | |
| # of Prison Days in Last 30 | <table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> | | | | |
| | | | | | |
| | | | | | |
| # of Arrests in Last 6 Months | <table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> | | | | |
| | | | | | |
| | | | | | |

| | | | |
|---|--|--|--|
| Medical/Physical/Mental Health | | | |
| Medical/Physical Health | | | |
| ^ Number of Times in ER in Past 30 Days | <table border="1"><tr><td></td></tr><tr><td></td></tr></table> | | |
| | | | |
| | | | |
| ^ Number of Hospital Overnights in Past 30 Days | <table border="1"><tr><td></td></tr><tr><td></td></tr></table> | | |
| | | | |
| | | | |
| ^ Number of Days Medical Problems in Past 30 Days | <table border="1"><tr><td></td></tr><tr><td></td></tr></table> | | |
| | | | |
| | | | |
| +^ HIV Tested | Circle: Y / N | | |
| +^ HIV Test Results Received | Circle: Y / N | | |
| ∞ Pregnant at any time during Treatment | Circle: Y / N | | |
| Mental Health | | | |
| ∞ Mental Illness Diagnosed | Circle: Y / N | | |
| ^ Number of Times Outpatient ER MH Services in Past 30 Days | <table border="1"><tr><td></td></tr><tr><td></td></tr></table> | | |
| | | | |
| | | | |
| ^ Number of Days of Psychiatric Facility Stay of more than 24 Hrs in Past 30 Days | <table border="1"><tr><td></td></tr><tr><td></td></tr></table> | | |
| | | | |
| | | | |
| ^ Mental Health Medication in Past 30 Days | Circle: Y / N | | |

Section 2 Consents

| | |
|------|---|
| F201 | Consent to Release Information |
| F202 | Admission Agreement / Consent for Treatment |
| F203 | Client Personal Rights |
| F204 | Title 22 Fair Hearing Rights * |
| F205 | Notice of Privacy Practice/HIPAA |
| F206 | Consent to Follow Up |
| F207 | Consent for Photo, TV, Video |
| F208 | Coordination of Care Consent Form |
| | Additional Policies and Consents |

*Medi-Cal providers

Consent to Release Information

This is not a standardized form. Place current consent to release information used by your agency in this section.

Admissions Agreement Consent for Treatment

This is not a standardized form. Place current Admission Agreement/Consent for Treatment used by your agency in this section.

Client Personal Rights

REQUIRED FORM:

This form is a required document in the client file

WHEN:

Completed at Intake/Admission

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- **Client Signature:** Client must sign and date the form.

NOTES:

Providers may use their own version of the Client Personal Rights form. In accordance with Alcohol and/or Other Drug Program Certification Standards, the Client Personal Rights form must include the following seven (7) elements:

1. The right to confidentiality as provided for in Title 42, Code of Federal Regulations, Part 2.
2. To be accorded dignity in contact with staff, volunteers, board members and other persons.
3. To be accorded safe, healthful and comfortable accommodations to meet his or her needs.
4. To be free from verbal, emotional, physical abuse and/or inappropriate sexual behavior.
5. To be informed by the program of the procedures to file a grievance or appeal discharge.
6. To be free from discrimination based on ethnic group identification, religion, age, sex, color, or disability.
7. To be accorded access to his or her file.

The client shall review, sign, and be provided at admission, a copy of the Client Personal Rights. The program shall place the original signed document in the client's file.

CLIENT PERSONAL RIGHTS

In accordance with Alcohol and/or Other Drug Program Certification Standards, the Client Personal Rights include, but are not limited to, the following:

- The right to confidentiality as provided for in Title 42, Code of Federal Regulations, Part 2.
- To be accorded dignity in contact with staff, volunteers, board members and other persons.
- To be accorded safe, healthful and comfortable accommodations to meet his or her needs.
- To be free from verbal, emotional, physical abuse and/or inappropriate sexual behavior.
- To be informed by the program of the procedures to file a grievance or appeal discharge.
- To be free from discrimination based on ethnic group identification, religion, age, sex, color, or disability.
- The right to refuse religious activities
- To be accorded access to his or her file.

COMPLAINTS

In accordance with Title 9, Chapter 4, Section 10544(c), of the California Code of Regulations, any individual may request an inspection of an alcoholism or drug abuse recovery or treatment facility. Complaints should be directed to:

Department of Health Care Services
SUD Compliance Division
1501 Capitol Avenue
PO Box 997413, MS 2601
Sacramento, CA 95899-7413

Attention: Complaint Coordinator
(916) 322-2911
TTY (916) 445-1942
www.dhcs.ca.gov

Acknowledgement

I have been personally advised and have received a copy of my personal rights and have been informed of the provisions for complaints at the time of my admission to: _____

(Client's Signature)

(Date)

Title 22 Fair Hearing Rights

REQUIRED FORM:

This form is a required document in client file for Medi-Cal providers only

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Authorized agency representative and client

REQUIRED ELEMENTS:

- **Print Client's Name:** Print client's full name and client shall have a copy of this document.
- **Client's Signature and Date:** Client must sign and date when reviewed.
- **Staff Signature and Date:** The staff reviewing this form with client will sign and date.

TITLE 22 FAIR HEARING RIGHTS

(STATE ADP- 7-1-97 AMENDMENT)

All clients have the right to a fair hearing related to denial, involuntary discharge, or reduction in Short-Doyle Drug Medi-Cal substance abuse services as it relates to eligibility or benefits, pursuant to Section 50951.

(Provider) shall advise clients in writing at least ten (10) calendar days prior to the effective date of the intended action to terminate or reduce services. The written notice shall include:

1. A statement of the action intends to take
2. The reason for the intended action
3. A citation of the specific regulation(s) supporting the intended action
4. An explanation of the client's rights to a fair hearing for the purpose of appealing the intended action
5. An explanation that the client may request a fair hearing by submitting a written request to:

Department of Social Services
State Hearings Division
P.O. Box 944243, M.S. 9-17-37
Sacramento, CA 94244-2430

Oral request should be directed to:

Telephone: 1-800-952-5253
TDD: 1-800-952-8349

6. An explanation that **(Provider)** shall continue treatment services pending a fair hearing decision only if the client appeals in writing to DSS (address above) for a hearing within ten (10) calendar days of the mailing or personal delivery of the notice of intended action.

ALL FAIR HEARINGS SHALL BE CONDUCTED IN ACCORDANCE WITH SECTION 50953.

I, (Print Client's Name) _____, have read and understand my rights for a fair hearing and have been given a copy of this document.

Client's Signature

Date

Staff Signature

Date

Notice of Privacy Practices/HIPAA

This is not a standardized form. Place current Notice of Privacy Practices/HIPAA used by your agency in this section.

Consent to Follow Up

This is not a standardized form. Place current Consent to Follow Up form used by your agency in this section.

Consent for Photo, TV, Video

This is not a standardized form. Place current Consent for Photo, TV and Video used by your agency in this section.

Coordination of Care Consent Form

REQUIRED FORM:

This form is a required document in the client file. Care Coordination is an essential part of providing behavioral health services to ensure client needs are met, including physical health needs. These forms facilitate communication with primary care at intake regarding significant changes with medication and at client discharge. Within 30 days of opening to services, it is important that client is connected to primary care provider (PCP).

WHEN:

Completed at Intake, but no later than 30 days from admission

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

There are two forms to facilitate communication with primary care.

FORM 1: Coordination and/or Referral of Physical & Behavioral Health Form (4 page form)

- Provider complete form at intake, but no later than 30 days from admission
- Provider obtain written consent from the client/guardian
- For clients that do not have a PCP, provider will connect them to a medical home
- Provider will send completed form to PCP for completion.
- Provider shall check the appropriate box at the top of form (on pg 1 of 4), noting if this is a:

Referral for ***Physical Healthcare****

Referral for ***Physical Healthcare & Medication Management****

Referral for ***Total Healthcare*** or

Coordination of Care notification only

*if the referral is for ***Physical Healthcare*** or ***Physical Healthcare & Medication Management***, please enter your program name in the blank space and select the appropriate box for program type: Mental Health or Alcohol and Drug

Section A: Client Information

Complete all client information as prompted by the form.

Section B: Behavioral Health Provider Information

Complete this section with your program's information as prompted.

Section C: Primary Care Physician Information

If the client has a Primary Care Physician, provide the PCP's relevant information in this section. If the client does not have a PCP, provide the information of the doctor or clinic to which client is being referred.

Section D: (For Primary Care Physician Completion)

Signature of Individual or Legal Representative:

Client or client's legal representative provides signature and date in this section.

Expiration:

Provide an expiration date, event or condition (i.e. discharge) for the authorization. Client, with the guidance of authorized agency representative, will select the type of information they wish to authorize for release by checking all applicable check boxes.

I Would Like a Copy of This Authorization:

Client or authorized agency staff will check the corresponding yes or no check box indicating whether the client wishes to receive a copy of the authorization.

This form should be faxed to client's Primary Care Physician or Medical Home to which client is being referred.

FORM 2: Coordination of Physical and Behavioral Health Update Form (1 pg form)

- Provider will complete form if there are significant changes to client medication (change in dosage of current medication reported at the discretion of psychiatrist).
- On upper right side box of form—"Date Release of Information Signed" provider are to enter the ***original*** date that was signed by the client/guardian on the ***Coordination and/or Referral of Physical & Behavioral Health Form*** (on pg 3 of 4)
- Provider will send **completed** form to PCP when client is discharged from program (this form shall be completed prior to completion of a discharge summary).

NOTES:

- Users of these forms are responsible to have a system in place to track:
 1. **Expiration Date** of the authorization
 2. **Written Revocation** of the authorization
 3. **Discontinue** of the authorization upon termination of treatment (60 days after discharge)

Coordination with Primary Care Physicians and Behavioral Health Services

Coordination of care between behavioral health care providers and health care providers is necessary to optimize the overall health of a client. Behavioral Health Services (BHS) values and expects coordination of care with health care providers, linkage of clients to medical homes, acquisition of primary care provider (PCP) information and the entry of all information into the client's behavioral health record. With healthcare reform, BHS providers shall further strengthen integration efforts by improving care coordination with primary care providers. Requesting client/guardian authorization to exchange information with primary care providers is mandatory, and upon authorization, communicating with primary care providers is required. **County providers shall utilize the *Coordination and/or Referral of Physical & Behavioral Health Form & Update Form*, while contracted providers may obtain legal counsel to determine the format to exchange the required information. This requirement is effective immediately and County QI staff and/or COTR will audit to this standard beginning FY 13-14.**

For all clients:

Coordination and/or Referral of Physical & Behavioral Health Form:

- Obtain written consent from the client/guardian on the *Coordination and/or Referral of Physical & Behavioral Health Form*/ contractor identified form at intake, but no later than 30 days of episode opening.
- For clients that do not have a PCP, provider shall connect them to a medical home. Contractor will initiate the process by completing the *Coordination and/or Referral of Physical & Behavioral Health Form* /contractor form and sending it to the PCP within 30 days of episode opening. It is critical to have the specific name of the treating physician.
- Users of the form shall check the appropriate box at the top of the *Coordination and/or Referral of Physical & Behavioral Health Form* /contractor form noting if this is a referral for physical healthcare, a referral for physical healthcare and medication management, a referral for total healthcare, or coordination of care notification only. If it is a referral for physical healthcare, or physical healthcare and medication management, type in your program name in the blank, and select appropriate program type.

Coordination of Physical and Behavioral Health Update Form:

- Update and send the *Coordination of Physical and Behavioral Health Update Form* /contractor form if there are significant changes like an addition, change or discontinuation of a medication.
- Notify the PCP when the client is discharged from services by sending the *Coordination of Physical and Behavioral Health Update Form* /contractor form. The form shall be completed prior to completion of a discharge summary.

Tracking Reminders:

- Users of the form shall have a system in place to track the expiration date of the authorization to release/exchange information.
- Users of the form shall have a system in place to track and adhere to any written revocation for authorization to release/exchange information.
- Users of the form shall have a system in place to track and discontinue release/exchange of information upon termination of treatment relationship. Upon termination of treatment the provider may only communicate the conclusion of treatment, but not the reason for termination.



Coordination and/or Referral of Physical & Behavioral Health Form

- Referral for *physical* healthcare – [_____] will continue to provide specialty behavioral health services
 Mental Health Alcohol and Drug
- Referral for *physical* healthcare & Medication Management – [_____] will continue to provide limited specialty behavioral health services
 Mental Health Alcohol and Drug
- Referral for *total* healthcare – [_____] is no longer providing specialty behavioral health services.
 Available for psychiatric consult.
- Coordination of care notification only.

Section A: CLIENT INFORMATION

| | | | | |
|-------------------|-------|----------------|-----------------------|---|
| Client Name: Last | First | Middle Initial | AKA | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Street Address | | | Date of Birth | |
| City | | | Telephone # | |
| Zip | | | Alternate Telephone # | |

Section B: BEHAVIORAL HEALTH PROVIDER INFORMATION

| | |
|---|---|
| Name of Treatment Provider: | Name of Treating Psychiatrist (If applicable) |
| Agency/Program | |
| Street Address | City, State, Zip |
| Telephone # | Specific provider secure fax # or secure email address: |
| Date of Initial Assessment: | |
| Focus of Treatment (<i>Use Additional Progress Note if Needed</i>) | |
| Case Manager/ Mental Health Clinician/ Alcohol and Drug Counselor/ Program Manager: | Behavioral Health Nurse: Phone #: |



| | |
|----------------|-------------------------------------|
| Date Last Seen | Mental Health Diagnoses: |
| | Alcohol and Drug Related Diagnoses: |

Current Mental and Physical Health Symptoms *(Use Additional Progress Note if Needed)*

Current Mental Health and Non-Psychiatric Medication and Doses
(Use Additional Medication/Progress Note if Needed)

Last Psychiatric Hospitalization
 Date: None

Section C: PRIMARY CARE PHYSICIAN INFORMATION

Provider's Name

Organization OR Medical Group

Street Address

City, State, Zip

| | |
|--------------|---|
| Telephone #: | Specific provider secure fax # or secure email address: |
|--------------|---|

**Section D: FOR PRIMARY CARE PHYSICIAN COMPLETION
 ACCEPTED FOR TREATMENT OR REFERED BACK TO SDCBHS
 PROGRAM (PLEASE COMPLETE THE FOLLOWING INFORMATION AND
 RETURN TO BEHAVIORAL HEALTH PROVIDER WITHIN TWO WEEKS
 OF RECEIPT)**

Coordination of Care notification received.
 If this is a primary care referral, please indicate appropriate response below:

1. Patient accepted for physical health treatment only
2. Patient accepted for physical healthcare and psychotropic medication treatment while additional services continue with behavioral health program
3. Patient accepted for total healthcare including psychotropic medication treatment
4. Patient not accepted for psychotropic medication treatment and referred back due to:



Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax:

I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524.

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

| | |
|------------|-------|
| SIGNATURE: | DATE: |
|------------|-------|

Client Name (Please type or print clearly)

| | | |
|--------------|---------------|----------------|
| Last: | First: | Middle: |
|--------------|---------------|----------------|

| | |
|--|-----------------------------|
| IF SIGNED BY LEGAL REPRESENTATIVE, PRINT NAME: | RELATIONSHIP OF INDIVIDUAL: |
|--|-----------------------------|

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.

- | | |
|--|--|
| <input type="checkbox"/> Information Contained on this form <input type="checkbox"/> Current Medication & Treatment Plan <input type="checkbox"/> Substance Dependence Assessments <input type="checkbox"/> Assessment /Evaluation Report | <input type="checkbox"/> Discharge Reports/Summaries <input type="checkbox"/> Laboratory/Diagnostics Test Results <input type="checkbox"/> Medical History <input type="checkbox"/> Other _____ |
|--|--|

The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the medical records and Information/updates concerning the patient. The purpose of such a release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.



I would like a copy of this authorization **Yes** **No**
Clients/Guardians Initials

➔ Please place a copy of this Form in your client's chart

TO REACH A PLAN REPRESENTATIVE

Care1st Health Plan
(800) 605-2556

Community Health Group
(800) 404-3332

Health Net
(800) 675-6110

Kaiser Permanente
(800) 464-4000

Molina Healthcare
(888) 665-4621

Access & Crisis Line
(888) 724-7240





COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH UPDATE FORM

CLIENT NAME

Last First Middle

Date of Birth Male Female

BEHAVIORAL HEALTH UPDATE

Date: _____

Treating Provider Name

Phone _____

FAX _____

Treating Psychiatrist Name (If applicable)

Phone _____

FAX _____

Medications prescribed on _____
Date

Name/Dosage: _____

Medications changed on _____
Date

Name/Dosage: _____

Medications discontinued on _____
Date

Name/Dosage: _____

Medications prescribed on _____
Date

Name/Dosage: _____

Medications changed on _____
Date

Name/Dosage: _____

Medications discontinued on _____
Date

Name/Dosage: _____

Diagnosis Update :

Key Information Update:

Discharge from Treatment Date:

Follow-up Recommendations:

PRIMARY CARE PHYSICIAN UPDATE

Please provide any relevant Update/Change to Patient's Physical Health Status.

Section 3 Assessments

| | |
|---------|--|
| F301 | Stay Review Justification * |
| F302 | Alcohol/Drug History |
| F303 | ASI/YAI |
| F304 | Co-Occurring Conditions Screening |
| F305a,b | High Risk Assessment (HRA) and High Risk Index (HRI) |
| | Additional Assessments |

*Medi-Cal providers

Stay Review Justification

REQUIRED FORM:

This form is a required document in client file for Medi-Cal providers only

WHEN:

This form must be completed no sooner than five months and no later than six months from client's admission to program, or last Stay Review Justification.

COMPLETED BY:

Authorized agency representative and Medical Director

REQUIRED ELEMENTS:

- **Client Name:** Complete client's full name.
- **Admission Date:** Complete the date of admission.
- **Client ID#:** Complete the client ID number as determined by agency guidelines.
- **Client's progress in treatment during the past six months (detailed & descriptive):** Complete a detailed and descriptive summary of client's progress in treatment during the past six months.
- **Medical/psychological reasons to continue treatment (include DSM-IV criteria for substance abuse or substance dependence) (DSM-IV):** Complete DSM-IV code and document medical/psychological reasons that client should continue treatment including criteria for substance abuse or substance dependence.
- **Consequences of discontinuing treatment:** Complete consequences that may occur if client discontinues treatment. (e.g., recidivism, relapse).
- **Target date for client to complete treatment:** Complete the expected target date client will complete treatment.
- **Verification of continued Medi-Cal eligibility confirmed by program:** Complete client's confirmed verification of Medi-Cal eligibility, and then check "yes" box.
- **What is expected to be achieved during continued treatment (Must include Client's Prognosis):** Mark the appropriate box for client's prognosis (good, fair, poor) and explain. Complete a summary of what client is expected to achieve during continued treatment.
- **Primary Counselor Signature and Date:** Counselor completing form and determining that continued treatment is medically necessary must sign and date.
- **Medical Director Signature and Date:** Medical Director reviewing this form to determine the need for continuing services must sign and date.

NOTES:

- If Stay Review Justification to continue services is missing from client's file, all Medi-Cal billings submitted after the date the justification was due (within six months from admission date) will be disallowed.

Stay Review Justification

Client Name: _____ Admission Date: _____

Client I.D. #: _____

Client's progress in treatment during the past six months (detailed & descriptive):

Medical/psychological reasons to continue treatment (include DSM-IV criteria for substance abuse or substance dependence) DSM-IV: _____

Consequences of discontinuing treatment:

Target date for client to complete treatment: _____

Verification of continued Medi-Cal eligibility confirmed by program yes, see file for M/C eligibility report(s).

What is expected to be achieved during continued treatment: **(MUST include Client's Prognosis)**

Client's Prognosis is: Good Fair Poor (elaborate)

After reviewing the above information, I have determined that continued treatment is medically necessary.

Primary Counselor Date

Medical Director Signature Date

Alcohol and Drug History

REQUIRED FORM:

This form is an optional document in client file

WHEN:

Completed at Screening/Intake Admission or at the time of Assessment

COMPLETED BY:

Authorized agency representative with client

REQUIRED ELEMENTS:

- **Client Name:** Complete the client's full name.
- **Date:** Complete the date the form is completed.
- **Drug Name:** Complete the name of specific drug or type of alcohol.
- **Age First Used:** Complete the age client first used specific alcohol or drug.
- **Age Regular use began:** Complete the age client used specific alcohol or drug regularly. Regular use refers to the pattern of use becoming more frequent.
- **Frequency 30 Days Prior to Treatment:** Complete the frequency of use. Frequency refers to the number of days the specific alcohol or drug used (i.e., daily, every other day, once a week, etc.).
- **Usual Route:** Complete the usual route of administration. Usual route refers to the preferred method(s) the client uses specific alcohol or drugs (e.g., oral, smoking, inhalation, injection, other).
- **Date last Used:** Complete the last date client used specific alcohol or drugs.
- **Average Amount Used at One Time:** This section refers to amount of alcohol or drug client used at one setting (e.g., four 24 oz of light beer, one gram of heroin, etc.).
- **Problem Rank:** This section reflects the client's self-reported level of concern or problem with specific alcohol or drugs. The ranking is numerical, with number one being the most troubling substance.

Alcohol & Drug History

Client Name: _____ Date: _____

| Drug (Circle if Ever Used) | Drug Name | Age First Used | Age Regular Use Began | Frequency 30 Days Prior to Treatment | Usual Route (Oral, Smoke, Inhalation, I.V.) | Date Last Used | Average Amount Used at One Setting | Problem Rank* |
|-------------------------------|-----------|----------------------|--------------------------------|--|---|-------------------|---|------------------|
| Alcohol | | | | | | | | |
| Amphetamine | | | | | | | | |
| Cocaine | | | | | | | | |
| Heroin | | | | | | | | |
| Marijuana/Hash | | | | | | | | |
| Other Opiates | | | | | | | | |
| Sedatives | | | | | | | | |
| Hallucinogens | | | | | | | | |
| Inhalants | | | | | | | | |
| Club Drugs | | | | | | | | |
| PCP/Angel Dust | | | | | | | | |
| Non-Prescribed Methadone | | | | | | | | |
| Over The Counter | | | | | | | | |
| Other | | | | | | | | |

*Rank is numerical with 1 being most troubling substance.

Staff Signature: _____ Date: _____

ASI (Addiction Severity Index Lite) and YAI (Youth Assessment Index)

REQUIRED FORM:

This form is a required document in client's file

WHEN:

This form must be completed within the following timelines:

Outpatient- within 30 days of admission

Long-term residential- (31 days or more) – within 14 days of admission

Short-term residential- (30 days or less) – within 10 days of admission

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- All sections of the ASI/YAI must be completed.
- Follow all guidelines on the ASI and YAI instrument.
- Refer to the ASI/YAI manual for any further instructions.

NOTES:

It is a good practice to conduct the ASI/YAI as soon as possible to develop a treatment plan in a timely manner. Programs may complete this form on paper, CalOMS, or other electronic format.

Addiction Severity Index *Lite* - CF

Clinical/Training Version

Thomas McLellan, Ph.D.

John Cacciola, Ph.D.

Deni Carise, Ph.D.

Thomas H. Coyne, MSW

Remember: This is an interview, not a test

≠Item numbers circled are to be asked at follow-up.≠

≠Items with an asterisk* are cumulative and should be rephrased at follow-up.≠

≠Items in a double border gray box are questions for the interviewer. Do not ask these questions of the client.≠

INTRODUCING THE ASI: Seven potential problem areas: Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Psychological. All clients receive this same standard interview. All information gathered is confidential.

There are two time periods we will discuss:

1. The past 30 days
2. Lifetime Data

Patient Rating Scale: Patient input is important. For each area, I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you for the area being discussed.

The scale is:

- 0 - Not at all
- 1 - Slightly
- 2 - Moderately
- 3 - Considerably
- 4 - Extremely

If you are uncomfortable giving an answer, then don't answer.

Please do not give inaccurate information!

INTERVIEWER INSTRUCTIONS:

1. Leave no blanks.
2. Make plenty of Comments (if another person reads this ASI, they should have a relatively complete picture of the client's perceptions of his/her problems).
3. X = Question not answered.
N = Question not applicable.
4. Terminate interview if client misrepresents two or more sections.
5. When noting comments, please write the question number.
6. Tutorial/clarification notes are preceded with "•".

HALF TIME RULE: If a question asks the number of months, round up periods of 14 days or more to 1 month. Round up 6 months or more to 1 year.

CONFIDENCE RATINGS: ⇒ Last two items in each section.
⇒ Do not over interpret.
⇒ Denial does not warrant misrepresentation.
⇒ Misrepresentation = overt contradiction in information.

Probe and make plenty of comments!

HOLLINGSHEAD CATEGORIES:

1. Higher execs, major professionals, owners of large businesses.
2. Business managers of medium sized businesses, lesser professions, i.e., nurses, opticians, pharmacists, social workers, teachers.
3. Administrative personnel, managers, minor professionals, owners/proprietors of small businesses, i.e., bakery, car dealership, engraving business, plumbing business, florist, decorator, actor, reporter, travel agent.
4. Clerical and sales, technicians, small businesses (bank teller, bookkeeper, clerk, draftsman, timekeeper, secretary).
5. Skilled manual - usually having had training (baker, barber, brakeman, chef, electrician, fireman, lineman, machinist, mechanic, paperhanger, painter, repairman, tailor, welder, policeman, plumber).
6. Semi-skilled (hospital aide, painter, bartender, bus driver, cutter, cook, drill press, garage guard, checker, waiter, spot welder, machine operator).
7. Unskilled (attendant, janitor, construction helper, unspecified labor, porter, including unemployed).
8. Homemaker.
9. Student, disabled, no occupation.

LIST OF COMMONLY USED DRUGS:

| | |
|------------------------------|---|
| Alcohol: | Beer, wine, liquor |
| Methadone: | Dolophine, LAAM |
| Opiates: | Pain killers = Morphine, Dilaudid, Demerol, Percocet, Darvon, Talwin, Codeine, Tylenol 2,3,4, Syrups = Robitussin, Fentanyl |
| Barbiturates: | Nembutal, Seconal, Tuinal, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinal |
| Sed/Hyp/Tranq: | Benzodiazepines = Valium, Librium, Ativan, Serax Tranxene, Dalmane, Halcion, Xanax, Miltown, Other = Chloral Hydrate, Quaaludes |
| Cocaine: | Cocaine Crystal, Free-Base Cocaine or Crack, and "Rock Cocaine" |
| Amphetamines: | Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal |
| Cannabis: | Marijuana, Hashish |
| Hallucinogens: | LSD (Acid), Mescaline, Psilocybin (Mushrooms), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstasy |
| Inhalants: | Nitrous Oxide (Whippits), Amyl Nitrite (Poppers), Glue, Solvents, Gasoline, Toluene, Etc. |
| Just note if these are used: | Antidepressants, Ulcer Meds = Zantac, Tagamet Asthma Meds = Ventolin Inhaler, Theodur Other Meds = Antipsychotics, Lithium |

ALCOHOL/DRUG USE INSTRUCTIONS:

The following questions look at two time periods: the past 30 days and lifetime. Lifetime refers to the time prior to the last 30 days. However if the client has been incarcerated for more than 1 year, you would only gather lifetime information, unless the client admits to significant alcohol /drug use during incarceration. This guideline only applies to the Alcohol/Drug Section.

- ⇒ 30 day questions only require the number of days used.
- ⇒ Lifetime use is asked to determine extended periods of use.
- ⇒ Regular use = 3+ times per week, binges, or problematic irregular use in which normal activities are compromised.
- ⇒ Alcohol to intoxication does not necessarily mean "drunk", use the words felt the effects", "got a buzz", "high", etc. instead of intoxication. As a rule of thumb, 5+ drinks in one setting, or within a brief period of time defines "intoxication".
- ⇒ "How to ask these questions:
→ "How many days in the past 30 have you used....?"
→ "How many years in your life have you regularly used....?"

