



LIVE WELL
SAN DIEGO

SmartCare Residential Training

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Client Search/Inquiry/New Client

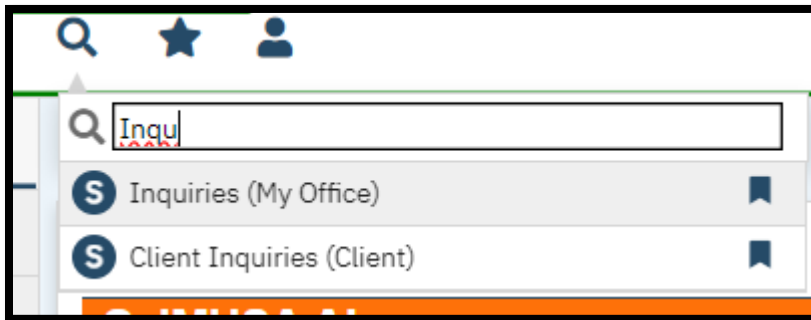
In SmartCare the proper sequence when receiving a new client is to:

1. Open an Inquiry
2. Search for the client to see if they are already in the system
3. Complete the Inquiry
4. Create the client if they were not already in the system

Open Inquiry

The Inquiry is a screen which allows the user to document a request for services.

1. Search for and select “Inquiries (My Office)”



2. Click the New Icon



Client Search

If you have not already selected a client, the Client Search screen will open next.

1. Enter a Last Name
2. Enter a First Name
3. Click Broad Search
4. Enter Social Security Number
5. Click SSN Search
6. Enter Date of Birth
7. Click DOB Search

The screenshot shows the 'Client Search' window with the following elements and callouts:

- 3**: Broad Search button
- 1**: Last Name input field
- 2**: First Name input field
- 4**: SSN input field
- 5**: SSN Search button
- 6**: Date of Birth input field
- 7**: DOB Search button
- 8**: Records Found table area showing 'No data to display'
- 9**: Select button
- 10**: Inquiry (New Client) button

Name Search Include Client Contacts Only Include Active Clients (Checking will not allow option to create new Client)

3 Broad Search Narrow Search Type of Client Individual Organization

Last Name **1** First Name **2** Program

Other Search Strategies

5 SSN Search **4** Phone # Search

7 DOB Search **6** Master Client ID Search

Primary Clinician Search Client ID Search

Authorization ID / # Insured ID Search

Records Found

| ID | Master ID | Client Name | △ | Chosen Name | SSN/EIN | DOB | Status | City | Primary Clinician |
|--------------------------------|-----------|-------------|---|-------------|---------|-----|--------|------|-------------------|
| 8 No data to display | | | | | | | | | |

9 Select **10** Inquiry (New Client) Cancel

8. Clients matching your search criteria will appear in the Records Found section
9. If a record matching the client appears, click Select
10. If no matching records are found, click Inquiry (New Client)

Complete Inquiry

Initial Tab

The screenshot shows a form titled "Inquirer Information" with a "Crisis" checkbox. The form contains several input fields: "Relation To Client" (a dropdown menu with "Self" selected), "First Name", "Middle Name", and "Last Name" (text boxes), "Call Back", "Ext", and "Email" (text boxes), and "Start Date" (a date picker with "T", "Y", and a calendar icon) and "Start Time" (a time picker with a "Now" button). Red circles with letters a through h are placed over the form to identify specific fields: 'a' is over the Crisis checkbox, 'b' is over the Relation To Client dropdown, 'c' is over the First Name field, 'd' is over the Call Back field, 'e' is over the Ext field, 'f' is over the Email field, 'g' is over the Start Date field, and 'h' is over the Start Time field.

1. Field Definitions: Inquirer Information

- a. **Crisis Checkbox:** Select this checkbox to display the Crisis tab. Do not use this at this time. This has not been setup completely.
- b. **Relation to Client:** Indicates whether the potential client contacted your organization or if someone did so on the client’s behalf. If the client made the contact, the information from the client search will also pull into the Client Information (Potential) section discussed below. Select the relationship between the potential client and the inquirer.
- c. **First Name, Middle Name, Last Name:** Enter the first, middle, and last name of the inquirer. If Self is selected in the Relation To Client field, this information populates from the Client Search window.
- d. **Call Back:** Enter the phone number to call the inquirer back should the call be ended prior to gathering all information. If Relation to Client = Self, this information will also pull into the Home Phone field in the Client Information (Potential) section of the Initial tab
- e. **Ext:** Pairs with the Call Back field to document an extension, if applicable
- f. **Email:** Enter an email address for the inquirer. If Relation to Client = Self, this information will also pull into the Email field in the Client Information (Potential) section of the Initial tab.
- g. **Start Date:** Enter the date that the Inquiry occurred.
 - This field also has paired buttons, T and Y, for today and yesterday, respectively. Click the T button to set the date to today. Click the Y button to set the date to yesterday.
 - Enter the date in the mm/dd/yyyy format or click the calendar icon to select the date.

- Click the double caret (<< or >>) to navigate backward or forward by one year. Click the single caret (< or >) to navigate backward or forward by one month.
 - For pre-set dates, click the applicable hyperlink in the Streamline Date/Time Language section at the bottom of the pop-up calendar. Click <<More>> to display a menu of shortcuts.
- h. **Start Time:** Time that the Inquiry began. Next to the Start Time field is a Now button. Clicking this button sets the Start Time to the current time. You can also manually enter the start time and include AM or PM. If you do not enter a time, the system defaults to 12:00 AM.

The screenshot shows a web form titled "Client Information (Potential)". The form contains the following fields and callouts:

- a:** First Name (required, indicated by a red asterisk)
- b:** Client ID
- c:** Sex (dropdown menu)
- d:** SSN
- e:** Date of Birth (DOB) field
- f:** Age (dropdown menu)
- g:** Home Phone
- h:** Email
- i:** Address1
- j:** Urgency Level (dropdown menu)
- k:** Inquiry type (dropdown menu)
- l:** Contact type (dropdown menu)
- m:** Current Client Information (If any) (text area)
- n:** Presenting Problem (text area)

Other fields include Middle Name, Last Name (required), SSN Unknown/Refused (checkbox), Cell, Address2, City, State, and Zip.

2. Field Definitions: Client Information (Potential)

- First Name, Middle Name, Last Name:** If information exists in the client record for these fields, the data initializes and is not editable. If there is no information in the client's record to initialize and the field was not created via the client search, data can be entered into the field.
- Client ID:** If the client is pre-existing, an ID displays here as a hyperlink that can be used to navigate to the client record. If there is no pre-existing information, this field remains empty until the potential client becomes a client.
- Sex:** If information exists in the client record for this field, the data initializes. If there is no information in the client's record to initialize, a value can be

selected from the dropdown. This pertains to the legal gender for billing insurance.

- d. **SSN:** Select this checkbox to indicate a lack of documentable SSN for the client. If applicable, selecting this checkbox fulfills the requirement for a SSN. If the SSN Unknown/Refused checkbox is selected, the field remains empty until the Inquiry is saved and then the field is populated with the value 999-99-9999.
- e. **DOB:** If information exists in the client record for this field, the data initializes. If there is no information in the client's record to initialize, a value can be entered.
- f. **Age:** This field is populated after the DOB field is populated.
- g. **Home Phone, Cell:** If information exists in the client record for these fields, the data initializes. If there is no information in the client's record to initialize, a value can be entered.
- h. **Email:** Enter an email address for the client.
- i. **Address, City, State, Zip:** If information exists in the client record for these fields, the data initializes. If there is no information in the client's record to initialize, a value can be entered.
- j. **Urgency Level (Required):** Select a value related to the client's urgency need relative to their request.
- k. **Inquiry Type:** Select a value to categorize the type of Inquiry.
- l. **Contact Type (Required):** Select a value to describe the mode of contact used by the client.
- m. **Current Client Information** (If any): If the client for whom an Inquiry is being documented has previously been a client with the organization, the following information, if it is in the client's record, initializes here:
 - Client ID
 - Last Inquiry Date
 - Coverage History
 - Episode Number from Episodes tab of client information
 - Registration Date from Episodes tab of client information

- Discharge Date from Episodes tab of client information

n. **Presenting Problem:** Free text to enter the client’s presenting problem.

The screenshot shows a form titled "Inquiry Handled By" with the following fields:

- Recorded By:** a dropdown menu with "rogadmin" selected. A red circle labeled 'a' is over the dropdown arrow.
- Information Gathered By:** a dropdown menu with "rogadmin" selected. A red circle labeled 'b' is over the dropdown arrow.
- Program:** a dropdown menu. A red circle labeled 'c' is over the dropdown arrow.
- Gathered By Other:** a text input field. A red circle labeled 'd' is over the input field.
- Location:** a dropdown menu. A red circle labeled 'e' is over the dropdown arrow.
- Assigned To:** a dropdown menu. A red circle labeled 'f' is over the dropdown arrow.

1. Field Definitions: Inquiry Handled By

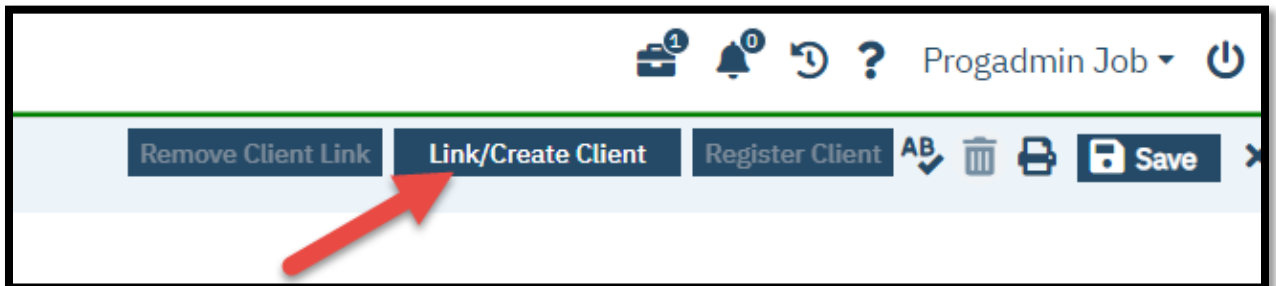
- Recorded:** Defaults to the logged in user and cannot be edited.
- Information Gathered By:** Select which staff member gathered the information from the client. This is usually the same as Recorded By. However, if an Inquiry is received by one person and logged by another, this field is available.
- Program:** Select which program information or services were being inquired about or by which program the Inquiry was handled.
- Gathered By Other:** Enter text to note if the Inquiry was gathered by someone other than a staff member, such as a community partner.
- Location:** Select where the client was calling from.
- Assigned to:** Select to whom the Inquiry is assigned.

4. When finished entering information, click the Save button in the top right corner

Create New Client If Needed

If the client was not found in the above client search, they must be created now.

1. Select the “Link/Create Client” button at the top of the Inquiry Details. This will bring up the client search window.



2. To verify that the client is not already in the system the search must be repeated.
 - a. Click the Broad Search or Narrow Search button.
 - b. Click the SSN Search button
 - c. Click the DOB Search button
 - d. If no records are found based on the search you do, an alert will show at the top of the window
 - e. The Create New Client Record button will become active

The screenshot shows the 'Client Search' window. At the top, there is a 'Clear' button and a red alert box with a star icon and the text 'No Search Records Found'. Below this is the 'Name Search' section with checkboxes for 'Include Client Contacts' and 'Only Include Active Clients (Checking will not allow option to create new Client)'. There are buttons for 'Broad Search' (marked with a red 'a') and 'Narrow Search'. The 'Type of Client' is set to 'Individual'. Search fields include 'Last Name' (Restest), 'First Name' (John), and 'Program'. Below this is the 'Other Search Strategies' section with buttons for 'SSN Search' (marked with a red 'b'), 'DOB Search' (marked with a red 'c'), 'Phone # Search', 'Master Client ID Search', 'Client ID Search', 'Primary Clinician Search', and 'Insured ID Search'. The 'Records Found' section shows a table with columns: ID, Master ID, Client Name, Chosen Name, SSN/EIN, DOB, Status, City, and Primary Clinician. The table is empty with the text 'No data to display'. At the bottom right, there are buttons for 'Select', 'Cancel', 'New Registrations', and 'Create New Client Record' (marked with a red 'e').

3. Click the Create New Client Record button
4. The Client Search window will close and the new Client ID and Current Client Information fields will populate on the Inquiry Details.

Client has now been created but must be added to your program before documentation can occur.

Residential Bedboard

Residential Bedboard is a list page used by residential programs to manage beds. The Residential Bedboard list page shows all beds and identifies whether the bed is in use or

not. You can use Residential Bedboard to manage new admissions and discharges, clients' attendance, and change beds and programs. Admitting a client using this Bedboard will automatically enroll the client in the designated Program.

How to Open the Residential (My Office) List Page

1. Click the Search icon.
2. Type 'Residential' into the search bar.
3. Click to select Residential (My Office).
4. Ensure that you have set the filter to today's date and the program you should be viewing.

How to Schedule Admission of a Client to a Bed

If you are uncertain if the client will actually be admitted to your program, you may choose to use the Schedule Admission function. This will add the client to your program in a Requested Enrollment status and allow you to document screening and any services provided before a decision to Admit has been made.

After you have selected the client you are going to admit to your program and navigated to the Residential (My Office) List Page:

1. Locate an empty bed in your facility on the Residential (My Office) List Page.
2. Click the down arrow in the Status column in the row for the target bed.
3. Choose the Schedule Admission link.
4. The Census Management – Schedule Admission screen will open.
 - a. Verify the Scheduled Date is set to today
 - b. Verify the correct Program is selected
 - i. SUD Admission to different level of care at same facility:
 1. Uncheck the box for "Only show beds for selected program"
 2. In the dropdown for Program choose the correct Level of Care for the Client
 - c. Choose the correct Client Type
 - d. Choose the correct Admission Type
5. Click the Save Icon. A requested enrollment to the Program associated with the bed will be created automatically and documentation may proceed.
6. When the decision is made to Admit the client, return to the Residential Bedboard, locate the client and click the down arrow in the Status column
7. Choose the Admit link
 - a. Verify the Admit Date and Time are correct
 - b. Verify the correct Program is selected

- i. SUD Admission to different level of care at same facility:
 - 1. Uncheck the box for “Only show beds for selected program”
 - 2. In the dropdown for Program choose the correct Level of Care for the Client
 - c. Choose the correct Client Type
 - d. Choose the correct Admission Type
- 8. Click the Save Icon. The requested enrollment will be updated to Enrolled.

How to Admit a Client to a Bed

If you have decided to fully admit the client to your program you must complete the admission.

After you have selected the client you are going to admit to your program and navigated to the Residential (My Office) List Page:

1. Locate an empty bed in your facility on the Residential (My Office) List Page.
2. Click the down arrow in the Status column in the row for the target bed.
3. Choose the Admit link.
4. The Census Management –Admit screen will open.
 - a. Verify the Admit Date and Time are correct
 - i. Verify the correct Program is selected SUD Admission to different level of care at same facility:
 1. Uncheck the box for “Only show beds for selected program”
 2. In the dropdown for Program choose the correct Level of Care for the Client
 - b. Choose the correct Client Type
 - c. Choose the correct Admission Type
5. Click the Save Icon. An enrollment to the Program associated with the bed will be created automatically.

How to Make a Client Non-Billable

Clients are in a billable status by default. SmartCare will generate bed day services automatically as long as the client is admitted to your facility. If the client has not received services necessary for billing, their billing code must be manually adjusted to prevent the service from being created. Billing for each day must be determined by midnight of that day. Any errors after the service is created must be corrected via MHBUS.

1. From the Residential (My Office) List Page, locate the client.
2. Click the down arrow in the Status column.

3. Choose the Billing Code Change link.
4. The Census Management – Billing Code Change screen will open
 - a. Verify the Start Date and Time is correct
 - b. In the Billing Procedure dropdown, select Non-billable Bed Procedure
5. The client must be changed back to the previous bed procedure for charges to resume

SUD - How to Change a Client to a Different Level of Care

1. From the Residential (My Office) List Page, locate the client.
2. Click the down arrow in the Status column.
3. Choose the Transfer link
4. The Census Management – Transfer screen will open
 - a. Uncheck the box for “Only show beds for selected program”
 - b. In the dropdown for Program choose the new Level of Care for the Client
 - c. If the client is moving to a new bed, select the new bed using the Bed dropdown
5. Click the Save icon in the upper right corner
6. The Enrollment for the previous level of care will be discharged automatically
7. An Enrollment for the new level of care will be created automatically

Safety Check Order

In order to make a link for the Safety Check appear on the Whiteboard, an order must be placed.

1. Click the Search icon
2. Type Client Orders in the search bar
3. Click to select Client Orders (Client)
4. Click the New icon in the top right corner
5. If there are no other active Orders, the CDAG Program Enrollment window will popup. Select the appropriate program with the correct enrollment date and click OK.
6. The Client Order screen will open.
 - a. Order Entry Details
 1. Entered by should be the Staff entering the order
 2. Order Mode: Electronic
 3. Order Status: Active
 4. Ordering Physician: for this order it can be the
 5. Onsite Specimen Collection N/A

6. Read back and verified N/A
- b. Order
 1. Type Safety in the search bar
 2. Select one of the Safety Check orders with the appropriate frequency
 3. Preference: N/A
 4. Discontinued: N/A
 5. Priority: Now
 6. Start: Other
 7. Start Date enter date the order should start on
 8. Start Time enter time the order should start
 9. Enter an end date and time if applicable (leave blank if order should continue until discontinued)
 10. Program: will prepopulate with the residential program
 11. Comments: if needed
7. Click Insert and the order will be inserted into the Order List
8. Click Sign. The order is now active and will populate the Next Check column of the Whiteboard.

Intake

After the client has been added to a Program, documentation may proceed. Any of the below may be done while the client is still in “Scheduled Admission” status.

Timeliness

SmartCare has 4 Timeliness documents available

[How to Complete the MH Non-Psychiatric SMHS Timeliness Record](#)

[How to Complete the MH Psychiatric SMHS Timeliness Record](#)

[How to Complete the DMC Opioid Timeliness Record](#)

[How to Complete the DMC Outpatient Timeliness Record](#)

SUD: BQUIP

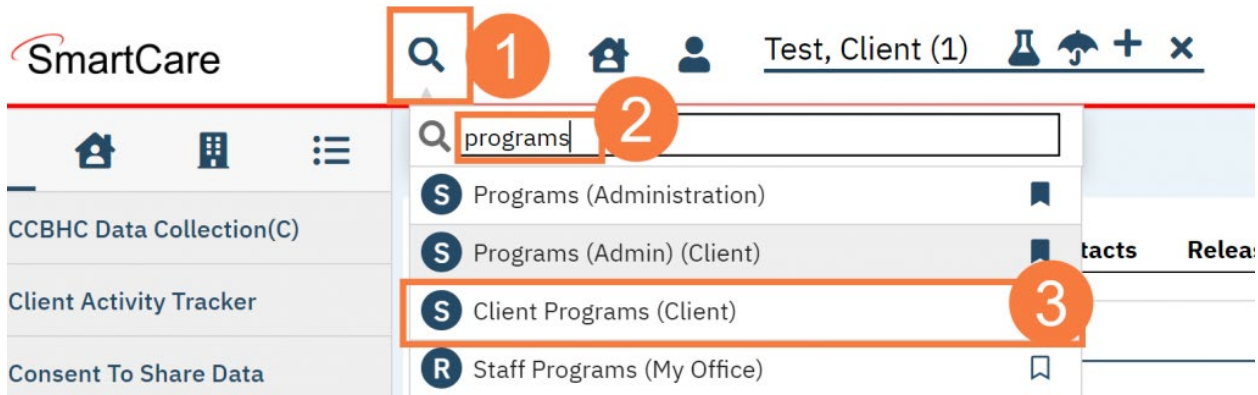
[How to Complete a BQuIP SUD Screening Tool](#)

SUD – CalOMS

Before opening the CalOMS document, follow these steps to generate an FSN so it will be prepopulated in the CalOMS form:

1. With the client open, **click the Search icon.**

2. **Type Programs** in the search bar.
3. **Click to select Programs (client).**



4. On the Client Programs list page, **click the Enrolled hyperlink** for the appropriate program.

Client Programs (4)

| Program Name | Status | Enrolled | Discharged | Assigned Staff | Primary | Last DOS | Next DOS |
|----------------------|--------------------------|------------|------------|----------------|---------|---------------------|----------|
| SUD Access | Enrolled | 10/02/2023 | | Vera, Monique | Yes | | |
| SUD Residential | Enrolled | 09/01/2023 | | | No | | |
| SUD Youth Outpatient | Enrolled | 07/12/2023 | | Rowe, Charla | No | | |
| SUD Outpatient | Enrolled | 07/06/2023 | | | No | 09/25/2023 10:00 AM | |

5. On the Programs Assignment Details page, navigate to the comment box and **enter a generic note**. For example, CalOMS UPDATE.
6. **Click Save.**

Program Assignment Details

Program Assignment

General

Program Name: SUD Access-10/02/2023 Primary Current Status: Enrolled

Client: Test, Client

Assigned Staff: Vera, Monique

Requested Date: 10/01/2023

Enrolled Date: 10/02/2023

Discharged Date:

Next Schedule Service:

Comment:

Save

[How to Complete a CalOMS Admission](#)

[How to Complete a CalOMS Referral/Transfer](#)

MH – CSI Standalone Collection

[How to Complete a CSI Demographic Record](#)

Authorization

Program Request for Authorization

Use current paper submissions for Authorization. Optum will then enter the Authorization into SmartCare.

Documentation

LPHA/Non-LPHA

1. Diagnosis Document (LPHA)
 - [How to Add a Diagnosis](#)
 - [How to Delete a Diagnosis](#)
 - [How to Modify and/or Re-Order a Diagnosis](#)
 - [How to Modify a Diagnosis After the Document is Generated](#)
 - [How to Save a Favorite Diagnosis](#)
 - [How to Pull a Diagnosis Forward from Another Program](#)
 - [Reordering Diagnoses List](#)
2. Assessment
 - a. MH - CalAIM Assessment
 - [CalAIM Assessment](#)
 - b. SUD – ASAM/Problem List
 - [ASAM Assessment](#)
3. MSE
 - [Mental Status Exam \(MSE\)](#)
4. Safety
 - a. Risk Assessment (if applicable)
 - i. With the client open, click the Search icon
 - ii. Type “Risk Assessment (client)” in the search bar
 - iii. Select “Risk Assessment (client)” from the search results
 - iv. The CDAG Program Enrollment window will popup. Select the appropriate program with the correct enrollment date.
 - v. Click OK.

- vi. This will bring you to the Risk Assessment document screen.
Complete the entire document.
- vii. If you are completing the Risk Assessment after the fact or are entering in the answers from a paper version, make sure your effective date is the date the assessment actually took place.
- viii. When you are finished with the document, click Sign.
- ix. This will bring you to the PDF. You may now click the Close icon.
- b. Safety/Crisis Plan (if applicable)
[How to Complete the Safety Plan](#)
- 5. Valuables and Belongings
[How to Complete the Personal Effects Inventory \(PEI\)](#)
- 6. Safety Checks (Whiteboard)
 - a. Click the Search icon
 - b. Type Whiteboard in the search bar
 - c. Click to select Whiteboard (My Office)
 - d. Click the time link to the next Safety Check in the Next Check column
 - e. The Flowsheet Detail Popup screen will open
 - i. Date/Time
 - 1. Ensure the correct Date/Time is entered
 - ii. Safety Check
 - 1. Select Status Complete
 - 2. If the Check was performed by another Staff, change the Completed by to the correct name
 - 3. Enter a comment if applicable
 - iii. Current Behavior / Client Status
 - 1. Select Status
 - 2. Select Activity
 - 3. Select Location
 - 4. Other/Comments free text as applicable
 - f. Click Save & Close when finished
 - g. Cancel without saving if needed
 - h. Safety Checks can be reviewed in the Flow Sheet
- 7. Shift Summary (Services/Notes)
[How to Document an End of Shift Summary](#)

Nursing

- 1. Home medications
Dr First training separate

2. Allergies

a. To view Allergies

[Allergies \(Client\) List Page](#)

b. To enter Allergies

- i. Click on the Search icon, with the client open
- ii. Type “Client Allergies (Client)” in the search bar
- iii. Select “Client Allergies (Client)” from the search results
- iv. This will bring up the Client Allergies Screen

The screenshot shows the 'Client Allergies' interface. At the top right, there is a 'Save' button (12) and a close icon. Below the title bar, there is a 'Review' tab and a 'Status' dropdown menu. The main form area includes a checkbox for 'No known allergies' (1), an 'Allergy' text input field (2), an 'Active' checkbox, and an 'Added/Modified by' dropdown menu. Below these are 'Reaction' (7) and 'Severity' (8) dropdown menus, and a 'Comments' text area (9). At the bottom of the form, there are 'Insert' and 'Clear' buttons (10). Below the form is an 'Allergy list' section (11) with a 'Show Active Only' checkbox. It contains a table with columns: Allergies, Type, SNOMED Code, Active, and Added/Modified by. One entry is visible: Aspirin, Allergy, Yes, Beck, James on Aug 5 2024 10:20 AM.

The screenshot shows the 'Client Allergies Popup' dialog. It features a search bar (3) at the top. Below it is a list of allergy types with radio buttons: Panglobulin (selected), Panoxyl, Penicillamine, Penicillanic Sulfone BL Beta-Lactamase Inhibitors, Penicillin G, penicillin G benzathine, Penicillin G Procaine, Penicillin V, and Penicillins. There is a text input field (5) below the list. At the bottom, there are 'OK' and 'Cancel' buttons (6). Below the buttons are radio buttons for 'Allergy' (selected), 'Intolerances', and 'Failed Trials', and a checked 'Active' checkbox.

1. If client has No Known Allergies, check the box for No known allergies

2. If the client reports an allergy, type the allergy in the Allergy field and hit Enter.
 3. Choose the correct substance in the Client Allergies Popup
 4. Choose Allergy / Intolerances / Failed Trials
 5. Enter a comment if needed
 6. Click OK when finished
 7. Enter a Reaction
 8. Enter a Severity
 9. Comments from (5) appear here, edit if needed
 10. Click Insert
 11. Allergy will appear in Allergy list
 12. Click Save when finished
3. History and Physical form does not share documentation with other notes/assessments H&P also may be documented in the Nursing Evaluation Note [History and Physical Standalone Form](#)
 4. Vitals
[How to Document Vitals](#)
 5. AIMS
[How to Complete the AIMS Assessment](#)
 6. Review MAR/Chart medications - Dr First training separate
 7. Nursing Assessment
[Psych/Medical Note Training](#)
[How to Complete the Psych/Medical Note](#)
 8. Other Nursing Notes
[How to Write a Progress Note for an Unscheduled Service](#)
 - a. Nurse Progress Note – Incident Documentation
 - b. Shift Summary – End of shift documentation if program requires

Prescriber

1. Review Client Information
2. Diagnosis Document (if applicable)
 - [How to Add a Diagnosis](#)
 - [How to Delete a Diagnosis](#)
 - [How to Modify and/or Re-Order a Diagnosis](#)
 - [How to Modify a Diagnosis After the Document is Generated](#)
 - [How to Save a Favorite Diagnosis](#)
 - [How to Pull a Diagnosis Forward from Another Program](#)
 - [Reordering Diagnoses List](#)

3. Assessment
Prescriber Assessment E/M (OP) [90792]
[Psych/Medical Note Training](#)
[How to Complete the Psych/Medical Note](#)
4. Medication Reconciliation
Dr First training separate

Service Entry

Group Services

- [How to Add a New Client to a Group](#)
- [How to Add or Change a Staff Member in a Group](#)
- [How to Set Up a Group](#)
- [How to Write a Group Progress Note](#)
- [Group Documentation Videos](#)

Peer Services

- [How to Write a Progress Note for an Unscheduled Service](#)
 1. Behavioral Health Prevention Education service
 2. Self-help/peer service

Medication Services

- [How to Write a Progress Note for an Unscheduled Service](#)
 1. Prescriber New E/M [99201-99205]
 2. Prescriber Progress E/M [99212-99215]

Discharge

Update CalOMS

- [How to Complete a CalOMS Discharge](#)

Update CSI

- [How to Complete a CSI Demographic Record](#)

CalMHSA Discharge Summary

How to Complete the Discharge Summary

Discharge from Program

Discharge the client and remove them from the bed using the Residential Bedboard.

1. Click the Search icon.
2. Type 'Residential' into the search bar.
3. Click to select Residential (My Office).
4. Ensure that you have set the filter to today's date and the program you should be viewing.
5. Find the client to be discharged in and click the down arrow in the Status column
6. Choose the Discharge link
7. The Census Management – Discharge screen will open
 - a. Ensure that the Discharge Date/Time are accurate
 - b. Choose a Discharge Type
8. Click the Save icon
9. The client will now be discharged from the program and removed from the bed