SANWITS INTRO TO ADMIN FUNCTIONS TRAINING

Samples

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

***These examples are for training purposes only, and do not necessarily meet State and County documentation standards.*

03/2020

County of San Diego
Behavioral Health Services

Provider Id: _____
Client Name: _____
Client #: _____
Data Entry Date: _____
Data Entry Int: _____
CalOMS Serial #:W_____

CalOMS Profile

CLIENT PROFILE (*REQUIRED)

***Current First Name**	**State Client ID aka Unique Client Number** (Auto-populates after data is saved)	**State Client No** (Auto-populates after data is saved)	
Middle Name (Create a Middle Name for your client)	**Provider Client ID** (Internal Client # if applicable)		
***Current Last Name**	***SSN** 99902	99900-Declined to State 99902-Not applicable (if client does not have a SSN)	99904-Unable to answer (only if client is in detox or developmentally disabled)
***Birth First Name (Use Current First Name)**	***Driver's License #** (State ID# is acceptable) 99902	99900-Declined to State 99902-Not applicable (if client does not have a DL/ ID) 99904-Unable to answer (only if client is in detox or developmentally disabled	***Driver's License State**
***Birth Last Name (Use Current Last Name)**	**Medicaid #**		
***Mother's First Name** Mother	**Date of Death** (Client)		
***Gender** 1-Male 2-Female 99903-Other	***Place of Birth** San Diego	***State** CA	
***DOB (For training purposes, indicate a DOB over the age of 21)**	***Consent on File for Future Contact** □ YES ☒ NO		
No Readmit Until	**Has Paper File** (Always select YES) □ YES		

ALTERNATE NAMES (*REQUIRED)

Last Name	First Name	Middle Name	Client Alias Type

ADDITIONAL INFORMATION (*REQUIRED)

***Ethnicity** (Select One) 1- Not Hispanic	1-Not Hispanic 2-Mexican/Mexican American 3-Cuban	4-Puerto Rican 5-Other Hispanic/Latino
***Primary Race/Ethnicity** (Select One) White	☒ White □ Black/African American □ Mexican/Latino/Hispanic	□ Asian/Pacific Islander □ Native American □ Other

***Required Field**

County of San Diego
Behavioral Health Services

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CalOMS Profile

ADDITIONAL INFORMATION (*REQUIRED)

***Races** (Select at least one; not to exceed 5)

1- White

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

***Disabilities** (Select All That Apply)

2- Visual

1-None
2-Visual
3-Hearing
4-Speech
5-Mobility
6-Mental
7- Developmentally Disabled
8- Other Disability (Not AOD)
99900-Declined to State
99904-Unable to Answer (only if client is in detox)

General Client Comments

Sexual Orientation (Select One)

□ Bisexual
□ Gay Male
□ Heterosexual
□ Intersex
□ Lesbian
□ Questioning
□ Transgender
□ Other
□ Decline to State

Religious Preference (Select One)

□ Agnostic
□ Babi & Baha'I Faith
□ Baptist
□ Bon
□ Brethren
□ Buddism
□ Cao Dai
□ Celticism
□ Christian (non-Catholic, non-specific)
□ Christian Scientist
□ Church of Christ
□ Church of God
□ Confucianism
□ Congregational
□ Cyberculture Religion
□ Disciples of Christ
□ Divination
□ Eastern Orthodox
□ Episcopalian
□ Evangelical Covenant
□ Fourth Way
□ Free Daism
□ Friends
□ Full Gospel
□ Gnosis
□ Hinduism
□ Humanism
□ Independent
□ Islam
□ Jainism
□ Jehovah's Witness
□ Judaisim
□ Latter Day Saints
□ Lutheran
□ Mahayana
□ Meditation
□ Messianic Judaism
□ Methodist
□ Mitraism
□ Native American
□ Nazarene
□ New Age
□ Non-Roman Catholic
□ None
□ Occult
□ Orthodox
□ Other
□ Paganism
□ Pentecostal
□ Presbyterian
□ Process, The
□ Protestant
□ Protestant,No Denomination
□ Reformed
□ Reformed/ Presbyterian
□ Roman Catholic Church
□ Salvation Army
□ Satanism
□ Scientology
□ Shamanism
□ Shiite (Islam)
□ Shinto
□ Sikism
□ Spiritualism
□ Sunni (Islam)
□ Taoism
□ Theravada
□ Unitarian Universalist
□ Unitarian Universalism
□ United Church of Christ
□ Universal Life Church
□ Vajrayana (Tibetan)
□ Veda
□ Voodoo
□ Wicca
□ Yaohushua
□ Zoroastrianism

***Preferred Language** (Select One)

English

□ American Sign Language
□ Amharic
□ Arabic
□ Armenian
□ Braille
□ Cambodian
□ Cantonese
□ Chinese
□ Czech
□ Dutch
☒ English
□ Fang Yan
□ Farsi
□ Finnish
□ French
□ German
□ Greek
□ Gujarati
□ Hebrew
□ Hindi
□ Hmong
□ Hungarian
□ Ilocano
□ Indian (General)
□ Italian
□ Japanese
□ Korean
□ Lakota Sioux
□ Laotian
□ Large Print English
□ Malay
□ Mandarin
□ Marathi
□ Mien
□ Norwegian
□ Other Non-English Language
□ Polish
□ Portuguese
□ Puyallup
□ Romanian
□ Russian
□ Salish
□ Samoan
□ Spanish
□ Tagalog
□ Thai
□ Tigrigna
□ Turkish
□ Ukranian
□ Unknown Language
□ Vietnamese
□ Yakama

***Required Field**

County of San Diego
Behavioral Health Services

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CalOMS Profile

ADDITIONAL INFORMATION		(*REQUIRED)
Interpreter Needed ☐ YES ☐NO		
***Are you a veteran?** **No**	1-Yes 0-No	99900-Client declined to state 99904-Client unable to answer (Only if client is in detox or developmentally disabled)

CONTACT INFO		(*REQUIRED)
Home Phone #	**Preferred Method of Contact**	□ Phone □ Email □ Letter
Work Phone #		
Mobile #		
Other Phone #		
Fax #		
Email Address		

Address Type (Select One)			**Confidential**
1- Client Billing	1-Client Billing 2-Client Home 3-Client Mailing	4-Client Previous 5-Client Unknown 6-Client Work	□ YES ☐ NO

Address Line 1		
3160 Camino Del Rio S		
Address Line 2		
County		
City	**State**	**Zip**
San Diego	**CA**	**92108**

***Required Field**

County of San Diego
Behavioral Health Services

LIVE WELL SAN DIEGO

Provider Id: _____
Client Name: _____
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Data Entry Int: _____
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SanWITS Contact Screen

CONTACT (*REQUIRED)

***Initial Contact Date** (MUST BE ORIGINAL DATE CLIENT MADE CONTACT) **XX/01/XX**	***Stop Date** (Required if contact method= Phone, should be same date as initial contact date)	**Status** (Auto-populates when saved)	
***Start Time** (required if contact method = Phone)	***Stop Time** (Required if Contact Method = Phone)	**Duration** (Auto-populates when saved)	**Created Date** (Auto-populates when saved)
***Contact Reason** X Routine Service □ Urgent □ Information □ Other	***Contact Method** □ Electronic □ Phone X Walk-In	**If Other, Specify** (Required if Contact Reason = **Other** is selected)	
***Source of Referral** (Selection populates to the Intake screen and is read only; Important to review for accuracy before completing the review) **2- Alcohol/Drug Abuse Program**	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- Probation or Parole	8- Post-release Community Supervision (AB109) 9- DUI/DWI 10- Adult Felon Drug Court 11- Dependency Drug Court 12- Court/Criminal Justice Referral 13- Other Community Referral 14- Child Protective Services	
***Call Taker** –(Auto-populates based on staff login; can be changed to reflect actual staff name)	**Requestor Name**	**Requestor Phone #**	
Location	□ By Appointment □ Community Service Patrol □ Drop-in/Office	□ Emergency Outreach intervention □ Hospital/On-call intervention □ Phone	□ In home □ In community □ Other
***Contact Made By** **Self**	X Self □ Family Member □ Justice System □ Other SUD Provider	□ Primary Health Care Provider □ MH Provider □ Other	**LMHA**
***Benefit Type** **Medi-Cal**	X Medi-Cal □ Medicare □ Medi-Cal/Medicare □ No Insurance	□ Other/Private Insurance □ Tricare □ Veterans Admin □ NA (Use when No appointment is made)	
Presenting Needs			
***Disposition** **Made an Appointment**	X Made an Appointment □ No Appointment Made □ Declined appointment	□ Ref Out to Another Level of Care □ Ref Out for Non-SUD Services □ Ref to Private Insurance Carrier	
Unsigned Notes			

Appointments (Required when Disposition = Made Appointment)	* 1st Available Intake/Screening Appt **XX/01/XX**	* 2nd Available Intake/Screening Appt **XX/02/XX**	* 3rd Available Intake/Screening Appt **XX/03/XX**	* 1st Accepted Intake/Screening Appt **XX/01/XX**

***Required Field**

County of San Diego
Behavioral Health Services

Provider Id: _____
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SanWITS Intake Screen

INTAKE			(*REQUIRED)
***Intake Facility** (Auto-populates; DO NOT CHANGE; if wrong facility, go to Home Page to select correct facility)			**Case #** (Auto-populates)
***Intake Staff** (Auto-populates based on staff login; can be changed to reflect actual intake staff)		***Case Status** (Auto-populates) **1-Open Active**	
***Manner of Contact** (Auto-populates based on Contact Form)		***Initial Contact Date** (Auto-populates based on Contact Form)	
***Residence** (CA County) **San Diego**		***Intake Date** (mm / dd /yyyy) **XX/01/XX**	
***Source of Referral** (Auto-populates based on Contact Form)		***Pregnant** □ Yes □ No (Auto-populates for Male) □ 99901 – Not Sure/Don't Know	***Due Date** (For pregnant females only)
Referral Contact	***Chronic Life-Threatening Illness** (CLTI) □ YES **X** NO □ UNKNOWN		***Injection Drug User** □ YES **X** NO □ UNKNOWN
Referral Date		**Assessment Date**	
Presenting Problem (In Client's Own Words)			
Appointments	***1st Available Tx Appt** **XX/01/XX**	***2nd Available Tx Appt** **XX/02/XX**	***3rd Available Tx Appt** **XX/03/XX**	***1st Accepted Tx Appt** **XX/01/XX**
Risk Categories □ None □ All Other Injection Drug User □ Cognitive Impaired □ Criminal Justice □ Foster Youth	**X** Homeless □ Isolated Elderly □ LGBTQ + □ Parenting Injection Drug User □ Parenting Substance User	□ Pregnant Injection Drug User □ Pregnant Substance User □ Refugee □ Veteran	
Date Closed	***Closure Reason** (Reason required only if Date Closed is entered) □ Client left/or Referred Out □ Closed to Recovery Services	□ Completed Courtesy Dosing □ Completed Prop 47 Aftercare □ Client Discharged	

***Required Field**

County of San Diego
Behavioral Health Services

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Benefit Plan Enrollment

PAYOR GROUP ENROLLMENT - for BILLING ONLY

*Payor-Type		*Plan-Group	
Medicaid	o Medicaid o Self-pay o Group Insurance o Medicare o Other	**ODS DMC - NonPeri-Medi-Cal Non Perinatal**	o ODS DMC- Non-Peri-Medi-Cal Non Perinatal o ODS- Peri-Medi-Cal- Perinatal

Payor Priority Order	Policy#
X 1 o 2	

PAYOR GROUP ENROLLMENT - for BILLING ONLY (*REQUIRED)

*Coverage Start (mm /dd /yyyyy)	End (mm / dd / yyyyy)	Payment Scale
XX/01/XX		

*Aid Code (DMC Required)	*Relationship to Subscriber/Responsible Party	
M1	X Self □ Spouse □ Life Partner □ Child	□ Cadaver Donor ☐ Employee ☐ Organ Donor ☐ Other Relationship ☐ Unknown

Subscriber / Responsible Party Info (Auto-populates when Subscriber/Responsible Party is "Self")

*First Name	Middle	*Last Name

*Birthdate	*Gender	*Subscriber#
		12345677R

*Address 1
3160 Camino Del Rio S
Address 2

*City	*State	*Zip
San Diego	CA	92108

Government Contract Enrollment

Government Contract Enrollment

*PlanType	*Contract	
Government Contract	559999, 559999	
Payor Priority Order o 1 X 2	*Start Date (mm /dd /yyyyy) XX/01/XX	End (mm / dd / yyyyy)

*Plan-Group

ODS Residential- Residential Bed Day

o ODS Residential- Justice Override County Billable
o ODS Residential- Out of County Bed Day
o ODS Residential- Residential Bed Day

Subscriber #
 # will pre-populate with client UCN

*Required Field

ASAM

Type of Assessment:

☒Intial Assessment ☐Follow-up Assessment

Severity Rating – Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential) *Please Check one of the following levels of severity*				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Fully functioning, no signs of intoxication or W/D present.	Mild to moderate intoxication interferes with daily functioning, but does not pose a danger to self/others. Minimal risk of severe W/D.	Intoxication may be severe, but responds to support; not posing a danger to self or others. Moderate risk of severe W/D.	Severe signs/symptoms of intoxication indicate an imminent danger to self/others. Risk of severe but manageable W/D; or W/D is worsening.	Incapacitated, with severe signs/symptoms. Severe W/D presents danger, such as seizures. Continued use poses an imminent threat to life (e.g., liver failure, GI bleeding, or fetal death).

Severity Rating – Dimension 2 (Biomedical Conditions and Complications) *Please Check one of the following levels of severity*				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Fully functioning and able to cope with any physical discomfort or pain.	Adequate ability to cope with physical discomfort. Mild to moderate symptoms (such as mild to moderate pain) interfere with daily functioning.	Some difficulty tolerating physical problems. Acute, non-life threatening medical symptoms (such as acute episodes of chronic, distracting pain, or signs of malnutrition or electrolyte imbalance) are present. Serious biomedical problems are neglected.	Poor ability to tolerate and cope with physical problems, and/or general health condition is poor. Serious medical problems neglected during outpatient or IOT services. Severe medical problems (such as severe pain requiring medication, or hard to control Type 1 Diabetes) are present but stable.	The person is incapacitated, with severe medical problems (such as extreme pain, uncontrolled diabetes, GI bleeding, or infection requiring IV antibiotics).

Severity Rating – Dimension 3 (Emotional, Behavioral or Cognitive (EBC) Conditions or Complications) *Please Check one of the following levels of severity*				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Good impulse control, coping skills and sub-domains (dangerousness/lethality, interference with recovery efforts, social functioning, self-care ability, course of illness).	There is a suspected or diagnosed EBC condition that requires intervention, but does not significantly interfere with treatment. Relationships are being impaired but not endangered by substance use.	Persistent EBC condition, with symptoms that distract from recovery efforts, but are not an immediate threat to safety and do not prevent independent functioning.	Severe EBC symptomatology, but sufficient control that does not require involuntary confinement. Impulses to harm self/others, but not dangerous in a 24-hr. setting	Severe EBC symptomatology; requires involuntary confinement. Exhibits severe and acute life-threatening symptoms (e.g., dangerous or impulsive behavior or cognitive functioning) posing imminent danger to self/others.

Severity Rating – Dimension 4 (Readiness to Change) *Please check one of the following levels of severity*				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Engaged in treatment as a proactive, responsible participant. Committed to change.	Ambivalent of the need to change. Willing to explore need for treatment and strategies to reduce or stop substance use. May believe it will not be difficult to change, or does not accept a full recovery treatment plan.	Reluctant to agree to treatment. Able to articulate negative consequences (of substance use and/or mental health problems) but has low commitment to change. Passively involved in treatment (variable follow through, variable attendance)	Minimal awareness of need to change. Only partially able to follow through with treatment recommendations.	Unable to follow through, little or no awareness of problems, knows very little about addiction, sees no connection between substance use/consequences. Not willing to explore change. Unwilling/unable to follow through with treatment recommendations.

Severity Rating – Dimension 5 (Relapse, Continued Use, or Continued Problem Potential) *Please check one of the following levels of severity*				
☐ 0: None	☐ 1: Mild	☐ 2: Moderate	☐ 3: Significant	☐ 4: Severe
Low or no potential for further substance use problems or has low relapse potential. Good coping skills in place.	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.	Impaired recognition and understanding of substance use relapse issues. Able to self-manage with prompting.	Little recognition and understanding of relapse issues, poor skills to cope with relapse.	Repeated treatment episodes have had little positive effect on functioning. No coping skills for relapse/addiction problems. Substance use/behavior places self/others in imminent danger.

Severity Rating – Dimension 6 (Recovery/Living Environment) *Please check one of the following levels of severity*				
☐ 0: None	☐ 1: Mild	☐ 2: Moderate	☐ 3: Significant	☐ 4: Severe
Supportive environment and/or able to cope in environment.	Passive/disinterested social support, but not too distracted by this situation and still able to cope.	Unsupportive environment, but able to cope with clinical structure most of the time.	Unsupportive environment and the client has difficulty coping, even with clinical structure.	Environment toxic/hostile to recovery (i.e. many drug-using friends, or drugs are readily available in the home environment, or there are chronic lifestyle problems). Unable to cope with the negative effects of this environment on recovery (i.e. environment may pose a threat to recovery).

Residential

Recommended Level of Care: 3.1-Clinically Managed Low-Intensity Residential Service
Actual Level of Care: 3.1-Clinically Managed Low-Intensity Residential Service
Additional Level of Care:

Outpatient

Recommended Level of Care: 1- Outpatient Services
Actual Level of Care: 1- Outpatient Services
Additional Level of Care:

Opioid

Recommended Level of Care: OTP- Opioid Treatment Program
Actual Level of Care: OTP- Opioid Treatment Program
Additional Level of Care:

Assessment Date: XX/01/XX

County of San Diego
Behavioral Health Services

Provider Id: _____
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CalOMS Admission

ADMISSION PROFILE (*REQUIRED)

Screening

Potential Client for MH □ **YES** ☐ **NO**	□ Based on Screening □ Based on Referral □ Based on Testing Result	□ Court Ordered Treatment □ Court Ordered Screening/Assessment
Potential Client for TBI □ **YES** ☐ **NO**	□ Based on Screening □ Based on Referral □ Based on Testing Result	□ Court Ordered Treatment □ Court Ordered Screening/Assessment

***Admission Date** **XX/01/XX**	**Codependent/Collateral** □ **YES** X☐ **NO**
***~~Admission/Transaction Type~~** 1- Initial Admission 2- Transfer or Change in Service	***CalWORKs Recipient** □ **YES** X☐ **NO** ☐ **Not Sure/Don't Know**
***Type of Treatment Service** 1- Nonresidential/Outpatient Treatment/Recovery 2- Nonresidential/Outpatient Day Program-intensive 3- Nonresidential/Outpatient Detoxification 5- Residential Detoxification (non-hospital) 6- Residential Treatment/recovery (30 days or less) 7- Residential Treatment/recovery (31 days or more)	***SA Tx Under CalWORKs** □ **YES** X☐ **NO** ☐ **Not Sure/Don't Know**

***Submit to CalOMS** (All DHCS funded programs must submit CalOMS. Check with program manager if unsure.)

X☐**YES** ☐ **NO**

***Admission Staff** (Auto-populates based on staff login; can be changed to reflect actual intake staff)

***Number of Days Waited to Enter Tx** Must select # between 0 and 999 Number of days waited for services due to unavailability of slots starting on the day client was accepted for treatment services, ending first day services began. Do not include days waited due to other circumstances unique to client's life. **0- Days**	***Special Services Contract ID** (Always NA) □ **NA**
***Number of Prior Episodes** **2**	***Special Services/Contract County Code** (Always Not Applicable) □ **Not Applicable**

ADMISSION ADMINISTRATION (*REQUIRED)

Program Fees	**Intake Fees**
Drug Testing Participation □ **YES** ☐ **NO** ☐ **Not Sure/Don't Know**	**Testing Level Indicator**
Baseline UA Completed □ **YES** ☐ **NO** ☐ **Not Sure/Don't Know**	**Drug Screening Fees**
Pictures Taken □ **YES** ☐ **NO** ☐ **Not Sure/Don't Know**	**Encounter Fees**

***Required Field**

County of San Diego
Behavioral Health Services

LIVE WELL SAN DIEGO

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CalOMS Admission

ADMISSION ADMINISTRATION (*REQUIRED)

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

***Special Population Program**
(Not related to Funding Source)

None

- □ Non BHS Contract
- □ AB 109 Participant
- □ CalWORKs Participant
- □ Drug Court Participant
- □ Juvenile Drug Court Participant
- □ ReEntry Court Participant
- □ Prop 47 Participant
- □ PC 1000 Participant
- ☒ None

***How did you hear about us?**

7- Homeless Shelter

1-Access and Crisis Line (ACL)
2-SUD/Prevention Brochures
3-County SUD Web Site
4-Help/Info Line (211)
5- Any Crim Justice i.e. Probation/Court/Parole/Law Enforcement
6- ER/Trauma/Hospital
7-Homeless Shelter
8- Mental Health Program
9- Primary Care Physician/Health Clinic
10- Family Member
11-Outreach Worker (HOW, HOT, etc.)
12-Return Participant
13-Other – Please Explain
14-Not Applicable

If Other, Specify

Administrative Checklist
(Select all that apply)

- □ Personal Rights Given
- □ Emergency Contract release signed
- □ Property Inventory done
- □ Have the rules been read and signed
- □ Medical assessment form
- □ Release of Information Form has been signed
- □ Acknowledgement of receipt of privacy
- □ Chemical Free agreement, has it been read and signed
- □ Orientation Packet been reviewed and signed
- □ Consent to Treatment
- □ Health Questionnaire Given

ALCOHOL & DRUG USE (*REQUIRED)

Primary Drug

***Drug Type**

2- Alcohol

Drug Name
(+Must specify name)

0-None (Will be rejected)
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 (Will be rejected)
99903-Other (specify)+

***Number of Days Used in Past 30 Days**

25

Must select # between 0 and 30
99902-None or Not Applicable

***Route of Administration**

1- Oral

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

***Age of First Use**

19

Must select # between 5 and 105
99904-Unable to answer (only if client is in detox or developmentally disabled)

Secondary Drug

***Drug Type**

0- None

0-None (Will be rejected)
1-Heroin
2- Alcohol
3- Barbiturates+
8- Cocaine/Crack
9- Marijuana/Hashish
10-PCP
11-Other Hallucinogens+
16-Other Opiates or Synthetics+
17-Inhalants+
18-Over-the-Counter+
19-Ecstasy

***Required Field**

County of San Diego
Behavioral Health Services

LIVE WELL SAN DIEGO

Provider Id: _____
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CalOMS Admission

Drug Name (+Must specify name)	4-Other Sedatives or Hypnotics+ 5-Methamphetamine 6-Other Amphetamines+ 7-Other Stimulants+	12-Tranquilizers (e.g.Benzodiazepine)+ 13-Other Tranquilizers+ 14-Non-Prescription Methadone 15-OxyCodone/OxyContin	20-Other Club Drugs+ 99901-Unknown (Will be rejected) 99903-Other (specify)+

***Number of Days Used in Past 30 Days** **99902- N/A or None**	Must select # between 0 and 30 99902-N/A or None		
***Route of Administration** **99902- None or not applicable**	1- Oral 2- Smoking	3-Inhalation 4-Injection (IV / intramuscular)	99902-None or not applicable 99903-Other
***Age of First Use** **NA**	Must select # between 5 and 105 99904-Unable to answer (only if client is in detox or developmentally disabled)		

Tertiary Drug

***Drug Type** **Drug Name** (+Must specify name)	0-None (Will be rejected) 1-Heroin 2- Alcohol 3- Barbiturates+ 4- Other Sedatives or Hypnotics+ 5-Methamphetamine 6-Other Amphetamines+ 7-Other Stimulants+	8- Cocain/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 (Will be rejected) 99903-Other (specify)+

***Number of Days Used in Past 30 Days**	Must select # between 0 and 30 99902-N/A or None		
***Route of Administration**	1- Oral 2- Smoking	3-Inhalation 4-Injection (IV / intramuscular)	99902-None or not applicable 99903-Other
***Age of First Use**	Must select # between 5 and 105 99904-Unable to answer (only if client is in detox or developmentally disabled)		

***Number of Days Alcohol Used in Past 30 Days**	***Number of Days IV Used in Past 30 Days** **0**	***Used Needles in Past 12 Months** ☐ YES ☒ NO ☐ Unable to Answer/99904

TOBACCO / NICOTINE (*REQUIRED)

***Have you ever used Tobacco/Nicotine products?** ☐ YES ☒ NO ☐ Unknown	**Answering NO or UNKNOWN will cause remaining fields to auto-populate; if YES, continue answering the questions.*		
***Smoker Status**	Current every day smoker Current some day smoker		Smoker, current status unknown Former smoker
At what age did you first use tobacco/nicotine product(s)?	1-<=10 2-11-14 3-15-19	4-20-25 5-26-30	6->=31 97-Unknown
In the past 30 days, what tobacco/nicotine product did you use most frequently?	0-No Tobacco Use 1-Cigarettes 2-Cigars or Pipes		3-Smokeless Tobacco 4-Combo/more than 1
Other/Please Describe *(Unable to add or modify information in this field – leave blank)*			

***Required Field**

County of San Diego
Behavioral Health Services

Provider Id: _____
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CalOMS Admission

TOBACCO / NICOTINE (*REQUIRED)

In the past 30 days, how often did you use tobacco/nicotine product(s)?	1- 1-3 times in the past 30 days 2- Once a week 3- 3-6 times a week 4- Daily	5- 3-6 times a day 6- More than 6 times a day 97- Unknown
In the past 30 days, how many cigarettes did you smoke per week?		

FAMILY / SOCIAL (*REQUIRED)

***Number of Days Social Support in Past 30** Must select # between 0 and 30 **3**	***Number of Children Under 18** Must select # between 0 and 30 **0**
***Current Living Arrangements** 1- Homeless 2- Dependent Living 3- Independent Living **1-Homeless**	***Number of Children Age 5 or Less** Must select # between 0 and 30 **0**
***Number of Days Living w/User of Alcohol or Drugs in Past 30** Must select # between 0 and 30 **30**	***Number of Children Living w/Someone Else Because of a Child Protection Order** Must select # between 0 and 30 **0**
***Number of Days Family Conflict in Past 30** Must select # between 0 and 30 **15**	***Number of Children Living w/Someone Else for whom Parental Rights have been Terminated** Must select # between 0 and 30 **0**
***Current Zip Code** 00000-Homeless **00000- Homeless**	

Abuse Characteristics

***Does episode involve physical abuse?** **No**	□ Perpetrator □ Victim	X No □ Unwilling to Answer
***Does episode involve sexual abuse?** **No**	□ Perpetrator □ Victim	X No □ Unwilling to Answer
***Does episode involve domestic abuse?** **No**	□ Perpetrator □ Victim	X No □ Unwilling to Answer

EMPLOYMENT (*REQUIRED)

***Employment Status** **4- Unemployed not in the labor force**	1-Employed Full Time (35 hours or more) 2-Part time (less than 35 hours) 3- Unemployed looking for work 4- Unemployed not in the labor force (not seeking) 5-Not in the labor force (not seeking)
***Number of Paid Work Days in Past 30** **0**	Must select # between 0 and 30 99900-Decline to state 99904-Unable to answer (only if client is in detox or developmentally disabled)

***Enrolled in School**

□ **YES** X **NO** ☐ **Client declined to state/99900** ☐ **Client unable to answer/99904** (Only if client is in detox or developmentally disabled)

***Required Field**

County of San Diego
Behavioral Health Services

Provider Id: _____
Client Name: _____
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Data Entry Date: _____
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CalOMS Admission

EMPLOYMENT (*REQUIRED)

***Enrolled in Job Training**

☐ YES ☒ NO ☐ **Client declined to state/99900** ☐ **Client unable to answer/99904** (Only if client is in detox or developmentally disabled)

***Graduated from High School**

☒ YES ☐ NO ☐ **Client declined to state/99900** ☐ **Client unable to answer/99904** (Only if client is in detox or developmentally disabled)

***Highest School Grade Completed**

12th Grade

00-Kindergarten	11-11th Grade	22-22
01-1st Grade	12-12th	23-23
02-2nd Grade	Grade/GED	24-24
03-3rd Grade	13-13	25-25
04-4th Grade	14-14	26-26
05-5th Grade	15-15	27-27
06-6th Grade	16-16	28-28
07-7th Grade	17-17	29-29
08-8th Grade	18-18	30-30
09-9th Grade	19-19	99900-Client declined to state
10-10th Grade	20-20	99904-Client unable to answer (only if client is in detox or developmentally disabled
	21-21	

LEGAL / CRIMINAL JUSTICE (*REQUIRED)

***Number of Arrests in Last 30 Days** **1**	Must select # between 0 and 30 99904-Unable to answer (only if client is in detox or developmentally disabled)
***Number of Jail Days in Last 30** **3**	Must select # between 0 and 30 99904-Unable to answer (only if client is in detox or developmentally disabled)
***Number of Prison Days in Last 30** **0**	Must select # between 0 and 30 99904-Unable to answer (only if client is in detox or developmentally disabled)
***Number of Arrests in Last 6 Months** **2**	Must select # between 0 and 30 99904-Unable to answer (only if client is in detox or developmentally disabled)
***Criminal Justice Status** **2- Under parole supervision from CDC**	1- No criminal justice involvement 2- Under parole supervision from 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 (only if client is in detox or developmentally disabled)
Type of Sentence	Conditional Sentence Formal Probation Parole
***CDC Number** **A23456**	99900-Declined to state 99904-Unable to answer (only if client is in detox or developmentally disabled) 99901-Not sure 99902-None
CDC number is a valid six-character string of capital alpha (A-Z) and numeric (0-9) CDCR characters	

***Parolee Services Network (PSN)**

☐ YES ☒ NO ☐ **Client unable to answer/99904** (only if client is in detox or developmentally disabled)

***FOTP** (Always select NO – not offered in San Diego County) ☒ **NO**	***FOTP Priority Status** (Always select 99902) X **99902**

***Required Field**

County of San Diego
Behavioral Health Services

LIVE WELL SAN DIEGO

Provider Id: _____
Client Name: _____
Client #: _____
Data Entry Date: _____
Data Entry Int: _____
CalOMS Serial #:W_____

CalOMS Admission

MEDICAL / PHYSICAL HEALTH (*REQUIRED)

***Number of Times Emergency Room in Past 30** Must select # between 0 and 99 **0**	***Medi-Cal Beneficiary** **1- YES** **0- NO** ☐ **99904- Client unable to answer**	
***Number of Hospital Overnights in Past 30 Days** Must select # between 0 and 30 **0**	***Medication Prescribed as Part of Tx** 1-None 2- Methadone 3-LAAM **1- None**	4- Buprenophrine (Subutex) 5- Buprenorphine (Suboxone) 99903-Other

Medications – Report Only medications prescribed by the provider for SUD treatment; this field is checked against the state's Master Provider File to ensure the services being reported are consistent with what the provider is certified or licensed to provide.

***Number of Days Medical Problems in Past 30** Must select # between 0 and 30 **0**	***Communicable Diseases: Tuberculosis** ☐ **YES** ☒ **NO** ☐ **Client declined to state/99900** ☐ **Client unable to answer/99904**
***HIV Tested** ☐ **YES** ☒ **NO** ☐ **Client declined to state/99900** ☐ **Client unable to answer/99904**	***Communicable Diseases: Hepatitis C** ☐ **YES** ☒ **NO** ☐ **Client declined to state/99900** ☐ **Client unable to answer/99904**
***HIV Test Results Received** ☐ **YES** ☒ **NO** ☐ **Client declined to state/99900** ☐ **Client unable to answer/99904**	***Communicable Diseases: STD** ☐ **YES** ☒ **NO** ☐ **Client declined to state/99900** ☐ **Client unable to answer/99904**
***Pregnant at Admission** ☐ **YES** ☒ **NO**	(Auto-populates based on gender and previous pregnancy questions.)

MENTAL HEALTH (*REQUIRED)

***Mental Illness Diagnosed**

1-YES **2- NO** **3- 99901-Not Sure/Don't Know**

***Number of Times Outpatient Emergency MH Services in Past 30 Days** **0**	Must select # between 0 and 99 99904-Unable to answer (only if client is in detox or developmentally disabled)
***Number of 24hr Psychiatric Facility Stays in Past 30 Days** **0**	Must select # between 0 and 30 99904-Unable to answer (only if client is in detox or developmentally disabled)

***Mental Health Medication in Past 30 Days**

☐ **YES** ☒ **NO** ☐ **Client unable to answer/99904** (only if client is in detox or developmentally disabled)

***Suicide Attempts**

☐ **YES** ☒ **NO**

***Was the attempt in the last 30 days?** (*Required field if suicide answer is YES)

☐ **YES** ☒ **NO**

***Required Field**

County of San Diego
Behavioral Health Services

LIVE WELL SAN DIEGO

Provider Id: _____
Client Name: _____
Client #: _____
Data Entry Date: _____
Data Entry Int: _____
CalOMS Serial #:W_____

CalOMS Admission

Client Diagnosis			
Type	Behavioral		
Diagnosis	F10.129 (305.00) Alcohol intoxication, With mild use disorder(DSM5)	Principal Diagnosis	Yes
Secondary			
Teirtiary			

Treatment Team			
Staff Name	Staff, Rendering	Start Date	XX/01/XX
Role/Relation	Counselor		
Review Member	Yes		
Primary Care Staff	Yes		
Deny Access to Client Records	No		
Staff Name	Case Manager, Fake	Start Date	XX/01/XX
Role/Relation	Case Manager		
Review Member	Yes		
Primary Care Staff	No		
Deny Access to Client Records	No		
Staff Name	QAR, Fake	Start Date	XX/01/XX
Role/Relation	Quality Assurance		
Review Member	Yes		
Primary Care Staff	No		
Deny Access to Client Records	No		

***Required Field**