SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Admission Form
MH Contracted Agencies

MR#:
Name:

NOTE: If you need to make a change to any of the information on this form that has already been submitted to MIS, simply cross out the information, write the correction above or next to it and re-submit to MIS at fax number 650-573-2110.

Admission and Registration Information

Registration Information				
Medical Record #		Social Security #		
Last Name		First Name		MI
A.K.A. (Last Name)		A.K.A. (First Name)		
A.K.A. (Last Name)		A.K.A. (First Name)		
Client's Preferred Name				
Name on Birth Certificate				
Mother's Maiden Name		Mother's First Name		
Birth Date		Birth State		
Birth County		Birth Country		
Veteran status				

Client's Contact information			
Phone Number (Primary)		☐ Cell ☐ Home ☐ Work	
Phone Number (Second)		☐ Cell ☐ Home ☐ Work	
Phone Number (Third)		☐ Cell ☐ Home ☐ Work	
Address		Apt/Ste	
City		Zip	

Referral Agency Information	
Referral Agency Name	

Care Coordinator	
Suggested Change of Care Coordinator?	☐ Yes ☐ No
If Yes, Change Care Coordinator to *(Agency Name)*	

CONFIDENTIAL PATIENT INFORMATION:
See California Welfare and Institutions Code Section 5328

Admitting Agency Information	
Agency/Provider/Team	
Type of Program	☐ Residential (05) ☐ Day Treatment (10) ☐ Outpatient (15)
Admit Date	
Assigned Psychiatrist Name	
Assigned Therapist Name	
Date Consent to Treatment Signed	

Client Demographic and CSI Information

SOGIE			
What is your sexual orientation?	☐ Straight or heterosexual ☐ Lesbian or Gay ☐ Another	☐ Bisexual ☐ Queer ☐ Asexual	☐ Don't know / Declined to Answer ☐ Did not ask
	If Another Sexual Orientation:		
What is your current gender identity?	☐ Male ☐ Female ☐ Another	☐ Male to Female / Transgender Female ☐ Female to Male / Transgender Male	☐ Genderqueer not exclusive male / female ☐ Declined to Answer ☐ Did n ot ask
	If Another Gender Identity:		
What are your pronouns?	☐ He / Him ☐ Another	☐ She / Him ☐ They / Them	☐ Declined to Answer ☐ Did not ask
	If Another Pronoun:		
What sex were you assigned at birth on your original birth certificate?	☐ Male ☐ Female ☐ Another	☐ Declined to Answer ☐ Did not ask	
	If Another Sex Assigned at Birth:		
Have you been diagnosed by a Doctor with an intersex condition?	☐ Yes ☐ No	☐ Declined to Answer ☐ Did not ask	

Ethnicity		
☐ Hispanic or Latino	☐ Not Of Hispanic Origin	☐ Unknown/ Not Reported

Race			
Check up to 5 race codes from below			
☐ American Native	☐ Filipino	☐ Laotian	☐ Other Pacific Islander
☐ Asian Indian	☐ Guamanian	☐ Mien	☐ Samoan
☐ Black or African American	☐ Hmong	☐ Native Hawaiian	☐ Vietnamese
☐ Cambodian	☐ Japanese	☐ Other	☐ Unknown/ Not Reported
☐ Chinese	☐ Korean	☐ Other Asian	☐ White / Caucasian

Language							
Client's Primary Language	Client's Preferred Language	Language of Client's Family		Client's Primary Language	Client's Preferred Language	Language of Client's Family	
☐	☐	☐	American Sign Language (ASL)	☐	☐	☐	Mandarin
☐	☐	☐	Arabic	☐	☐	☐	Mien
☐	☐	☐	Armenian	☐	☐	☐	Other Chinese Dialects
☐	☐	☐	Cambodian	☐	☐	☐	Other Non-English
☐	☐	☐	Cantonese	☐	☐	☐	Other Sign Language
☐	☐	☐	English	☐	☐	☐	Polish
☐	☐	☐	Farsi	☐	☐	☐	Portuguese
☐	☐	☐	French	☐	☐	☐	Russian
☐	☐	☐	Hebrew	☐	☐	☐	Samoan
☐	☐	☐	Hmong	☐	☐	☐	Spanish
☐	☐	☐	Llocano	☐	☐	☐	Tagalog
☐	☐	☐	Italian	☐	☐	☐	Thai
☐	☐	☐	Japanese	☐	☐	☐	Turkish
☐	☐	☐	Korean	☐	☐	☐	Unknown/ Not Reported
☐	☐	☐	Lao	☐	☐	☐	Vietnamese

Education

Education (Highest Grade level Completed) (CSI)

- ☐ None, Kindergarten
- ☐ Other – Includes vocational education and training.
- ☐ Unknown / Not Reported
- ☐ Grade levels – Indicate highest grade completed.
  Grades 1-20: _____
  (If the highest grade completed is greater than 20, code 20 as the highest grade completed.)

Living Arrangement at Admission

Number of Children **Under the Age of 18** the Client Cares for or Is Responsible For At Least 50% of the Time (CSI)	
Number of Dependent Adults **Age 18 or Older** the Client Cares for or Is Responsible For At least 50% of the Time (CSI)	

Living Arrangement (CSI)

- ☐ House or apartment (includes trailers, hotels, dorms, barracks, etc.)
- ☐ House or apartment and requiring some support with daily living activities (applies to adults only)
- ☐ House or apartment and requiring daily support and supervision (applies to adults only)
- ☐ Supported housing (applies to adults only)
- ☐ Board and Care
- ☐ Adult Residential Facility, Social Rehabilitation Facility, Crisis Residential, Transitional Residential, Drug Facility, Alcohol Facility
- ☐ Justice Related (Juvenile Hall, CYA home, correctional facility, jail, etc.)
- ☐ Community Treatment Facility
- ☐ Mental Health Rehabilitation Center (24 hour)
- ☐ Skilled Nursing Facility / Intermediate Care Facility / Institute of Mental Disease (IMD)
- ☐ Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), or Veterans Affairs (VA) Hospital
- ☐ State Hospital
- ☐ Residential Treatment Center (includes Levels 13-14 for children)
- ☐ Group Home (includes Levels 1-12 for children)
- ☐ Foster family home
- ☐ Homeless, no identifiable residence
- ☐ Other
- ☐ Unknown / Not Reported

Homeless Category (CSI)

Required if indicated Homeless above

- ☐ Shelter
- ☐ Transitional
- ☐ Doubling Up
- ☐ Street (Including vehicle, RV, tent)
- ☐ Permanent Supportive Housing
- ☐ Unknown

Marital Status

- ☐ Divorced / Annulled
- ☐ Domestic Partnership
- ☐ Married
- ☐ Remarried
- ☐ Separated
- ☐ Single / Never Married
- ☐ Unknown
- ☐ Widowed

Conservatorship / Court Status at Admission

Conservatorship / Court Status (CSI)

- ☐ Temporary Conservatorship (W&I Code, Section 5353)
- ☐ GGRC Referral (W&I Code, Section 6500)
- ☐ Lanterman-Petris-Short (W&I Code, Section 5358)
- ☐ Murphy (W&I Code, Section 5008)
- ☐ Probate (Probate Code, Division 4, Section 1400)
- ☐ PC 2974 (Penal Code, Section 2974)
- ☐ Representative Payee Without Conservatorship (W&I Code, Sect 5686)
- ☐ Juvenile Court, Dependent of the Court (W&I Code, Sect 300)
- ☐ Juvenile Court, Ward – Status Offender (W&I Code, Sect 601)
- ☐ Juvenile Court, Ward – Juvenile Offender (W&I Code, Section 602)
- ☐ Not Applicable
- ☐ Unknown / Not Reported

Employment Status at Admission

Employed in Competitive Job Market

- ☐ Employed in competitive job market (Full Time, 35 hours or more per week)
- ☐ Employed in competitive job market (Part Time, less than 35 hours per week)

Employed in Non-competitive job market (shelter workshop, protected environment)

- ☐ Employed in noncompetitive job market (Full Time, 35 hours or more per week)
- ☐ Employed in noncompetitive job market (Part Time, less than 35 hours per week)

Not in paid work force

- ☐ Actively looking for work
- ☐ Homemaker
- ☐ Student
- ☐ Volunteer Worker
- ☐ Retired
- ☐ Resident / Inmate of Institution
- ☐ Other
- ☐ Unknown / Not Reported

Farmworker Information

- ☐ Farmworker
- ☐ Seasonal Farmworker
- ☐ Migratory Farmworker
- ☐ Aged and Disabled Migratory Farmworker

Additional CSI Information at Admission

Has client experienced traumatic events?	☐ Yes	☐ No	☐ Unknown
Does client have a substance abuse/dependence diagnosis?	☐ Yes	☐ No	☐ Unknown / Not Reported

Client Diagnosis at Admission

Problem List at Admission

DSM V Diagnosis / Problem List Item	ICD 10 Code	Date Added	Date Removed	Added or Removed By (Full Name of Staff)	Provider Title / Discipline	Primary Dx	SUD Dx
			This column will be implemented in early 2025.			☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

General Medical Conditions Check identifying physical health condition(s) as reported by client.

17 = Allergies ☐	11 = Cirrhosis ☐	04 = Hyperlipidemia ☐	31 = Physical Disability ☐
16 = Anemia ☐	07 = Cystic Fibrosis ☐	05 = Hypertension ☐	08 = Psoriasis ☐
01 = Arterial Sclerotic Disease ☐	25 = Deaf/Hearing Impaired ☐	14 = Hyperthyroid ☐	36 = Sexually Transmitted ☐
19 = Arthritis ☐	12 = Diabetes ☐	13 = Infertility ☐	32 = Stroke ☐
35 = Asthma ☐	09 = Digest Reflux, Irritable Bowel ☐	27 = Migraines ☐	33 = Tinnitus ☐
06 = Birth defects ☐	34 = Ear Infections ☐	28 = Multiple Sclerosis ☐	10 = Ulcers ☐
23 = Blind/Visually Impaired ☐	26 = Epilepsy/Seizures ☐	29 = Muscular Dystrophy ☐	00 = No Gen. Medical Condition ☐
22 = Cancer ☐	02 = Heart Disease ☐	15 = Obesity ☐	37 = Other ☐
20 = Carpal Tunnel Syndrome ☐	18 = Hepatitis ☐	21 = Osteoporosis ☐	99 = Unk/Not Report'd. GMC ☐
24 = Chronic Pain ☐	03 = Hypercholesterolemia ☐	30 = Parkinson's Disease ☐	31 = Physical Disability ☐

Admission Form Finalization

Date Assessment Completed	

Assessor's Name/Discipline – Printed Conducted the Mental Status Exam and provided Diagnosis.	**Assessor's Signature and Discipline** Date
Authorized Clinical Staff* – Printed	**Authorized Clinical Staff*** Signature and Date Date

Assessor **must** be a *Licensed/Registered/Waivered MD/OD/NP, MFT, LCSW, LPCC, PhD/PsyD, RN with Psych MS or Trainee with co-signature.*

(At minimum the assessor is responsible for reviewing the completed assessment, conducting the mental status exam, providing a clinical formulation and providing the diagnosis. Assessor signs here to co-sign for assessments provided by trainees.)

*Authorized Clinical Staff is the supervisor who co-signs the notes for those assessors who require co-signature.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Authorization and Assignment of Benefits

BHRS - Provider Billing - 2000 Alameda de Las Pulgas, Suite, 280, San Mateo, CA 94403

Confidential Patient Information: See California Welfare and Institutions Code Section 5328.

Client Name: Client No.:

Release of Information and Assignment of Insurance Benefits

I hereby authorize the County of San Mateo to release information to my insurance companies that is required for the purpose of filing a medical claim to receive reimbursement for services rendered by County Behavioral Health and Recovery Services. Information to be released is limited to that requested and not to exceed a general description of the services rendered including dates and duration of visits, diagnosis and clinician's name.

This consent is subject to revocation by the undersigned at any time except to the extent that action has been initiated in reliance hereon.

I further hereby authorize the insurance companies to pay directly to San Mateo County Behavioral Health and Recovery Services, or its authorized community mental health agent, any benefits otherwise payable to me for all services rendered but not to exceed the actual cost and/or the reasonable customary charges for such services.

In the event that I receive a check from my insurance company, I agree to endorse the check and forward it to San Mateo County BHRS at the address listed above.

Signature of Patient / Insured / Guardian _____ Date _____

Medicare Assignment

By signing this form you will permit us to bill Medicare on your behalf. No billing on your part will be necessary. I request that payment of authorized Medicare benefits be made either to me, or on my behalf to Behavioral Health and Recovery Services of San Mateo County for any services furnished to me by that physician/supplier. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made, and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim is completed, my signature authorizes releasing of the information to the insurer. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-pay, and non-covered services. Co-pay and deductible are based upon the charge determination of the Medicare carrier.

You will be expected to pay the lower amount of either what Medicare requires or the sliding fee established for you by County Mental Health Services.

Signature of Patient / Guardian _____ Date _____

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BEHAVIORAL HEALTH & RECOVERY SERVICES

Autorización y asignación de beneficios

BHRS - Provider Billing - 2000 Alameda de Las Pulgas, Suite, 280, San Mateo, CA 94403

Información Confidencial del Paciente: Ver California Welfare and Institutions Code Section 5328.

Nombre de Cliente: Número de Cliente:

Comunicado de información y asignación de beneficios del seguro

Autorizo al condado de San Mateo a enviar la información necesaria a las compañías de seguros, con el fin de presentar una factura médica para recibir el reembolso por servicios prestados por Behavioral Health and Recovery Services del Condado. La información a ser enviada está limitada a lo solicitado y no debe exceder una descripción general de los servicios prestados incluyendo fechas, la duración de las visitas, el diagnóstico y el nombre del médico. Esta autorización está sujeta a la revocación por el/la abajo firmante en cualquier momento, excepto cuando la acción se haya iniciado. Además autorizo a las compañías de seguros a pagar directamente al Departamento de Behavioral Health and Recovery Services del Condado de San Mateo, o al agente autorizado de salud mental de la Comunidad, cualquier beneficio que de otra manera sea pagadero a mí por todos los servicios prestados, pero sin exceder el costo real y/o los cargos razonables habituales por tales servicios.

En el caso de que reciba un cheque de mi compañía de seguros, estoy de acuerdo en aprobar el cheque y remitirlo al Condado de San Mateo BHRS a la dirección arriba mencionada.

Firma del / la Paciente / asegurado / guardian _____ Fecha _____

Asignación de Medicare

Al firmar este formulario usted nos permitirá facturar a Medicare en su nombre. No facturación de su parte será necesaria. Solicito que el pago de beneficios autorizados por Medicare sean hechos a mi, o en mi nombre a al Departamento de Behavioral Health and Recovery Services del Condado de San Mateo, por cualquiera de los servicios médicos prestados por dicho Doctor/proveedor. Autorizo a cualquier administrador de información médica para enviar a la Administración financiera de Cuidados de Salud y sus agentes toda la información necesaria para determinar estos beneficios o los beneficios pagaderos por los servicios relacionados. Entiendo que mi firma solicita que se haga el pago, y autoriza el envío de información médica necesaria para pagar la factura. Si la sección número 9 del formulario HCFA-1500 está completa, mi firma autoriza el envío de la información a la compañía de seguros. En los casos asignados a Medicare, el médico o el proveedor se compromete a aceptar la determinación de pago de la compañía portadora de Medicare como pago completo, y el paciente es responsable sólo por el deducible, el co-pago y los servicios no cubiertos. Co-pago y deducible se basan en la determinación de pagos de Medicare. Se espera que usted pague la cantidad más baja de lo que Medicare requiere, o de los honorarios establecidos para usted por el Departamento de Behavioral Health and Recovery Services del Condado de San Mateo.

Firma del / la Paciente / Guardián _____ Fecha _____