CalOMS Profile Form
Instructions

REQUIRED FORM:

The Profile form is a required document in the client's file.

WHEN:

This form will be created **IF** the client profile does not already exist in SanWITS. A thorough search is required. An existing profile should be reviewed and updated if needed for each new episode.

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

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

NOTE:

To effectively manage client information, each client should have only one profile. To reduce the number of duplicate client records, SanWITS does not allow a social security number to be used more than once or a participant ID to be used for more than one client. The State Client ID aka Unique Client number aka participant ID is based on the first and last initial of the birth name, the middle initial (the system will enter a zero if there is no middle name), a code for sex (1-male, 2-female and 9-Other) as well as the date of birth (DOB). Carefully search for a client before adding them to the database. Check your SanWITS User's Manual for different search criteria.

Fields in the client profile are linked to other areas in SanWITS. The Admission, Annual Update and Discharge record will not be uploaded to the state if the Profile form is not completed in SanWITS.

Payor Group Enrollment is part of the profile. This section is required only for Drug Medi-Cal (DMC) billing.

Collateral Contacts are part of the Profile but are not required unless your program requires this information. Because various contacts can be entered, Collateral Contacts has its own form S109B.

County of San Diego
Behavioral Health Services

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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	**Provider Client ID** (Internal Client # if applicable)		
***Current Last Name**	***SSN**	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**	***Driver's License #** (State ID# is acceptable)	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**	**Medicaid #**		
***Mother's First Name**	**Date of Death** (Client)		
***Sex** 1- Male 2- Female 99903-Other	***Place of Birth** ☐ Other (Born outside CA)	***State**	
Gender Identity (Please specify)	☐ Identifies as Male ☐ Identifies as Female ☐ Transgender Male/Trans Man/Female to Male (FTM) ☐ Transgender Female/Trans Woman/Male to Female (MTF) ☐ Genderqueer, neither exclusively male or female ☐ Additional gender category or other, please specify* ☐ Chose not to disclose		
***DOB**	***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
Last Name	First Name	Middle Name	Client Alias Type
Last Name	First Name	Middle Name	Client Alias Type

***Required Field**

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ADDITIONAL INFORMATION (*REQUIRED)

***Ethnicity** (Select One)	1- Not Hispanic 2- Mexican/Mexican American 3-Cuban	4- Puerto Rican 5- Other Hispanic/Latino	
***Primary Race/Ethnicity** (Select One)	☐ White ☐ Black/African American ☐ Mexican/Latino/Hispanic	☐ Asian/Pacific Islander ☐ Native American ☐ Other	
***Races** (Select at least one; not to exceed 5)	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)	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	☐ Evangelical Covenant	☐ Mitraism	☐ Scientology
	☐ Babi & Baha'I Faith	☐ Fourth Way	☐ Native American	☐ Shamanism
	☐ Baptist	☐ Free Daism	☐ Nazarene	☐ Shiite (Islam)
	☐ Bon	☐ Friends	☐ New Age	☐ Shinto
	☐ Brethren	☐ Full Gospel	☐ Non-Roman Catholic	☐ Sikism
	☐ Buddism	☐ Gnosis	☐ None	☐ Spiritualism
	☐ Cao Dai	☐ Hinduism	☐ Occult	☐ Sunni (Islam)
	☐ Celticism	☐ Humanism	☐ Orthodox	☐ Taoism
	☐ Christian (non-Catholic, non-specific)	☐ Independent	☐ Other	☐ Theravada
	☐ Christian Scientist	☐ Islam	☐ Paganism	☐ Unitarian Universalist
	☐ Church of Christ	☐ Jainism	☐ Pentecostal	☐ Unitarian Universalism
	☐ Church of God	☐ Jehovah's Witness	☐ Presbyterian	☐ United Church of Christ
	☐ Confucianism	☐ Judaisim	☐ Process, The	☐ Universal Life Church
	☐ Congregational	☐ Latter Day Saints	☐ Protestant	☐ Vajrayana (Tibetan)
	☐ Cyberculture Religion	☐ Lutheran	☐ Protestant,No Denomination	☐ Veda
	☐ Disciples of Christ	☐ Mahayana	☐ Reformed	☐ Voodoo
	☐ Divination	☐ Meditation	☐ Reformed/ Presbyterian	☐ Wicca
	☐ Eastern Orthodox	☐ Messianic Judaism	☐ Roman Catholic Church	☐ Yaohushua
	☐ Episcopalian	☐ Methodist	☐ Salvation Army	☐ Zoroastrianism
			☐ Satanism	

***Required Field**

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

Preferred Language Proficiency	**Interpreter Needed** ☐ YES ☐ NO

*Are you a veteran?	☐ Yes ☐ No	☐ Client declined to state ☐ Client unable to answer (Only if client is in detox or developmentally disabled)

CONTACT INFORMATION (PHONE NUMBERS) (*REQUIRED)

Home Phone#	Work Phone#	Preferred Method of contact ☐ Phone ☐ Email ☐ Letter
Mobile #	Other Phone #	Fax #
Email Address		

CONTACT INFORMATION (ADDRESSES) (*REQUIRED)

Address Type (Select One)	☐ Client Billing ☐ Client Home ☐ Client Mailing	☐ Client Previous ☐ Client Work ☐ Client Unknown
Address Line 1		
Address Line 2		
County		

City	State	Zip

*Required Field

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PAYOR GROUP ENROLLMENT - for BILLING ONLY			(*REQUIRED)
***Payor-Type** ☐ Medicaid ☐ Self-pay	☐ Group Insurance ☐ Medicare ☐ Other	***Plan-Group** ☐ ODS DMC – Non-Peri-Medi-Cal-Non-Perinatal ☐ ODS DMC – Peri-Medi-Cal-Perinatal	☐ County Billable-County Billable ☐ County Billable-Out of County ☐ Other Health Coverage (OHC) - General
Payor Priority Order ☐ **1** ☐ **2**		**Policy#**	

***Coverage Start** (mm /dd /yyyyy)	**End** (mm / dd / yyyyy)	**Payment Scale**
***Aid Code** (DMC Required)	***Relationship to Subscriber/Responsible Party** ☐ 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#**
***Address 1**		
Address 2		
***City**	***State**	***Zip**

***Required Field**

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LIVE WELL SAN DIEGO

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COLLATERAL CONTACTS – IF APPLICABLE (*Required)

*First Name	*Last Name

*Relation			
☐ Attorney ☐ Attorney (Child's) ☐ Brother(s) ☐ Community Service ☐ Court ☐ Daughter(s)	☐ Father ☐ Guardian ☐ Judge ☐ Law Enforcement ☐ Mother ☐ Office of Children's Services ☐ Other	☐ Other Relatives ☐ Parole ☐ Pharmacy ☐ Physician ☐ Probation ☐ Regional Case Manager ☐ Sister(s)	☐ Social Worker(s) ☐ Son(s) ☐ Sponsor ☐ Spouse ☐ Treatment Case Manager ☐ Unrelated

Custodian	Gender	Date of Birth (mm / dd / yyyy)	SSN (9 digits)
☐ Yes ☐ No	☐ 1-Male ☐ 2-Female ☐ 99903-Other		

Home Phone	Work Phone	Mobile	Fax	Other

Legal Guardian	Active Date	Inactive Date

Address 1

Address 2

City	State	Zip

Email

*Can Contact	Consent on File
☐ Yes ☐ No	☐ Yes ☐ No

Notes

*Required Field