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		**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)
***Birth Last Name**		***Driver's License State**		
***Mother's First Name**		**Medicaid #**		
***Gender**	1-Male 2-Female 99903-Other	**Date of Death** (Client)		
***Place of Birth** (CA County or 99903-Other)		***State**		
***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**
Last Name	**First Name**	**Middle Name**
Last Name	**First Name**	**Middle Name**

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 Asian/Pacific Islander	Native American Other

***Required Field**

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ADDITIONAL INFORMATION (*Required)

***Races** (Select at least one; not to exceed 5)	1-White 2-Black/African American 3-American Indian 4-Alaskan Native 5-Asian Indian 6-Cambodian	7-Chinese 8-Filipino 9-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 Babi & Baha'I Faith Baptist Bon Brethren Buddism Cao Dai Celticism Christian (non-Catholic) 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	Mitraisim 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 Salvation Army	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 All That Apply)	English Amharic Arabic American Sign Lang Braille Cantonese Chinese Cambodian Czech Dutch Fang Yan Finnish French Farsi Gujarati Greek German	Hmong Hindi Hungarian Ilocano Indian (General) Italian Japanese Korean Laotian Lakota Sioux Large Print English Malay Mandarin Mien Marathi Not Collected	Norwegian Other Language Polish Puyallup Romanian Russian Samoan Salish Spanish Tagalog Tigrigna Thai Ukranian Unknown Language Vietnamese Yakama

***Required Field**

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ADDITIONAL INFORMATION (*Required)

Interpreter Needed

☐ YES ☐ NO

***Are you a veteran?**

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

CONTACT INFO (*Required)

Home Phone #	**Preferred Method of Contact**	1-Phone 2-Email 3-Letter
Work Phone #		
Mobile #		
Other Phone #		
Fax #		
Email Address		
Address Type (Select One) 1-Client Billing 2-Client Home 3-Client Mailing 4-Client Previous 5-Client Unknown 6-Client Work		**Confidential** ☐ YES ☐ NO
Address Line 1		
Address Line 2		
City	**State**	**Zip**

PAYOR GROUP ENROLLMENT - for BILLING ONLY (*Required)

***Payor-Type**		Medicaid Self-pay Group Insurance	Medicare Other
Payor Priority Order ☐ 1 ☐2	***Coverage Start Date** (mm /dd /yyyyy)	**Coverage End Date** (mm / dd / yyyyy)	***Aid Code** (DMC Required)
***Plan-Group**	Medi-Cal-ADP-Perinatal / Medi-Cal-Perinatal Medi-Cal-ADP-NonPerinatal / Medi-Cal-Non Perinatal	**Policy#**	
Payment Scale			

***Required Field**

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PAYOR GROUP ENROLLMENT - for BILLING ONLY		(*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**