COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
LANTERMAN-PETRIS-SHORT (LPS) ACT
RENEWAL AUTHORIZATION APPLICATION

(Please Print or Type)

TO BE COMPLETED BY CANDIDATE'S SUPERVISOR (Failure to complete all items may result in the application not being processed.)

DMH Employee ☐	NON - DMH Employee ☐
☐ Renewal Application	☐ Work Location Change From:
County Employee Number (non-county employees supply the last four digits of the SSN)	
Candidate's Name	Job Title
☐ Resident ☐ Professional Staff with Admitting Privileges ☐ Professional Staff without Admitting Privileges ☐ County/DMH or Contracted Facility Staff	
Name of Agency, Program, or Hospital	
Work Address / City / Zip Code	
Work Telephone / Fax / E-mail	
Number of years' experience as a licensed MH professional	List all other current facilities at which LPS Authorized (if applicable)
Start Date with LACDMH or Contracted Agency:	Required: Completed initial 6-month probationary period with LACDMH or Contracted Agency Yes ☐ No

Current job description of candidate which requires that he/she be authorized (please check one):

On-Site
- ☐ County Clinic/County Contracted Clinic Employee
- ☐ LPS Designated Facility (inpatient) Employee
- ☐ LPS Designated Facility (inpatient) MD

Mobile
- ☐ Hospital Employee
- ☐ County Clinic/County Contracted Clinic Employee

Field Based Services
- ☐ FSP Specify:
- ☐ FCCS Specify:
- ☐ Other, Specify:

Credential	☐ LPT ☐ LMFT ☐ LCSW ☐ RN ☐ NP ☐ LVN (clinics only) ☐ PhD/PsyD ☐ MD/DO ☐ Unlicensed Resident ☐ Other, Specify:
License No.	License Expiration Date

I attest that all statements made in the application are true and correct.

Applicant Signature_____ Date_____	Professional clinically in charge of Designated Facility or Agency *(If applicant is clinically in charge then immediate supervisor must sign.)* Print Name _____ Signature _____ Date_____

Office Use Only: This section to be completed after training and examination.

Test Score:	Pass:	Fail:	Test Date:	Designation Expiration:
DMH Regional Medical Director (Signature):				Date:

For Submission of:
LPS RENEWAL APPLICATION, NOTICE OF CHANGES &
QUESTIONS REGARDING LPS AUTHORIZATION STATUS
email: LPSCoordinator@dmh.lacounty.gov

For: INITIAL LPS TRAINING APPLICATION
QUESTIONS REGARDING TRAINING OR INITIAL APPLICATION (ONLY) *email*: MGlomah@dmh.lacounty.gov
County of Los Angeles - Department of Mental Health
695 S. Vermont Avenue, 15th Floor, Los Angeles, CA 90005 (213) 251-6854

Submit this form as a LPS renewal authorization or a change of work location. Form must be completed for each facility at which individual desires authorization. The Medical Director's Office provides final LPS authorization, once training has been completed and passing test score registered.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
ATTESTATION FOR LPS AUTHORIZED APPLICANTS

Certificate of Applicant:
I attest that all statements made in this application are true and correct. I acknowledge that any false or incomplete statement given here or an omission of material fact will result in my disqualification. I further acknowledge that I have reviewed the LACDMH "LPS Designation Guidelines and Process for Facilities within Los Angeles County," Seventh Edition (revised August 2015), and that I have read and understood this document, and will uphold all applicable legal, ethical, regulatory and reporting principles contained therein and in the standards of my professional license(s). Further, I will uphold basic ethical standards essential to the fulfillment of my responsibilities carried out in the application of my authority for involuntary detention, including but not limited to the following:

- Avoidance of circumstances where work based action may affect or appear to affect private financial interest or personal gain, financial or non-financial.
- Avoidance of any participation in a personal arrangement or business transaction which would generate potential or perceived conflict of interest or compromise my ability to provide treatment fairly and objectively.
- Avoidance of any circumstances that would hinder my ability to provide or refer to service that is of highest quality and effectiveness.
- Recognition and avoidance of any personal situation, habits or behaviors that might impair ability to provide competent care.
- Respect and protection of client confidential information, in accordance with applicable legal and regulatory standards.
- Performance of all duties in a manner that demonstrates an understanding of each client's personal dignity.
- Demonstration of highest standards of personal integrity in all work related activities carried out in the application of my authority for involuntary detention.

I acknowledge that, if I am given authority for involuntary detention, my failure to comply with the above principles and all laws, policies, by-laws or regulations related to involuntary detention, or with those portions of the LACDMH "LPS Designation Guidelines and Process for Facilities within Los Angeles County," Seventh Edition (revised August 2015) related to individuals (including any revisions thereafter adopted), will result in withdrawal of my involuntary detention authority. I acknowledge that involuntary detention authority may also be withdrawn without cause at any time by the LACDMH Director.

Signature of Applicant | **Print Name** | **Date**

Credential, License No. | **Expiration Date**

Designated Facility or Directly Operated Program or Contract Site Approved to Initiate LPS Involuntary Holds

Address | **City** | **State** | **Zip Code**

Work Telephone | **Email Address**

Professional Clinically in Charge of Designated Facility or Approved Site (Print Name) | **Signature**