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:_____ Email:_____

Number of years' experience as a licensed MH professional:_____ List all other current facilities at which LPS Authorized (if applicable):_____

Start Date with DMH or Contracted Agency: _____ Required: Completed initial 6-month probationary period with DMH 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 ☐ PhD/PsyD ☐ MD/DO ☐ Unlicensed Resident ☐ LVN (clinics only) ☐ 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 (ONLY)
or QUESTIONS REGARDING TRAINING,
email: LPSTraining@dmh.lacounty.gov
County of Los Angeles – Department of Mental Health, Workforce Education and Training Division
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 DMH LPS Designation Guidelines and Process for Facilities within Los Angeles County, Seventh Edition (revised February 2016), 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 DMH LPS Designation Guidelines and Process for Facilities within Los Angeles County, Seventh Edition (revised February 2016) 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 DMH 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**