



APPLICATIONS ACCESS FORM

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
PROVIDER SUPPORT OFFICE

REQUEST TYPE

Effective Date ____/____/____	<input type="checkbox"/> Add New User	<input type="checkbox"/> Update Existing User	<input type="checkbox"/> Add Reporting Unit <input type="checkbox"/> Delete Reporting Unit <input type="checkbox"/> Name Change	<input type="checkbox"/> Add Role <input type="checkbox"/> Delete Role Unit <input type="checkbox"/> Termination	<input type="checkbox"/> Add User Access <input type="checkbox"/> Delete User Access
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EMPLOYEE STATUS

DMH Permanent DMH Temporary FFS IP FFS OP MHSA NGA DHS

APPLICATION INFORMATION

User/Logon ID		Last Name		First Name		MI	Last 4 Digits of SSN	
Date of Birth MM/DD	Sex Code	Ethnicity Code	Handicap Code	Language Code	Name of Facility/Bureau/FFS Network Provider/Pharmacy			
Program Name/Unit			Address			Suite/Floor		
City		State	Zip Code	Phone Number		E-Mail Address		

ROLE(S)

Provider using Web Services? Yes No

SELECT CLASS CODE & AUTHORIZED PROVIDER NO.

DMH Provider No(s) <input type="text"/> <input type="text"/> <input type="text"/>	NGA Legal Entity No. <input type="text"/>
DHS Provider No(s) <input type="text"/> <input type="text"/> <input type="text"/>	FFS Provider No. <input type="text"/>

SELECT APPLICATION ACCESS

Integrated System STAR Provider Connect* PRM* Other (please specify _____)

The following forms must be signed and sent with this document:

COLA Agreement for Acceptable Use Oath of Confidentiality E-Signature Agreement

SIGNATURES

Applicant Name	Signature	Date Completed
Contact (Print Name)	Phone Number	Date Completed
Program Head/Authorized Designee (Print Name)	Signature	Date Completed

FOR PSO USE ONLY

User ID	HEAT Call Ticket	Date Received
Processed By	Remarks	Date Completed

*Provider Connect or PRM User Access?

Scan and Email forms to:
DMHPSO@dmh.lacounty.gov

User Access for all other Applications?

Mail all forms to:
DMH PSO Systems Access Unit
695 S. Vermont Avenue
Los Angeles, CA 90005