**EXHIBIT B**

**Information Technology Safeguarding**

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| *Please read the Data Privacy and Security Guidelines in the Instructions, starting on page 4 before completing Exhibit B.* | | | |
| Protection of Information and Safeguarding the Infrastructure | | | |
| 1. Principal Investigator: | Click here to enter text. | | |
| 1. Research Study Title: | Click here to enter text. | | |
| 1. Contact information for the individual filling out the form: | | Name: Click here to enter text.  Email: Click here to enter text.  Telephone: Click here to enter text. | |
| 1. How will the data be provided/collected?   *Provide the contact information for each checked box below, including contact person’s name, email, and telephone.* | | | |
| DMH Directly-Operated Clinics: Click here to enter text.  DMH Headquarters/DMH Executives and CIOB: Click here to enter text.  DMH LE Contracted Providers: Click here to enter text.  Directly from Clients: Click here to enter text. | | | |
| 1. Will you be conducting direct interviews with the participants?  Yes  No   *If yes, please indicate all applicable categories that the interviewees will be selected from.* | | | |
| DMH Employees  DMH LE Contracted Provider Employees  DMH Clients  DMH LE Contracted Provider Clients  Public | | | Children/Adolescents  Pregnant Women  Older Adults  Adults  Homeless |
| 1. Describe the recruitment process and all the methods of communication that will be used to connect or contact participants during the research (e.g. flyer, pamphlet, email, mail, telephone, voicemail). Explain how the communication will be secured and protected from unauthorized access. | | | |
| Click here to enter text. | | | |
| 1. Indicate where you will be recruiting research participants.   *Provide the information for each checked box below, including facility name, address, and contact person for each clinic* | | | |
| DMH Directly-Operated Facilities: Click here to enter text.  DMH LE Contracted Providers: Click here to enter text.  Other: Click here to enter text. | | | |
| 1. Indicate where you will be interviewing research participants.   *Provide the information for each checked box below, including facility name, address, and contact person for each clinic.* | | | |
| DMH Directly-Operated Facilities: Click here to enter text.  DMH LE Contracted Providers: Click here to enter text.  Other: Click here to enter text. | | | |
| 1. Will participants be compensated for their participation?  Yes  No   *Please describe when, where, and how the compensation will be exchanged.* | | | |
| Click here to enter text. | | | |
| 1. Will the acknowledgment of receipt of compensation contain any identifiable information  Yes  No   *If yes, how will the information be safeguarded?* | | | |
| Click here to enter text. | | | |
| 1. Will participants be communicating with the investigator via telephone?  Yes  No   *Describe your protocol for leaving voice messages for the participants.* | | | |
| Click here to enter text. | | | |
| 1. Will participants be communicating with the investigator via e-mail?  Yes  No   Describe your protocol for exchanging e-mail messages. | | | |
| Click here to enter text. | | | |
| 1. Please select all the data elements/data fields that will be collected during the project. | | | |
| |  |  |  |  | | --- | --- | --- | --- | |  | Names |  | Medical Record Numbers | |  | All geographical subdivisions smaller than a State (street address, city, zip) |  | Health Plan Beneficiary Numbers | |  | All elements of dates (except year) for dates directly related to an individual (birth date, admission date, discharge date) |  | Biometric identifiers (finger and voice prints) | |  | Telephone Numbers |  | Full face unique identifying number, characteristic, or code | |  | Fax Numbers |  | Device identifiers and serial numbers | |  | Electronic Mail Addresses |  | Account Numbers | |  | Social Security Numbers |  | Internet Protocol (IP) address numbers | |  | Certificate/License Numbers |  | Web Universal Resource Locators (URLs) | |  | Vehicle identifiers and serial numbers (license plate numbers) |  | Any other unique identifying number, characteristic, or code  Other: Click here to enter text. | | | | |
| 1. Describe in detail the data’s flow from collection to destruction.   *Thoroughly describe the workflow by explaining how the information will be protected from unauthorized access throughout every process and procedure.* | | | |
| Click here to enter text. | | | |
| 1. What methods of transportation will be used when transporting paper documents that contain PHI or confidential data? | | | |
| Click here to enter text. | | | |
| 1. Are you transmitting data electronically?  Yes  No   *Describe the security protocol that will be in place during transmission that will secure the information from unauthorized access.* | | | |
| Click here to enter text. | | | |
| 1. How long will the PHI/Confidential data be stored?   *Describe the security protocol that will be in place when data is at rest to secure the information from unauthorized access and for how long? (i.e., 2 years, June 2020)* | | | |
| Click here to enter text. | | | |
| 1. What methods of destructions will be used when discarding both electronic and paper documents with PHI or confidential data? | | | |
| Click here to enter text. | | | |
| 1. If you are using an audio or video recording device, list the make/model of each device. | | | |
| Click here to enter text. | | | |
| 1. If you are uploading data (de-identified, PHI, or confidential data) to a website, list the URL. | | | |
| Click here to enter text. | | | |
| 1. Will any data (including de-identified data) be accessed, shared or exchanged with anyone other than the PI and team (e.g., Transcription Service)? If so, please describe the PI’s relationship with the person(s) or entity (Contract – Business Associate Agreement – Other Arrangement). | | | |
| Click here to enter text. | | | |
| 1. Describe your Incident Response and Escalation Procedures for reporting unauthorized access, use or disclosure of PHI or confidential data. | | | |
| Click here to enter text. | | | |

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| NO RESEARCH ACTIVITY CAN BEGIN BEFORE  FINAL APPROVAL FROM THE HSRC LACDMH CIOB Information Security Officer or Designee Approval | |
| LACDMH CIOB Information Security Officer has reviewed the proposed study, and finds the data plan described consistent with DMH policy and meets or exceeds standards for protection of sensitive data/PHI, with the exception of the following:  Click here to enter text. | |
| Print Name: Click here to enter text. | Date: Click here to enter a date. |
| Signature: Digital Image or Physical Signature Only. | |

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| 1. Are you requesting any electronic data from LACDMH Clinical Informatics?  Yes  No   *If yes, describe in detail the resources requested from LACDMH Clinical Informatics.* | |
| Click here to enter text. | |
| LACDMH Chief, Clinical Informatics Approval (if Applicable) | |
| LACDMH Clinical Informatics has reviewed the proposed project as described in this application and will support the project with the necessary resources (only required if requesting data from Clinical Informatics). | |
| Print Name: Click here to enter text. | Date: Click here to enter a date. |
| Signature: Digital Image or Physical Signature Only. | |
| 1. Are you requesting any electronic data from LACDMH CIOB?  Yes  No   *If yes, describe in detail the resources requested from LACDMH CIOB.* | |
| Click here to enter text. | |
| LACDMH CIOB Chief Information Officer Approval (if Applicable) | |
| LACDMH CIOB Chief Information Officer has reviewed the proposed project as described in this application and will support the project with the necessary resources (only required if electronic data is requested). | |
| Print Name: Click here to enter text. | Date: Click here to enter a date. |
| Signature: Digital Image or Physical Signature Only. | |

