Los Angeles County Department of Mental Health (LACDMH)

Provider Quality Assurance and Performance Improvement Report (2026)

Information Gathering Tool

The Provider Quality Assurance and Performance Improvement Report is used to monitor and support Directly Operated and Contracted Organizational Providers' adherence to key requirements and responsibilities consistent with LACDMH's contract with the California Department of Health Care Services.

Tool Use Guidance:

1. This tool can be utilized to prepare and gather all information and responses required to complete the Provider Quality Assurance and Performance Improvement Report.
2. It is recommended for agency/program staff designated to complete the Provider Quality Assurance and Performance Improvement Report to do so in collaboration with executive team members, directors, managers, supervisors, area of responsibility leads and subject matter experts within their agency/program to ensure accuracy.
3. Once all information and responses requested below have been completed, they are to be entered into the electronic Provider Quality Assurance and Performance Improvement Report via the link below and submitted by **11/16/2026**.
   Electronic Provider Quality Assurance & Performance Improvement Report
4. Please do not submit this tool to the Quality Assurance Unit as it does not constitute completion/submission of the Provider Quality Assurance and Performance Improvement Report. **All providers must submit the Report electronically via the link above**.
5. Supporting information requested in "**Response**" column and Corrective Action Plan (CAP) forms are to be sent/submitted via email to DMHQAP@dmh.lacounty.gov .
6. Please feel free to save this completed tool for your agency's/program's records.

   ***If there any questions regarding this tool, please contact the DMHQAP@dmh.lacounty.gov.**

Legal Entity Name (if not directly operated provider): _____ Legal Entity Number (if not directly operated provider): _____ Provider Number(s): _____

Primary Contact Name: _____ Contact Phone Number: _____ Email Address: _____

QUALITY MANAGEMENT	RESPONSE	*REFERENCE/GUIDANCE*

1. Has your agency/program completed a Written Quality Management Program form?	☐ Yes – If "Yes", please send via email
	☐ No - If "No", please briefly explain below and complete a CAP.
		• *Requirement references:*
		  ○ *LACDMH Policy 401.03 Clinical Documentation for All Payer Sources,*
		  ○ *OP-OP Contract – 5.1 County's Quality Assurance Plan*
		• *The agency/program representative responding should be directly aware of or can consult with those within their agency/program with knowledge of the areas of information needed to complete the Written Quality Management Process.*
		• Written Quality Management Program Form

2. Does your agency/program conduct chart reviews of active clinical records?	☐ Yes
	☐ No - If "No", please briefly explain below and complete a CAP.
		• *Requirement references:*
		  ○ *LACDMH Policy 401.03 Clinical Documentation for All Payer Sources,*
		  ○ *OP-OP Contract – 5.1 County's Quality Assurance Plan*
		• *The agency/program representative responding should be directly aware of or can consult with those within their agency/program responsible for specific oversight of chart reviews or of the agency's/program's Quality Management Program.*

3. Does your agency/program use the current chart review tool from LACDMH Website's QA page under Chart Review Requirements for internal chart reviews?	☐ Yes ☐ No - If "No", please briefly explain below and complete a CAP.	• *Requirement reference: LACDMH QA Bulletin 23-02 UPDATED QA REVIEWS AND TRAINING UNDER CALAIM* • *The agency/program representative responding should be directly aware of or can consult with those within their agency/program responsible for specific oversight of chart reviews or of the agency's/program's Quality Management Program.*

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4. I attest that our agency/program monitors the following Behavioral Health Accountability Set (BHAS) Measures, as applicable and per DMH policy to assist LACDMH in achieving and exceeding Minimum Performance Levels (MPL): ➢ FUM (Follow-Up After Emergency Department Visit for Mental Illness- at 30 days) ➢ FUH (Follow-Up After Hospitalization for Mental Illness- at 7 days and 30 days) ➢ APP (Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics) ➢ SAA (Adherence to Antipsychotic Medications for Individuals with Schizophrenia) ➢ SSD (Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications) ➢ CDF (Screening for Depression and Follow-Up Plan)	☐ Yes ☐ No - If "No", please explain below.	• *Requirement references*: ○ *LACDMH Policy 1100.01 Quality Assurance and Performance Improvement Program*, ○ *OP-OP Contract Attachment A. Quality Control Plan* • *For more information regarding current BHAS Measure can also go to the "Accountability Sets" page of the DHCS website (Accountability Sets | DHCS).* • *Agency/program representative attesting should be directly aware of or can consult with those within their agency/program responsible for areas relevant to the BHAS measures or responsible for oversight of monitoring BHAS to confirm status of relevant monitoring for their agency/program.*
5. Does a representative from your agency/program regularly attend at least one of the quarterly Regional Quality Improvement Committee (QIC) meetings as required?	☐ Yes – If "Yes", please indicate which region and staff attending further below ☐ No - If "No", please briefly explain below and complete a CAP. *Please check all regions that apply. ☐ North Region _____ (Name and title of staff attending) ☐ South Region _____ (Name and title of staff attending)	• *Requirement references:* ○ *LACDMH Policy 1100.01 Quality Assurance and Performance Improvement Program pg.2,* ○ *OP-OP Contract – 5.3 County's Quality Assurance Plan* • *The agency/program representative responding should be directly aware of or can consult with those within their agency/program to confirm there is a designated staff that regularly attends the regional QIC meeting and which region attended.*
6. I attest that all required staff of our agency/program have completed annual Cultural Competency training.	☐ Yes ☐ No - If "No", please briefly explain below. Need for a CAP to be determined upon review.	• *Requirement reference: OP-OP Contract – 5.4 County's Quality Assurance Plan* • *The agency/program representative attesting should be directly aware of or can consult with those within their agency/program responsible for ensuring that all required staff within their agency/program complete annual Cultural Competency training.*

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7. I attest that our agency/program is aware of and adhering to the requirements for Transgender, Gender Diverse, and Intersex (TGI) training.	☐ Yes
	☐ No - If "No", please briefly explain below. Need for a CAP to be determined upon review.
		• *Requirement references:*
		  ○ *LACDMH QA Bulletin 25-08 Transgender, Gender Diverse, Intersex Training Requirement,*
		  ○ *OP-OP Contract – 5.4 County's Quality Assurance Plan*
		• *The agency/program representative attesting should be directly aware of status of completion of TGI training for all agency/program staff that have contact with members or can consult with those within their agency/program responsible for ensuring that all required staff complete required TGI training once every three years.*
		• *Completion of TGI training is required at least once every 3 years. When completed can satisfy the completion of annual cultural competency training requirement.*

LICENSING & PROGRAM APPROVAL	**RESPONSE**	***REFERENCE/GUIDANCE***
8. I attest that all our contracted agency's programs/sites providing Specialty Mental Health Services maintain the required licenses, certifications, and mental health program approvals, as applicable.	☐ N/A – Directly Operated Provider ☐ Yes ☐ No - If "No", please briefly explain below. Need for a CAP to be determined upon review.	• *Requirement reference: OP-OP Contract - Exhibit H, 3.2.1, Licenses, Permits, Registrations, and Certificates* • *The contracted agency representative attesting should be directly aware of or have consulted with those within their contract agency with knowledge of status of applicable required licenses, certifications, and mental health program approvals.*
CREDENTIALING		
9. I attest that our contracted agency ensures that all staff directly employed and subcontracted that are required to be licensed or certified to perform their assigned duties are credentialed at minimum once every three years.	☐ N/A – Directly Operated Provider ☐ Yes ☐ No - If "No", please briefly explain below. Need for a CAP to be determined upon review.	• *Requirement reference: OP-OP Contract - Exhibit H, 3.2.1.4, Licenses, Permits, Registrations, and Certificates* • *The contracted agency representative attesting should be directly aware of or have consulted with those within their contract agency who are responsible for and oversee the process for credentialing of those for whom it is required.*
MAINTENANCE OF SITE REQUIREMENT ADHERENCE	**RESPONSE**	***REFERENCE/GUIDANCE***
10. Does your agency/program have a documented process for reporting the following changes, as applicable? • Staffing changes • Organizational or corporate structure changes • Addition of Day Treatment or Medication Support Services when clinically indicated • Physical plant/building changes • Changes in ownership or location • Complaints regarding provider • Unusual events, accidents, or injuries requiring medical treatment • Satellite site changes	☐ Yes - If "Yes", please provide via email related written process/policy and procedures. ☐ No - If "No", please briefly explain below and attach a CAP.	• *Requirement reference: LACDMH Organizational Provider's Manual Chapter 7, Regulations and Requirements for Short-Doyle/Medi-Cal Provider Certification* • *The agency/program representative responding should be directly aware of or have consulted with those within their agency/program with knowledge of presence or absence of a process for reporting listed agency/program changes.*

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COMPLIANCE	RESPONSE	*REFERENCE/GUIDANCE*

11. Does your contracted agency maintain written policies and procedures addressing fraud, waste, and abuse?	☐ N/A – Directly Operated Provider
	☐ Yes - If "Yes", please provide via email related written process/policy and procedures.
	☐ No - If "No", please briefly explain below and attach a CAP.
		• *Requirement references:*
		  ○ *LACDMH Policy 106.05 - Fraud, Waste, and Abuse Prevention;*
		  ○ *OP-OP Contract - Exhibit A, Section N(4), Other Requirements for Contractors*
		• *The agency representative responding should be directly aware of or can consult with those within their contracted agency responsible for ensuring written policies and procedures for addressing fraud, waste and abuse are in place and maintained.*

12. Does your contracted agency provide training to its staff on fraud, waste, and abuse reporting requirements?	☐ N/A – Directly Operated Provider ☐ Yes - If "Yes", please identify staff responsible. ☐ No - If "No", please briefly explain below and attach a CAP.	• *Requirement reference: LACDMH Policy 106.05 - Fraud, Waste, and Abuse Prevention* • *The agency representative responding should be directly aware of or have consulted with those within their contracted agency who are responsible for providing and/or overseeing training on fraud, waste, and abuse reporting for staff.*
ACCESS TO CARE	**RESPONSE**	*REFERENCE/GUIDANCE*
13. I attest that hours of operation for our agency/program for Medi-Cal members are no less than those offered to non-Medi-Cal members when applicable.	☐ Yes ☐ No - If "No", please briefly explain below. Need for a CAP to be determined upon review.	• *Requirement reference: OP-OP Contract - Exhibit H Section 5.8, Hours of Operation* • *The agency/program representative attesting should be directly aware of or can consult with those within their agency/program with knowledge of status of consistency of the hours of operation offered for Medi-Cal and non-Medi-Cal members.*

14. Does your agency/program have a process in place for monitoring the timely and accurate submission of the CANS/PSC and the LOCUS when required?	☐ Yes - If "Yes", please provide via email related written process/policy and procedures.
	☐ No - If "No", please briefly explain below and attach a CAP.
		• *Requirement references:*
		  ○ *OP-OP Contract - Attachment A, Section 3, General Performance Requirements Summary Table;*
		  ○ *LACDMH QA Bulletin 26-08 Level of Care Tools*
		• *The agency/program representative attesting should be directly aware of or can consult with those within their agency/program responsible for ensuring timely submission and utilization of LOCUS and CANS to inform members' level of care and treatment needs.*

15. I attest that our agency/program completes the applicable LOCUS or CANS assessment at least every six months and that LOCUS and CANS are used to inform members' level of care and treatment needs.	☐ Yes
	☐ No - If "No", please briefly explain below. Need for a CAP to be determined upon review.
		• *Requirement references:*
		  ○ *LACDMH QA Bulletin 26-08 Level of Care Tools;*
		  ○ *OP-OP Contract - Attachment A, Section 3, General Performance Requirements Summary Table*
		• *The agency/program representative attesting should be directly aware of or can consult with those within their agency/program responsible for ensuring timely submission and utilization of LOCUS and CANS to inform members' level of care and treatment needs.*

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16. Does your agency/program have a process for monitoring and timely access and implementing procedures to improve timely access when falling below established benchmarks?	☐ Yes - If "Yes", please provide via email related written process/policy and procedures.
	☐ No - If "No", please briefly explain below and attach a CAP.
		• *Requirement references:*
		  ○ *LACDMH Policy 302.07 Access to Care; LACDMH QA Bulletin 21-02 Access to Care Expectations and Reminders;*
		  ○ *OP-OP Contract - Exhibit H, Section 1.1.2, Description of Services/Activities*
		• *The agency/program representative responding should be directly aware of or can consult internally to confirm who within their agency/program is designated to monitor/oversee adherence to timely access standards.*

17. Does your agency/program have designated staff responsible for entering referral, appointment, and enrollment data into SRTS, and have an established process for ensuring data accuracy and completeness?	☐ Yes - If "Yes", please identify staff responsible.
	☐ No - If "No", please briefly explain below.
		• *Requirement references:*
		  ○ *LACDMH Policy 302.07 Access to Care;*
		  ○ *OP-OP Contract - Exhibit H, Section 1.1.2, Description of Services/Activities;*
		  ○ *LACDMH QA Bulletin 21-02 Access to Care Expectations and Reminders*
		• *The agency/program representative responding should be directly aware of or can consult internally to confirm who within their agency/program is designated to monitor/oversee adherence to timely access standards.*

18. Does your agency/program have a process to ensure that Notice of Adverse Benefit Determination (NOABDs) are issued when required?	☐ Yes - If "Yes", please provide via email related written process/policy and procedures.
	☐ No - If "No", please briefly explain below and attach a CAP.
		• *Requirement references:*
		  ○ *LACDMH Policy 200.04 Beneficiary Problem Resolution Process;*
		  ○ *LACDMH Clinical Forms Bulletin 20-4 NOABDS forms;*
		  ○ *LACDMH QA Bulletin 21-02 Access to Care Expectations and Reminders*
		• *The agency/program representative responding should be directly aware of or can consult internally with knowledge of agency's/program's process for ensuring that NOABDs are issued when required.*

19. Does your agency/program have a process for ensuring that members are referred to SMHS services that they are deemed eligible to receive when your agency/program does not have that service available?	☐ Yes - If "Yes", please provide related written process/policy and procedures.
	☐ No - If "No", please briefly explain below and attach a CAP.
		• *Requirement references:*
		  ○ *OP-OP Contract Exhibit H, Sections 1.1.1 and 1.1.2, Description of Services/Activities;*
		  ○ *LACDMH Policy 250.01 Non-Specialty Mental Health Referrals to Medi-Cal Managed Care Plans;*
		  ○ *LACDMH Policy 302.14 - Responding to Initial Requests for Service*
		• *The agency/program representative responding should be directly aware of or can consult internally with those with knowledge of agency's/program's referral process for members requiring service outside of your agency/program.*

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21. Does your agency have clinical and administrative processes in place to facilitate transitions to Non-Specialty Mental Health Services when needed?	☐ Yes - If "Yes", please provide via email related written process/policy and procedures.
	☐ No - If "No", please briefly explain below and attach a CAP.
		• *Requirement references:*
		  ○ *LACDMH QA Bulletin 26-08 Level of Care Tools;*
		  ○ *LACDMH Policy 250.01 Non-Specialty Mental Health Referrals to Medi-Cal Managed Care Plans;*
		  ○ *LACDMH QA Bulletin 22-11 Screening and Transition of Care*
		• *The agency/program representative responding should be directly aware of or can consult internally with those with knowledge of agency's/program's process for transitions between SMHS and Non-SMHS and between levels of care.*

22. Does your agency/program have a documented process to educate members regarding Specialty Mental Health Services, Non-Specialty Mental Health Services, and transitions between levels of care?	☐ Yes - If "Yes", please provide via email related written process/policy and procedures.
	☐ No - If "No", please briefly explain below.
		• *Requirement references:*
		  ○ *LACDMH QA Bulletin 26-08 Level of Care Tools;*
		  ○ *LACDMH Policy 250.01 Non-Specialty Mental Health Referrals to Medi-Cal Managed Care Plans;*
		  ○ *LACDMH QA Bulletin 22-11 Screening and Transition of Care*
		• *The agency/program representative responding should be directly aware of or can consult internally with those with knowledge of agency's/program's process for educating members on the distinctions between SMHS and Non-SMHS and transitions between levels of care.*

NETWORK ADEQUACY	**RESPONSE**	***REFERENCE/GUIDANCE***

22. Has your agency/program designated staff responsible for updating/maintaining NAPPA information?	☐ Yes - If "Yes", please identify staff responsible.
	☐ No - If "No", please briefly explain below and attach a CAP.
		• *Requirement references:*
		  ○ *OP-OP Contract - Exhibit H, Section 5.6 County's Quality Assurance Plan;*
		  ○ *LACDMH - LE Contract & DO Providers Instructions for Utilizing the NAPPA Application*
		• *The agency/program representative responding should be directly aware of or can consult internally to confirm who within their agency/program is designated with the responsibility of ensuring NAPPA information is kept updated.*

23. I attest that NAPPA information is updated at least every 30 days, or more frequently when required (e.g., practitioners added or removed from a Service Location).	☐ Yes
	☐ No - If "No", please briefly explain below. Need for a CAP to be determined upon review.
		• *Requirement references:*
		  ○ *OP-OP Contract - Exhibit H, Section 5.6 County's Quality Assurance Plan;*
		  ○ *LACDMH - LE Contract & DO Providers Instructions for Utilizing the NAPPA Application*
		• *The agency/program representative attesting should be directly aware of or can consult internally with staff responsible for overseeing ensuring that NAPPA information for their agency/program is updated within the minimum required timeframe or more frequently when required.*

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24. Does your agency/program have designated staff responsible for attending monthly Network Adequacy/Access to Care (NA/ATC) webinars?	☐ Yes - If "Yes", please identify staff responsible. ☐ No - If "No", please briefly explain below.	• *Requirement reference: OP-OP Contract - Exhibit H, Section 5.6 County's Quality Assurance Plan* • *the agency/program representative responding should be directly aware of or can consult internally to confirm who is designated to attend regular NA/ATC webinars on behalf of their agency/program.*

25. Does your agency have a process to ensure all eligible practitioners are enrolled in PAVE?	☐ Yes - If "Yes", please provide via email related written process/policy and procedures.
	☐ No - If "No", please briefly explain below and attach a CAP.
		• *Requirement references:*
		  ○ *LACDMH QA Bulletin 20-07R - Provider Application and Validation for Enrollment Portal & Medi-Cal Rx Provider Web Portal Enrollment;*
		  ○ *LACDMH QA Bulletin 26-02 - Mandatory Medi-Cal PAVE Enrollment for Prescribers;*
		  ○ *LACDMH PAVE - Frequently Asked Questions, Revised 8/06/2026*
		• *The agency/program representative responding should be directly aware of or can consult internally with staff who have knowledge and/or oversee the process for ensuring PAVE enrollment for all their agency's/program's eligible practitioners.*

26. I attest that all eligible practitioners are enrolled in PAVE.	☐ Yes
	☐ No - If "No", please briefly explain below. Need for a CAP to be determined upon review.
		• *Requirement references:*
		  ○ *LACDMH QA Bulletin 26-02 - Mandatory Medi-Cal PAVE Enrollment for Prescribers;*
		  ○ *LACDMH QA Bulletin 20-07R - Provider Application and Validation for Enrollment Portal & Medi-Cal Rx Provider Web Portal Enrollment*
		• *the agency/program representative attesting should be directly aware of or can confirm internally with staff who have knowledge of the status of PAVE enrollment for all eligible practitioners in their agency/program.*

PATIENTS' RIGHTS	**RESPONSE**	*REFERENCE/GUIDANCE*

27. Does your agency have a documented process for reporting grievances to Patients' Rights within required time frames?	☐ Yes - If "Yes", please attach process/policy and procedures.
	☐ No - If "No", please briefly explain below and attach a CAP.
		• *Requirement references:*
		  ○ *OP-OP Contract- Exhibit H, Section 1.2.4, Nondiscrimination in Services; Section 1.3.1, Patients'/Clients' Rights;*
		  ○ *LACDMH Policy 200.04 - Beneficiary Problem Resolution Process*
		• *The agency/program representative responding should be directly aware of or can consult with those within their agency/program with knowledge and oversight of the process for reporting grievances to Patients' Rights within required time frames.*

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28. Does your contracted agency have a monthly process for monitoring Language Line utilization?	☐ N/A – Directly Operated Provider
	☐ Yes - If "Yes", please attach process/policy and procedures.
	☐ No - If "No", please briefly explain below and attach a CAP.
		• *Requirement references:*
		  ○ *LACDMH Policy 200.03 Language Translation and Interpreter Services;*
		  ○ *LACDMH Language Line Reporting Frequently Asked Questions*
		• *The contracted agency representative responding should be directly aware of or can consult with those within their agency with knowledge of and/or oversight over of the process for monitoring Language Line utilization.*

SERVICE DATA INFORMATION	**RESPONSE**	***REFERENCE/GUIDANCE***

29. Does your agency have a process to verify member demographic, insurance, and contact information and ensure updates are submitted timely to DMH?	☐ Yes - If "Yes", please attach process/policy and procedures.
	☐ No - If "No", please briefly explain below and attach a CAP.
		• *Requirement references:*
		  ○ *LACDMH Client Service Companion Guide, Version 3.4.6 (2024);*
		  ○ *OP-OP Contract - Exhibit H, Section 6.1.1, Patient/Client Records (Direct Services)*
		• *The agency/program representative responding should be directly aware of or have consulted with those within their agency/program with knowledge of and/or oversight over the process for verifying member demographic, insurance and contact information and ensuring related updates are submitted timely to LACDMH.*

CLAIMING	**RESPONSE**	***REFERENCE/GUIDANCE***

30. Does your agency have a documented process for reporting and resolving identified overpayments within required timeframes?	☐ Yes - If "Yes", please attach process/policy and procedures.
	☐ No - If "No", please briefly explain below and attach a CAP.
		• *Requirement references:*
		  ○ *LACDMH Policy 813.05 Reporting Overpayments Resulting from Waste, Fraud, and Abuse;*
		  ○ *OP-OP Contract - Exhibit A, Section N (4), Other Requirements for Contractors; Section P, Payments by Contractor to County*
		• *The agency/program representative responding should be directly aware of or have consulted with those within their agency/program with knowledge of and/or oversight responsibility for the claiming process and procedures including resolving identified overpayments within required timeframes.*

31. Does your agency have a process to verify Medi-Cal eligibility and ensure Medi-Cal is the payor of last resort?	☐ Yes - If "Yes", please attach process/policy and procedures.
	☐ No - If "No", please briefly explain below and attach a CAP.
		• *Requirement references:*
		  ○ *LACDMH Financial Screening Manual, revised December 31, 2025;*
		  ○ *OP-OP Contract - Exhibit A, Section L, Patient/Client Eligibility, UMDAP Fees; and Third-Party Revenues*
		• *The agency/program representative responding should be directly aware of or have consulted with those within their agency/program with knowledge of the process and/or oversight over the team responsible for verifying Medi-Cal eligibility and ensuring Medi-Cal is the payor of last resort.*

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CONSENT	RESPONSE	*REFERENCE/GUIDANCE*
32. I attest that our agency/program adheres to all requirements and guidance laid out in QA Bulletin 25-04 – Guidance for Minor Consent Confidentiality.	☐ Yes ☐ No - If "No", please briefly explain below. Need for a CAP to be determined upon review.	• *Requirement reference: LACDMH QA Bulletin 25-04 Guidance for Minor Consent Confidentiality* • *The agency/program representative responding should be directly aware of or can consult internally to confirm agency's/program has a process in place to ensure all requirements related to Minor Consent are met.*

33. I attest that telehealth consent is obtained prior to the delivery of telehealth services.	☐ Yes ☐ N/A
	☐ No - If "No", please briefly explain below. Need for a CAP to be determined upon review.
		• *Requirement references:*
		  ○ *LACDMH Policy 302.01 - First Service Contact;*
		  ○ *LACDMH QA Bulletin 22-07 Obtaining Consent*
		• *The agency/program representative responding should be directly aware of or have consulted with those within their agency/program with knowledge of or who oversee ensuring that all required consents are obtained.*

HEALTH INFORMATION MANAGEMENT	**RESPONSE**	*REFERENCE/GUIDANCE*

34. Has your agency designated a Custodian of Records?	☐ Yes - If "Yes", please identify staff responsible.
	☐ No - If "No", please briefly explain below and attach a CAP.
		• *Requirement references:*
		  ○ *LACDMH Policy 300.06 Non-Open Protected Health Information Record ;*
		  ○ *LACDMH Policy 401.01 Clinical Records Maintenance;*
		  ○ *Cal. Code Regs. Tit. 22, § 72543 - Patients' Health Records*
		• *The agency/program representative responding should be directly aware of or have consulted with those within their agency/program confirm the staff designated to the role of Custodian of Records and had knowledge of the related responsibilities.*

35. Does your agency maintain policies and procedures governing the protection and management of Protected Health Information (PHI)?	☐ Yes - If "Yes", please attach process/policy and procedures.
	☐ No - If "No", please briefly explain below and attach a CAP.
		• *Requirement references:*
		  ○ *OP-OP Contract - Exhibit H, Section 9.1.1;*
		  ○ *45 CFR Section 164 -- Security and Privacy;*
		  ○ *California Code, CIV 56.10.*
		• *The agency/program representative responding should be directly aware of or have consulted with those within their agency/program with knowledge of federal and State privacy regulations.*

36. I attest that required staff completed annual privacy and confidentiality training.	☐ Yes
	☐ No - If "No", please briefly explain below. Need for a CAP to be determined upon review.
		• *Requirement references:*
		  ○ *OP-OP Contract - Exhibit H, Section 1.6.3;*
		  ○ *45 CFR Section 164.530*
		• *The agency/program representative responding should be directly aware of or have consulted with those within their agency/program with knowledge of the legal requirements of privacy training for anyone handling protected health information (PHI).*

37. Does your agency maintain a process for responding to requests to amend records and requests for access to Protected Health Information (PHI)?	☐ Yes - If "Yes", please attach process/policy and procedures.
	☐ No - If "No", please briefly explain below and attach a CAP.
		• *Requirement references:*
		  ○ *OP-OP Contract - Exhibit H, Section 1.3.1;*
		  ○ *CA Health & Safety 123110 ;*
		  ○ *45 CFR. Sections 164.524; 164.526*
		• *The agency/program representative responding should be directly aware of or have consulted with those within their agency/program with knowledge of legal requirements of patients' rights to access and request amendments to their designated record set.*

LPS DESIGNATION/AUTHORIZATION	**RESPONSE**	***REFERENCE/GUIDANCE***

38. I attest that the agency complies with all applicable LPS Designation and/or LPS Authorization requirements, including required agreements, attestations, and applicable laws and regulations.	☐ Yes ☐ N/A
	☐ No - If "No", please briefly explain below. Need for a CAP to be determined upon review.
		• *Requirement references:*
		  ○ *Lanterman-Petris-Short Designation and Authorization Guidelines,*
		  ○ *Policy 307.01 Persons Authorized to Initiate Involuntary Lanterman-Petris-Short Detention*
		• *The agency/program representative responding should be directly aware of or have consulted with those within their agency/program with knowledge or responsibility for overseeing that agency/program is adhering to LPS Designation and Authorization requirements.*