INSTRUCTIONS FOR COMPLETING THE APPLICATIONS ACCESS FORM

REQUEST TYPE:
Check the appropriate box. This area applies to other sections of the form, which need to be completed.

EFFECTIVE DATE:
Enter the date that the form is being completed.

ADD NEW USER:
If this box is selected, **completely** fill out the form in its entirety.

INFORMATION UPDATE:
If this box is selected, you must **completely** fill out the **Applicant Information** Section of this form. Please select the correct box that is to be updated. Below is a description of each box.

ADD REPORTING UNIT:
Select this box to indicate the user is requesting access to a reporting unit not currently assigned.

DELETE REPORTING UNIT:
Select this box if the user no longer requires access to a reporting unit.

ADD ROLE:
Select this box to indicate the user is requesting to add a role that is not currently assigned.

DELETE ROLE:
Select this box if the user is requesting to remove a role currently assigned.

TERMINATION:
Select this box to terminate a user. All fields in the Application Information portion of this form must be **completed. Please enter the user's logon ID (i.e. C0XXXXX) in the County employee field under Applicant Information.**

NAME CHANGE:
Select this box if the users name has been changed (i.e. Jane Smith was recently married and her new name is Jane Jones) or if there was a mistake on the users name when the form was originally submitted. Please use the **From Location** and **To Location** boxes to demonstrate the change in names.

TRANSFER:
Select this box if the employee has changed work locations. Enter the previous location in the **From Location** field and the current location in the **To Location field.**

EMPLOYEE STATUS.
Check the box that describes the user's current place of employment.

Permanent	DMH Permanent Employee
Temporary	DMH Temporary Employee
Pharmacy	Employee assigned to the DMH Pharmacy

FFS Staff employee at a Fee for Service IP our OP Provider
MHSA DMH Employee indicating item is funded by Mental Health Services Act
NGA Non-Government Agency or Legal Entity Contract Provider
DHS Department of Health Services Employee

APPLICANT INFORMATION:
This section must be completed in its entirety to provide accurate information regarding the applicant. County employees will also need to complete this section in its entirety.

COUNTY EMPLOYEE NUMBER:
This is the key to staff information in the IS. For county employees enter your employee number. For Non-county enter your Logon ID (i.e. C0XXXXX). If the staff requesting access does not have a Logon ID please leave this space blank.
Contract Providers: if you are terminating staff, please enter the user's C0XXXXX number in the county employee number box.

LAST NAME, FIRST NAME, MIDDLE INITIAL:
Print full last name, first name and middle initial in boxes (avoid using nick names).

LAST 4 DIGITS of SSN:
Enter the last four digits of the user's social security number.

DATE OF BIRTH:
Enter the month and day of birth only. (For example: 05/10 represents someone born on May 10th).

SEX CODE:
Enter M (Male) or F (Female) as appropriate.

ETHNICITY, HANDICAP AND LANGUAGE CODES:
See Application Form Codes Sheet.

FACILITY/BUREAU NAME & PROGRAM NAME/UNIT:
The Program/Unit name may differ from the Facility/Bureau Name, for example, Special Programs would be the Bureau name and G.R.O.W. would be the unit name.

ADDRESS:
Enter the complete business address.

SUITE/FL:
Enter the Suite, Floor, or Room number of where the employee is located.

CITY, STATE, and ZIP CODE
Enter the City, State and Zip code of the location where the employee is located.

TELEPHONE NUMBER & EMAIL ADDRESS
Enter the business telephone number and business Email address of the employee.

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ROLES:
See the Integrated System Access Roles for descriptions. (eg. staff requiring read only access may be assigned roles CLN01R, CLN02R, or ADM01R)

PROVIDER USING WEB SERVICES?:
For Provider Connect User Access Only -- Check Yes or No.
Web Services is a form of communicating Client and Admission data to the IBHIS via electronic data interchange. Confirm with your provider's IT Manager if you are a web service provider.

SELECT CLASS CODE & AUTHORIZED PROVIDER NUMBER:
DMH Provider No. – For Department of Mental Health providers, enter your assigned provider number.
DHS Provider No. – For Department of Health Services providers, enter your assigned provider number.
NGA Legal Entity No. - Contract Providers; please enter your Legal Entity Number. (This will allow staff to enter data for all locations.) To specify specific locations complete the Applications Access Attachment #1.
FFS Provider No. - Fee-for Service Providers, or Billers, enter assigned provider number. For additional providers complete the Applications Access Attachment #1.

SELECT APPLICATION ACCESS:
Select the application(s) the applicant will need access to. Access to any of these applications requires a logon ID and a password. More than one application may be selected.

Integrated System (IS) - Used to view, add and/or modify Client Data.
Day Treatment Authorization – For day treatment providers to enter Service Plans for Clients.
STAR (System Treatment Authorization Requests) – DMH Staff Managed Care
To create and browse inpatient TARs through remote access using a modem.
Provider Connect – LE Day Treatment Provider, Fee-for-Service IP and OP Providers
To submit authorization requests. FFS IP and OP may also submit client and admission data.
PRM – Practitioner Registration and Maintenance System – LE Contract Providers
To modify or add new practitioners assigned to the legal entity.

COLA Agreement for Acceptable Use, Oath of Confidentiality, E-Signature
All three forms must be signed by the user and submitted with the Application Access Form.

SIGNATURES:
Applicant: The person requiring access must Sign and Print their name and enter the date completed.
Contact: The contact person must print their name and enter a phone number where they can be contacted in case there are problems with the submitted form.
Program Head/Authorized Signature: This is the staff's signature designated on the Provider's "***Individuals Authorized To Sign Application Access Forms"*** for the assigned location. This person must print and sign their name and enter the date the form was signed.

FOR PSO USE ONLY --DO NOT Write in this section

This form can be accessed online at:
http://dmh.lacounty.info/hipaa/index.html (all providers)
http://dmhweb/forms (DMH staff only)

Please submit the completed form (ORIGINALS ONLY) to:
Los Angeles County
DMH PSO – Systems Access Unit
695 S. Vermont Avenue
Los Angeles, CA 90005

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