

LAC-DMH  
Student Professional Development Program

**Entrance into the Student Professional Development Program begins with identification of students by Universities that have an Affiliation Agreement with DMH. Only students whose names are on a "Notice of Placement Form" from their University, are enrolled into the Student Internship Program.**

### **Application & Processing**

1. Students must complete the SPDP Student Intern Packet; the packet may be obtained by contacting SPDP, your school liaison or accessing the following web link: [http://dmh.lacounty.gov/Training&Workforce/student\\_professional\\_development\\_program.html](http://dmh.lacounty.gov/Training&Workforce/student_professional_development_program.html)
2. Additionally, students MUST provide copies of photo ID AND evidence of work eligibility, in the form of:
  - CA driver license /State ID AND Social Security card, OR
  - Current foreign passport and green card
3. **All documentation listed in 1 and 2 above (original copies) must be MAILED or hand delivered to:**

County of Los Angeles –Department of Mental Health  
Training Division – SPDP Attn - PAT ZAVALA-ANSEL  
695 S. Vermont Avenue, 15<sup>th</sup> Floor  
Los Angeles, CA 90005

**\*\*\* Remember to please retain a copy of the Entire Packet for your Records.**

4. The student applicant will be contacted by the Training Division / HR Liaison, Pat Zavala-Ansel, to arrange for Human Resources appointment. Appointments at HR will ONLY be granted when all required paperwork has been received by SPDP. HR appointment consists of a LiveScan and photo ID processing. For HR processing, **report to LAC – DMH Headquarters at 550 S. Vermont, 9<sup>th</sup> Floor, Room 904 Los Angeles, CA 90020**
5. DMH Parking available at 523 Shatto Place (Parking structure levels 3-8)  
Alternate Parking Options: 1. Across the street from 695 S. Vermont (\$3.50) 2. Limited Metered Parking around the Building. This site is also Metro accessible.
6. The student will arrive at the above address and check in with Security. Once issued a visitor badge, the student is to proceed to Human Resources Bureau, Room 904, for the scheduled appointment time.
7. The student will NOT be given a DMH photo ID at this time. The report on the fingerprint scan must be received "clear" before the ID is given to the student or Field Supervisor.



**County of Los Angeles**  
**DEPARTMENT OF MENTAL HEALTH**  
**STUDENT PROFESSIONAL DEVELOPMENT PROGRAM**

TRAINING DIVISION/PROGRAM SUPPORT BUREAU  
 695 S. Vermont Ave., 15th Floor  
 Los Angeles, CA 90005  
 213-251-6854

1. <b>DMH Internship Site:</b>	<b>Discipline:</b> <input type="checkbox"/> <b>Psychologist</b> <input type="checkbox"/> <b>SW</b> <input type="checkbox"/> <b>RN</b> <input type="checkbox"/> <b>MFT</b> <input type="checkbox"/> <b>Pharm</b> <input type="checkbox"/> <b>OT</b>  Please check your respective discipline.
2. <b>SOCIAL SECURITY NUMBER</b> <small>(needed for record control purposes)</small>	
3. <b>NAME</b> Last First M.I.	
OTHER NAMES USED IN EMPLOYMENT Last First MI	
4. <b>ADDRESS</b> Number Suite Apt # City State Zip	
5a. <b>HOME PHONE</b> ( ) 5b. <b>BUSINESS/MESSAGE PHONE</b> ( )	
5c. <b>E-MAIL ADDRESS</b>	

6. Expected year of graduation: \_\_\_\_\_

9. Have you ever been a County of Los Angeles employee?  YES  NO If "YES," please complete the following information.

Employee Number	Payroll Title	Item Number	Employment Status: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Recurrent
Department		Department Number	

10. Do you know any language other than English?  YES  NO  
 If "YES," indicate language(s):  
 A \_\_\_\_\_ B \_\_\_\_\_ C \_\_\_\_\_  
 Speak  Read  Write     Speak  Read  Write     Speak  Read  Write

11. If a license or certificate (including Bilingual Certificate) is required, list those you possess and provide dates of expiration.

License or Certificate	Number	Date Issued	Expiration Date

12. To qualify you must be either (a) a citizen of the United States of America, or (b) a registered alien, or student on visa, with government permission to work in this country. Does either statement (a) or (b) describe your status as a resident of this country?  YES  NO

13. Do you claim Veteran's Credit?  YES  NO  
 If "YES," attach a copy of your DD214.

14. Have you ever been fired or asked to resign?  YES  NO  
 (If "YES," please attach an explanation with the name and address of the company, and the date and the reason for the termination.)

15. Have you ever been convicted of a misdemeanor or felony by a criminal or military court?  YES  NO  
 (If "YES," please attach a copy of the court records.)

**CERTIFICATION OF APPLICANT:** I certify that all statements made in this application are true and complete to the best of my knowledge. I understand that any false statement(s) of material facts or omissions may subject me to disqualification or dismissal.

**Date:** \_\_\_\_\_ **Signature** \_\_\_\_\_

**COUNTY OF LOS ANGELES**  
**EQUAL EMPLOYMENT OPPORTUNITY QUESTIONNAIRE**

The following voluntary information is requested for the County of Los Angeles to evaluate its hiring practices and to prepare reports required by law for the State and Federal Government. This form will be detached from the application. This information will be confidential and will NOT be used to make a decision about your application.

<b>A. Please mark the group that best describes your race/ethnicity.</b> 1. <input type="checkbox"/> White 2. <input type="checkbox"/> Black/African American (not of Hispanic origin) 3. <input type="checkbox"/> Hispanic/Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race) 4. <input type="checkbox"/> Filipino 5. <input type="checkbox"/> American Indian (subject to verification) 6. <input type="checkbox"/> Asian or Pacific Islander (excluding Filipino)	<b>B. Gender</b> <input type="checkbox"/> Female <input type="checkbox"/> Male
<b>DATE OF BIRTH</b> Day Month Year	<b>NAME</b> Last First M.I.

Last  
Name  
Middle



LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH  
VOLUNTEER APPLICATION

<b>Placement:</b>	(This application is Confidential)	<b>Expiration Date:</b>
<b>Mr;Miss;Mrs;Ms and Name:</b>		
<b>Date of Birth:</b>	<b>Social Security #:</b>	
<b>Address:</b>	<b>Phone:</b>	
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Name of Person To Notify In An Emergency:</b>		
<b>Address:</b>	<b>Phone:</b>	
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Means of Transportation:</b>	<b>CA Drivers Lic. No.:</b>	<b>Exp. Date:</b>
<b>Automobile Insurance Carrier:</b>	<b>Exp. Date:</b>	
<b>Are You Employed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Type of Work:</b>		
<b>Name of Employer:</b>		<b>Phone No.:</b>
<b>Previous Volunteer Services:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Previous Work Experience:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Education:</b> (Grade School, High School, College or University, Business School, Special Training, I.E. Nurse/Nurse Aid)		
<b>CA License No. and/or Certificate No.:</b>		<b>Date Issued:</b> <b>Exp. Date:</b>
<b>Skills:</b>	<b>Type WPM</b>	<b>Shorthand WPM</b> <b>Speak a Language Other Than English</b> <input type="checkbox"/>
<b>Which Language(s)</b>		<b>Read and Write Language(s)</b>
<b>Interests (Music, Crafts, Sports, etc.):</b>		
<b>Organization / School Affiliations:</b>		
<b><u>Please check Appropriate Line (For Internal Use Only by DMH or Clinical Staff)</u></b>		
Student Intern [ BA MA(MSW) PhD] Medical Intern [ Nurse Doctor] Volunteer Clerical Volunteer Peer Advocate Patient Advocate Other _____		
<b>Are You disabled?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (please circle one) <b>If accommodations are necessary, please list below:</b>		

**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH  
VOLUNTEER INFORMATION – EMERGENCY CONTACT**

**VOLUNTEER/INTERN INFORMATION**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

(       )

City: \_\_\_\_\_

(       )

Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Other Phone \_\_\_\_\_

**PERSON TO CONTACT IN CASE OF EMERGENCY**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

(       )

City \_\_\_\_\_

(       )

Zip Code \_\_\_\_\_

Phone \_\_\_\_\_

Other Phone \_\_\_\_\_

**PHYSICIAN INFORMATION:**

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

(       )

City \_\_\_\_\_

Zip Code \_\_\_\_\_

Phone No. \_\_\_\_\_

Your Blood Type \_\_\_\_\_

**VOLUNTEER SERVICE SITE INFORMATION:**

Facility \_\_\_\_\_

(       )

Phone No. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

Zip Code \_\_\_\_\_

(       )

Supervisor's Name \_\_\_\_\_

Phone \_\_\_\_\_

5VOLUNTEER ASSIGNMENT AGREEMENT

<b>VOLUNTEER NAME</b>	<b>DATE ASSIGNED</b>
<b>ADDRESS</b>	<b>PHONE NUMBER</b>
<b>AREA PROGRAM COORDINATOR</b>	
<b>ADDRESS</b>	<b>PHONE NUMBER</b>
<b>VOLUNTEER AGREES TO PROVIDE THE FOLLOWING SERVICES</b>	
<p><b>VOLUNTEER RESPONSIBILITIES AND LIMITATIONS</b></p> <ol style="list-style-type: none"> <li><b>1.</b> All information as required must be kept confidential</li> <li><b>2.</b> Refrain from publishing any data gathered during the volunteer assignment or disseminating commercial advertisements, press releases, opinions or feature articles without prior written consent of the Volunteer and Special Programs Director.</li> <li><b>3.</b> Refrain from any type of solicitation or charging, requesting or accepting any fee, gift, reward or payment of any kind from individuals or staff for any services rendered as a volunteer.</li> <li><b>4.</b> Refrain from offering medical and/or legal advice and referral to individuals, even though you may be asked for such.</li> <li><b>5.</b> If you drive your car as part of your volunteer assignment, you must maintain a current driver's license and automobile liability insurance.</li> <li><b>6.</b> Report immediately any known or suspected incident of abuse to children, dependent adults, or elders, to a child protective services agency, the Elder Abuse Hotline, County Long Term Care Ombudsman or local law enforcement agency as well as to the Volunteer Coordinator.</li> <li><b>7.</b> Refrain from performing duties other than those listed above. If you want to provide new or additional services, a new agreement must be completed.</li> <li><b>8.</b> Refrain from handling personal resources such as bank accounts, cash, checks, notes, mortgages, trust deeds, sales contracts, stocks, bond, certificates or other liquid assets of individuals with whom you are working as a volunteer.</li> <li><b>9.</b> if your assignment is with a child, always carry your "Field Trip Authorization" form with you during activities.</li> <li><b>10.</b> Complete a report of your volunteer hours each month.</li> <li><b>11.</b> Always carry or wear your valid "Volunteer Photo Identification Card" when engaged in activities as a volunteer for this program.</li> <li><b>12.</b> Contact the individual with whom you are working as a volunteer, Office Liaison or Volunteer Coordinator whenever you cannot follow through with prearranged plan.</li> <li><b>13.</b> Contact the Office Liaison or Volunteer Coordinator immediately when any problems arise, i.e. if you or the individual with whom you are working is injured in the course of your volunteer assignment, when you are unable to contact individual, or when you feel that changes need to be made in your assignment.</li> <li><b>14.</b> ID Cards shall remain property of the Los Angeles County and at no time shall become personal property of any individual; therefore, it is the duty of all Volunteers/Interns/Locum Tenens/Transitional Subsidized Employment(TSE) Greater Avenue For Independence (GAIN)/Contractors/Student Workers             <ol style="list-style-type: none"> <li><b>A.-</b> to surrender their ID Cards at the moment of Terminations and ID Card Expirations to DMH</li> <li><b>B.-</b> to immediately report their lost ID Card and follow the Los Angeles County Loss of Badges Regulations</li> </ol> </li> </ol>	
I HAVE READ AND UNDERSTAND THE RESPONSIBILITIES AND LIMITATIONS AS STATED ABOVE AND I AGREE TO ABIDE BY THEM IN CARRYING OUT MY DUTIES	
<b>VOLUNTEER'S SIGNATURE:</b>	<b>DATE:</b>

LOS ANGELES COUNTY — DEPARTMENT OF MENTAL HEALTH

VOLUNTEER AGREEMENT

The \_\_\_\_\_ agrees to accept the services of \_\_\_\_\_ beginning,
(DMH Program/Clinic) Name of Volunteer (Print)

\_\_\_\_\_ and commits to the following:

Name of DMH Supervisor/Manager

- 1. To provide adequate information, training, and assistance for the volunteer to be able to meet the responsibilities of his/her position.
2. To ensure diligent supervisory aid to the volunteer and to provide feedback on performance.
3. To respect the skills, dignity and individual needs of the volunteer
4. To be receptive to any comments from the volunteer regarding ways in which we might mutually better accomplish our respective tasks.
5. To treat the volunteer as an equal partner with agency staff, jointly responsible for completion of the agency mission.

I, \_\_\_\_\_, agree to serve as volunteer and commit to the following:

Signature of Volunteer

- 6. Keep confidential all information as required.
7. Refrain from publishing any data gathered during the volunteer assignment of disseminating commercial advertisements, press releases, opinions or feature articles without prior written consent of the Department.
8. Refrain from any type of solicitation or charging, requesting or accepting any fee, gift, reward or payment of any kind from individuals or staff for any services rendered as a volunteer.
9. Refrain from offering medical and/or legal advice and referral to individuals, even though I may be asked for such.
10. If I drive my car as part of my volunteer assignment, I will maintain a current driver's license and automobile liability insurance.
11. Report immediately any known or suspected incident of abuse to children, dependent adults, or elders, to a child protective services agency, the Elder Abuse Hotline, County Long Term Care Ombudsman or local law enforcement agency as well as to the Clinic/Program Manager and Volunteer Coordinator.
12. Refrain from performing duties other than those listed above. If I want to provide new or additional services, a new agreement must be completed.
13. Refrain from handling personal resources such as bank accounts, cash, checks, notes, mortgages, trust deeds, sales contracts, stocks, bonds, certificates or other liquid assets of individuals with whom you are working as a volunteer.
14. If my assignment is with a child, always carry my "Field Trip Authorization" form with me during activities.
15. Complete a report of my volunteer hours each month.
16. Always cam, or wear my "Volunteer Photo Identification Card" when engaged in activities as a volunteer for DMH.
17. Contact the individual I am working for as a volunteer or the Volunteer Coordinator whenever I cannot follow through with prearranged plans.
18. Contact the Clinic management or Volunteer Coordinator when any problems arise, i.e., if I or the individual with whom I am working is injured in the course of my volunteer assignment, or when I feel that changes need to be made in my assignment.

AGREED TO:

Signature of Volunteer Date

Signature of DMH Program/Clinic Manager Date

Retention:
3 yrs. After Volunteer is inactive

Distribution:
ORIGINAL: Program Section Personnel Folder
FIRST COPY: Volunteer
SECOND COPY: Volunteer's Office Personnel Folder

**COUNTY OF LOS ANGELES — DEPARTMENT OF MENTAL HEALTH**

**ACKNOWLEDGEMENTS**

**Harassment Policy**

I acknowledge that I have received and read the Harassment Policy (605.2) Of the County of Los Angeles Department of Mental Health. I agree to abide by the policy.

I further agree to participate in a formal Harassment Prevention training within 90 days of issuance of my Volunteer Identification Badge, and then every 2 years thereafter. I will coordinate participation with my Supervisor.

\_\_\_\_\_  
**Signature**

---

**Code of Organizational Conduct and Ethics Handbook**

I acknowledge that I have received a copy of the Compliance Program: Code of Organizational Conduct (Policy #112.2) of the Los Angeles Department of Mental Health and the Department's Ethics Handbook. I agree to abide by the principles and standards set forth by the policy and handbook.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Work Location**

\_\_\_\_\_  
**Volunteer ID Number**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Supervisor Signature**

\_\_\_\_\_  
**Printed Name**

(\_\_\_\_\_)\_\_\_\_\_  
**Telephone Number**



**LEGAL**

Answer to the following questions fully. Existence of criminal conviction/adjudication may or may not, depending on the circumstances, disqualify you from consideration. However, any additional intentional misrepresentation or omission will disqualify you. Do not include minor traffic violations.

**HAVE YOU EVER BEEN:**

- convicted of any criminal offense by a civilian or by military authorities?  Yes  No
- adjudicated or held responsible as a juvenile offender of any criminal offense by a civilian court of by authorities?  Yes  No

**ARE YOU NOW:**

- under charges for any offenses or are any civil suits or judgements pending against you?  Yes  No
- on probation or parole?  Yes  No

if no, skip to "Certification" below.

If you answered yes to any of the questions above, please provide the following information:

DATE: \_\_\_\_\_ PLACE: \_\_\_\_\_  
MONTH/DAY/YEAR CITY STATE

Charge: \_\_\_\_\_ Action taken: \_\_\_\_\_

Court, Probation, or Parole Officer: \_\_\_\_\_ Phone: \_\_\_\_\_  
NAME AREA CODE

Address: \_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP CODE

You may attach any additional information or explanation on a separate sheet.

**CERTIFICATION**

Your application must be certified with your original signature in ink.

I certify that all of the statement made in this application are true correct, and complete, to the best of my knowledge, and are made in good faith. I understand that misinformation or omission of information could result in disqualifying and/or termination as a DMH Volunteer. Background check will be conducted.

**PRIVACY ACT NOTICE: The Privacy Act of 1974 (5 U.S.C. § 552a) requires that the following notice be provided to you: The authority for collecting information from you. In this application is contained in 42 U.S.C. 12592 and 12615 of the National and Community Service Act of 1990 as amended, and 42 U.S.C. 4953 of the Domestic Volunteer Service Act of 1973 as amended. You are advised that submission of the information is entirely voluntary, but the requested information is required in order for you to participate in DMH programs.**

The principal purpose for requesting this information is to process your application into the DMH volunteer program, and for the other general routine purposes associated with your participation in the DMH program. These routines purposes may include disclosures of the information to federal, state, or local agencies pursuant to lawfully authorized requests, to present and former employers, and educational institutions, for the purpose of verifying the information provided to you in your application. The information may also be provided to federal, state, and local law enforcement agencies to determine the existence of any prior criminal convictions. The information will not otherwise be disclosed to entities of the DMH without your prior written permission.

\_\_\_\_\_  
SIGNATURE DATE

**For Parent of Guardian or Applicants Under 18 of Age:** / have reviewed this application and / authorize my son/daughter/legal ward to apply to the DMH.

Signature

Name: \_\_\_\_\_ Date \_\_\_\_\_

Relation: \_\_\_\_\_ Phone: \_\_\_\_\_  
AREA CODE

Address: \_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP CODE

**COUNTY OF LOS ANGELES — DEPARTMENT OF MENTAL HEALTH**

**VOLUNTEER OATH OF CONFIDENTIALITY**

I, the undersigned, hereby agree not to divulge any information or records concerning any client/patient without proper authorization in accordance with California Welfare and Institutions Code, Section 5328, et seq.

I recognize the unauthorized release of confidential information may make me subject to a civil action under provisions of the Welfare and Institutions Code and Title 9, California Administrative Code, as follows:

W & I Code, 5330. (a) Any person may bring an action against an individual who has willfully and knowingly released confidential information or records concerning him or her in violation of this chapter, or of Chapter 1 (commencing with Section 11860) of Part 3 of Division 10,5 of the Health and Safety Code, for the greater of the following amounts:

- (1) Ten thousand dollars (\$10,000).
- (2) Three times the amount of actual damages, if any, sustained the plaintiff

(h) Any person may bring an action against an individual who has negligently released confidential information or records concerning him or her in violation of this chapter, or of Chapter 1 (commencing with Section 11860) of Part 3 of Division 10.5 of the Health and Safety Code, for both of the following:

- (1) One thousand dollars (\$1,000). In order to recover under this paragraph, it shall not be a prerequisite that the plaintiff suffer or be threatened with actual damages.
- (2) The amount of actual damages, if any, sustained by the plaintiff

(c) Any person may, in accordance with Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, bring an action to enjoin the release of confidential information or records in violation of this chapter, and may in the same action seek damages as provided in this section.

(d) In addition to the amounts specified in subdivisions (a) and (b), the plaintiff shall recover court costs and reasonable attorney's fees as determined by the court.

As a condition of performing my duties as an volunteer of the Mental Health Department, I agree not to divulge to any unauthorized person any client/patient data information obtained from my facility by the Department.

I recognize the unauthorized release of confidential information may make me subject to a civil action under the provisions of the Welfare and Institutions Code, and may result in the termination of any offer of volunteer service.

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Unit Where Assigned

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**COUNTY OF LOS ANGELES  
AGREEMENT FOR ACCEPTABLE USE AND  
CONFIDENTIALITY OF  
COUNTY'S INFORMATION TECHNOLOGY ASSETS,  
COMPUTERS, NETWORKS, SYSTEMS AND DATA**

As a Los Angeles County employee, contractor, vendor or other authorized user of County Information Technology (IT) assets including computers, networks, systems and data, I understand that I occupy a position of trust. I will use County IT assets for County management approved business purposes only and maintain the confidentiality of County's business and Citizen's private data. As a user of County's IT assets, I agree to the following:

1. Computer crimes: I am aware of California Penal Code 502(c) - Comprehensive Computer Data Access and Fraud Act (attached). I will immediately report any suspected computer misuse or crimes to my Management.
2. Security access controls: I will not subvert or bypass any security measure or system which has been implemented to control or restrict access to computers, networks, systems or data. I will not share my computer identification codes (log-in ID, computer access codes, account codes, ID's, etc.) or passwords.
3. Approved business purposes: I will use the County's Information Technology (IT) assets including computers, networks, systems and data for County management approved business purposes only.
4. Confidentiality: I will not access or disclose any County program code, data, information or documentation to any individual or organization unless specifically authorized to do so by the recognized information owner.
5. Computer virus and malicious code: I will not intentionally introduce any computer virus, worms or malicious code into any County computer, network, system or data. I will not disable or delete computer virus detection and eradication software on County computers, servers and other computing devices I am responsible for.
6. Offensive materials: I will not access or send any offensive materials, e.g., sexually explicit, racial, harmful or insensitive text or images, over County owned, leased or managed local or wide area networks, including the public Internet and other electronic mail systems, unless it is in the performance of my assigned job duties, e.g., law enforcement. I will report to my supervisor any offensive materials observed by me or sent to me on County systems.
7. Public Internet: I understand that the Public Internet is uncensored and contains many sites that may be considered offensive in both text and images. I will use County Internet services for approved County business purposes only, e.g., as a research tool or for electronic communication. I understand that the County's Internet services may be filtered but in my use of them I may be exposed to offensive materials. I agree to hold the County harmless should I be inadvertently exposed to such offensive materials. I understand that my Internet activities may be logged, are a public record, and are subject to audit and review by authorized individuals.
8. Electronic mail and other electronic data: I understand that County electronic mail (e-mail), and data, in either electronic or other forms, are a public record and subject to audit and review by authorized individuals. I will comply with County e-mail use policy and use proper business etiquette when communicating over e-mail systems.
9. Copyrighted materials: I will not copy any licensed software or documentation except as permitted by the license agreement.
10. Disciplinary action for non-compliance: I understand that my non-compliance with any portion of this Agreement may result in disciplinary action including my suspension, discharge, denial of service, cancellation of contracts or both civil and criminal penalties.



**County of Los Angeles Department of Mental Health  
TRAINING BUREAU**

**Non-Compensated DMH Personnel**

**LEARNING NET SYSTEM (LNS) ACCESS FORM**

**Instructions:** All information must be completed to add your name into the DMH LNS. This is required for DMH non-compensated personnel to register for training and download transcripts or continuing education (CE) unit credits.

<input type="text"/>	<input type="text"/>	<input type="text"/>
Starting Date with DMH	Last 4 digits of SSN	Last 4 digits of DL or CA ID number

New <input type="checkbox"/>	DMH Contracted <input type="checkbox"/>
Termination <input type="checkbox"/>	Intern/Student <input type="checkbox"/>
	Locum Tenen <input type="checkbox"/>
	Volunteer <input type="checkbox"/>

The last 4 digits of your SSN and the last 4 digits of your DL or CA ID is used to create your unique LNS logon ID. \*

<input type="text"/>	<input type="text"/>
Last Name (print)	First Name and Middle Initial (print)

<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
E-Mail Address**	Professional License No.	M/F

<input type="text"/>	<input type="text"/>
Program Bureau / Facility Name	Pay Loc (See Pg 2)
<input type="text"/>	<input type="text"/>
Area Code	Telephone No.

<input type="text"/>	<input type="text"/>
Address	Area Code
<input type="text"/>	Fax No.

<input type="text"/>	<input type="text"/>
City	Zip

<input type="text"/>	<input type="text"/>	<input type="text"/>
Supervisor/Manager's Name (print)	Employee. No.	Email Address

\*A passport id or an Alien Registration Card No. may be used in lieu of the DL/CA ID Card No. and SSN.

\*\*If the email address is not available the supervisor/manager's email will be used for registration of training until a permanent email is established.

**New: Complete and submit to HR for processing Terminations:**

LAC-DMH Training Division  
695 S. Vermont Ave., 15th Floor, Los Angeles, CA 90005  
Fax: (213) 252-8776 or 252-8775  
Phone: (213) 251-6854  
**Copy to: Program Analyst**

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH**  
**PAY LOCATION LISTING**

<b>PL</b>	<b>DIVISION</b>	<b>ADDRESS</b>	<b>TELEPHONE</b>
01	OFFICE OF THE DIRECTOR	550 S VERMONT AVENUE 12th Fl	LOS ANGELES, California 90020 213/738-4601
02	REVENUE MANAGEMENT DIVISION	695 S. VERMONT AVENUE 7TH FLOOR	LOS ANGELES, California 90005 213/738-2449
03	DIRECTOR OF FINANCIAL SERVICES	550 S VERMONT AVENUE 11th Fl	LOS ANGELES, California 90020 213/738-2891
04	SPECIALIZED CHILDREN & YOUTH SVCS	550 S VERMONT AVENUE 4th Floor	LOS ANGELES, California 90020 213/738-4644
05	HUMAN RESOURCES BUREAU	550 S VERMONT AVENUE 9th Fl.	LOS ANGELES, California 90020 213/351-7700
06	EDMUND D. EDELMAN WESTSIDE MHC - C & Y	11080 W OLYMPIC BLVD 1st Fl.	LOS ANGELES, California 90064 323/769-6100
07	CONTRACTS DEVELOPMENT & ADMIN. DIV.	550 S VERMONT AVENUE 5th Fl	LOS ANGELES, California 90020 213/738-4684
08	COMPLIANCE OFFICE	600 S COMMONWEALTH AVE ROOM 201	LOS ANGELES, California 90005 213/739-2390
09	ADMINISTRATIVE SERVICES BUREAU	550 S VERMONT AVENUE 2nd Flr	LOS ANGELES, California 90020 213/738-4639
10	PATIENT RIGHTS BUREAU	550 S VERMONT AVENUE Rm. 608	LOS ANGELES, California 90020 213/738-2716
11	PALMDALE MENTAL HEALTH CENTER	1529 EAST PALMDALE BLVD. Suite 150	PALMDALE, California 93550 661/575-1828
12	JAIL MENTAL HEALTH SERVICES	441 BAUCHET STREET ROOM #1017 1st Flr	LOS ANGELES, California 90012 213/974-9616
13	CHIEF INFORMATION OFFICE	695 S. VERMONT AVENUE 7th Fl	LOS ANGELES, California 90005 213/251-6481
14	OFFICE OF PUBLIC GUARDIAN	320 W TEMPLE STREET 15th Fl	LOS ANGELES, California 90012 213/974-0527
16	MHSA JAIL LINKAGE/AB2034	441 BAUCHET STREET ROOM #1017 Tower	LOS ANGELES, California 90012 213/738-4385
17	CHILDREN'S SYSTEMS OF CARE ADMIN	600 S COMMONWEALTH AVE 6th Floor	LOS ANGELES, California 90005 213/738-3489
18	ADULT SYSTEM OF CARE ADMIN	550 S VERMONT AVENUE 3 <sup>rd</sup> Flr	LOS ANGELES, California 90020 213/738-4945
19	JUVENILE COURT MENTAL HEALTH UNIT	201 CENTRE PLAZA DRIVE Rm 425	MONTEREY PARK, California 91754 310/766-4330
20	ARCADIA M.H. CENTER	330 E. LIVE OAK AVENUE	ARCADIA, California 91006 213/7384253
21	DPSS CO-LOCATED PROGRAM	550 S VERMONT AVENUE 11th Fl.	LOS ANGELES, California 90020 213/738-3715
22	OLDER ADULT SERVICES - ADMIN	550 S VERMONT AVENUE 6th Fl. Rm 601	LOS ANGELES, California 90020 213/738-3572
23	AB3632 ASSESSMENT UNIT	11303 W SUITE 200 WASHINGTON BLVD	LOS ANGELES, California 90066 310/268-2521
25	TRAINING & CULTURAL COMPETENCY	550 S VERMONT AVENUE RM 1202	LOS ANGELES, California 90020 213/738-4105
26	ACCESS CENTER	12440 FIRESTONE BLVD, SUITE 3001 2nd	NORWALK, California 90650 562/651-5002
27	DMH-COMMUNITY URGENT SERVICES	10605 BALBOA BLVD, SUITE 100	GRANADA HILLS, California 91344 818/832-6192
28	VALLEY COORDINATED CHILDREN'S	19231 VICTORY BLVD Suite 110	RESEDA, California 91335 818/708-4500
30	COMPTON FAMILY MENTAL HEALTH	921 E. COMPTON BLVD. 1st Fl	COMPTON, California 90220 310/668-6878
31	AUGUSTUS F. HAWKINS CCU	1720 E 120TH STREET 1st Fl. Rm 1040	LOS ANGELES, California 90059 310/668-3770
33	AB3632/SECTOR II PROGRAM	12440 FIRESTONE BLVD, SUITE 3001	NORWALK, California 90650 213/738-4628
34	MENTAL HEALTH COURT LINKAGE PROGRAM	1499 HUNTINGTON DRIVE Suite #101	SO. PASADENA, California 91030 626/403-4370
36	EMERGENCY OUTREACH BUREAU - ADMIN	550 S VERMONT AVENUE 10 <sup>th</sup> Fl	LOS ANGELES, California 90020 213/738-3489
37	EOB - COUNTYWIDE RESOURCE MGMT	1925 DALY 2nd Fl	LOS ANGELES, California 90031 323/226-4448
38	CalWORKs	550 S VERMONT AVENUE 11th FL	LOS ANGELES, California 90020 213/738-4253
39	LONG BEACH GEOGRAPHIC INTTITATIVE	100 OCEANGATE Suite #550	LONG BEACH, California 90802 562/435-2337
41	OFFICE OF THE MEDICAL DIRECTOR	550 S VERMONT AVENUE 12th Flr	LOS ANGELES, California 90020 213/738-2130
42	PROGRAM SUPPORT BUREAU	550 S VERMONT AVENUE 12th Fl	LOS ANGELES, California 90020 213/738-4105
44	WEST CENTRAL FAMILY M.H. CENTER	3751 STOCKER STREET	LOS ANGELES, California 90008 323/298-3680

45	ROYBAL FAMILY MENTAL HEALTH CENTER	4701 E. CESAR CHAVEZ 2nd Fl.	LOS ANGELES, California 90022	323/767-3400
46	HOLLYWOOD MENTAL HEALTH CENTER	1224 N VINE STREET	HOLLYWOOD, California 90038	323/769-6183
47	DOWNTOWN MENTAL HEALTH CENTER	529 SOUTH MAPLE AVENUE	LOS ANGELES, California 90013	213/4306899
48	NORTHEAST MENTAL HEALTH CENTER	5564 N FIGUEROA ST	LOS ANGELES, California 90042	213/738-4258
49	CSOC - COUNTYWIDE CASE MANAGEMENT	600 S COMMONWEALTH AVE 2ND FL	LOS ANGELES, California 90005	213/738-3940
50	JUVENILE JUSTICE MH PROGRAM - ADMIN	550 S VERMONT AVENUE 3rd Fl	LOS ANGELES, California 90020	213/738-2895
51	SERVICE AREA 3 PROGRAM ADMINISTRATION	600 S COMMONWEALTH AVE 6TH FLOOR	LOS ANGELES, California 90005	213/738-4978
52	INTERAGENCY CONSULTATION &	100 OceanGate Suite 550	LONG BEACH, California 90802	562/435-2337
53	CHILD YOUTH FAMILY PROG/SFC - CHILD	600 S COMMONWEALTH AVE 6TH FL	LOS ANGELES, California 90005	213/738-4620
54	LONG BEACH CHILD MENTAL HEALTH CENTER	240 E 20TH STREET	LONG BEACH, California 90806	562/435-2337
55	SAN ANTONIO FAMILY MHC - OUTPATIENT	2629 Clarendon Avenue.	Huntington Park, California 90255	213/500-4372
57	BIRTH TO FIVE - CFPA	600 S COMMONWEALTH AVE 6th Floor	LOS ANGELES, California 90005	213/738-3201
60	ANTELOPE VALLEY MENTAL HEALTH	349-A E AVENUE K-6	LANCASTER, California 93535	661/723-4261
65	SAN FERNANDO MENTAL HEALTH CENTER	10605 BALBOA BLVD, SUITE 100	GRANADA HILLS, California 91344	818/832-6161
66	WEST VALLEY MENTAL HEALTH CENTER	7621 CANOGA AVENUE	CANOGA PARK, California 91304	818/598-6900
67	SANTA CLARITA VALLEY MHS	23501 CINEMA DRIVE	SANTA CLARITA, California 91355	213/205-3743
70	LONG BEACH MENTAL HEALTH	1975 LONG BEACH BLVD	LONG BEACH, California 90806	562/435-2337
71	AMERICAN INDIAN COUNSELING CTR	17707 STUDEBAKER ROAD 208	CERRITOS, California 90703	213/738-4400
72	RIO HONDO MHC - C & Y AMERICAN INDIAN	17707 STUDEBAKER ROAD	CERRITOS, California 90703	562/403-0101
73	SAN PEDRO MENTAL HEALTH CENTER	150 WEST 7TH STREET	SAN PEDRO, California 90731	310/222-1643
74	SOUTH BAY MENTAL HEALTH CENTER	2311 W EL SEGUNDO BLVD	HAWTHORNE, California 90250	323/241-6890
75	TWIN TOWERS CORRECTIONAL FAC. - MENTAL	11705 S ALAMEDA ST RM. 8387-A 2ND	LYNWOOD, California 90262	323/568-4656
76	EDMUND D. EDELMAN WESTSIDE MHC	11080 W OLYMPIC BLVD	LOS ANGELES, California 90064	213/473-6183
77	LONG BEACH ASIAN MENTAL HEALTH CENTER	1975 LONG BEACH BLVD 2nd Fl.	LONG BEACH, California 90806	562/218-4042
78	HARBOR/UCLA MEDICAL CENTER ADMIN.	1000 W CARSON ST, BOX 498	TORRANCE, California 90509	310/222-1643
79	COASTAL ASIAN PACIFIC MH SERVICES	14112 S KINGSLEY DRIVE	GARDENA, California 90249	310/217-7309
80	CENTRAL JUVENILE HALL - MH UNIT	1605 EASTLAKE AVENUE	LOS ANGELES, California 90033	323/226-8826
81	LOS PADRINOS JUVENILE HALL - MH UNIT	7285 EAST QUILL DRIVE	DOWNEY, California 90242	213/738-6193
82	BARRY J. NIDORF JUV. HALL - MH UNIT	16350 FILBER STREET	SYLMAR, California 91342	818/364-6876
83	DOROTHY KIRBY CENTER - MH UNIT	1500 S MCDONNELL AVENUE	COMMERCE, California 90022	323/526-6361
84	CHALLENGER MH UNIT	5300 W AVENUE I	LANCASTER, California 93536	661/940-4050
85	WOMEN'S REINTEGRATION PROGRAM	8300 S VERMONT AVE 1ST	LOS ANGELES, California 90044	323/525-6400
86	EMPOWERMENT & ADVOCACY DIVISION	695 S. VERMONT AVENUE 8th Fl.	LOS ANGELES, California 90005	213/251-6580
87	SPECIALIZED FOSTER CARE SA 6	10421 S FIGUEROA ST	LOS ANGELES, California 90003	310/738-4620
88	COUNTYWIDE SPECIALIZED FOSTER CARE	600 S COMMONWEALTH AVE RM 67	LOS ANGELES, California 90005	213/739-5466
89	COUTYWIDE HOUSING, EMPLOYMENT AND	550 S VERMONT AVENUE 8TH FLOOR	LOS ANGELES, California 90020	213/351-5297
90	OFFICE OF ADMIN DEPUTY	550 S VERMONT AVENUE 12 <sup>TH</sup> Fl. Rm 227	LOS ANGELES, California 90020	213/738-2891
91	ANTELOPE VALLEY KIDZ CONNECTION	2323A E PALMDALE BLVD	PAMDALE, California 93550	661/223-3827
92	WEST VALLEY WELLNESS CENTER	6800 OWENSMOUTH RM 160	CANOGA PARK, California 91303	213/738-3111
93	CAMP ROCKEY - SOUTHERN MH CAMP PROGS	1900 N SYCAMORE CANYON RD	SAN DIMAS, California 91773	323/981-4308

**AFFLIATION AGREEMENT  
FOR STUDENT PROFESSIONAL DEVELOPMENT PROGRAMS  
BETWEEN THE COUNTY OF LOS ANGELES  
AND**

\_\_\_\_\_, STUDENT

**EXHIBIT A**

**AGREEMENT REGARDING PARTICIPATION IN  
STUDENT PROFESSIONAL DEVELOPMENT PROGRAM**

In consideration of my eligibility to participate in Student Professional Development Program established by (Sending Party/University) \_\_\_\_\_ and the Los Angeles County Department of Mental Health I, \_\_\_\_\_ hereby agree and consent to the following:

**ADHERENCE TO RULES AND REGULATIONS**

1. I acknowledge and agree that I will adhere to all policies, procedures, rules and regulations of any Los Angeles County Department of Mental Health facility in which I may receive training during my participation in such Student Professional Development Program. I agree to be bound by the policies and procedures established by (Sending Party/University)

\_\_\_\_\_ to resolve any disputes, including disciplinary actions, between myself and (Sending Party/University) \_\_\_\_\_ or the County of Los Angeles Department of Mental Health facility in which I may receive training to the Student Professional Development Program.

**RIGHTS OF MENTAL HEALTH FACILITIES**

2. I acknowledge and agree that the mental health facility in which I may receive training pursuant to the Student Professional Development Program shall have the right to restrict or terminate my participation in the training program and/or to refuse to certify that I have



successfully completed the training program. I understand that any such restriction, termination or refusal to certify shall be based upon my actions and performance during the training program and shall be taken in accordance with any and all relevant policies and procedures of such training program.

**AUTHORIZATION TO OBTAIN INFORMATION**

3. I authorize (Sending Party/University) \_\_\_\_\_ and the mental health facility in which I may receive training pursuant to such a training program to consult at any time with the administration and members of the faculty of any County of Los Angeles Department of Mental Health facility with which I have been associated who may have information bearing on my professional competence, character, physical and mental health status, ethics, and other qualifications, as may reasonably be related to my eligibility to perform services in such training mental health facilities. I hereby possess qualifications, as may reasonably be related to my eligibility to perform services in such training mental health facilities. I hereby further consent to the release by the administration of (Sending Party/University) \_\_\_\_\_ to County's Director of Mental Health or his designee of such records and documents relating to my education and training at (Sending Party/University) \_\_\_\_\_ as may be material to an evaluation of my professional qualifications and competence for satisfactory participation in any such mental health facilities' student professional development programs pursuant to such a training program.

**CONFIDENTIALITY OF MEDICAL RECORDS AND PATIENT INFORMATION**

4. I understand and agree that medical records and patient information are confidential under the Law and that I will not release any such information. I agree to seek guidance should I have any questions about confidentiality.

**RELEASE FROM LIABILITY**

5. I hereby release from liability all employees, agents, and representatives of (Sending Party/University) \_\_\_\_\_, County of Los Angeles, and any County

of Los Angeles Department of Mental Health facility in which I may receive training hereunder, including their respective professional staff and staff representatives, for their acts performed in good faith and without malice as an incident to any communication, action, proceeding, performance evaluation, certification, or review undertaken pursuant to this agreement or otherwise related to my participation in such a training program. I further expressly agree that the above releases shall apply to any act, communication, report, recommendation, or disclosure; and with respect to the named parties in whose favor such releases are given, are intended to and shall include all their officer, employees, and agents; and that, in addition to the above specific releases, such parties shall be entitled, to the fullest extent permitted by law, to absolute immunity from liability arising from any such act, communication, report, recommendation, or other disclosure. In furtherance of the foregoing, I agree that, upon request of (Sending Party/University) or the mental health facility to which I may be assigned under such a training program, I will execute releases in accordance with the tenor and import of the Agreement in favor of any individual or organization specified herein.

I understand that my execution of this Agreement indicates that I have read, understood, and agreed to be bound by the foregoing and by any and all provisions of California Law applicable to the Subject matter addressed herein.

\_\_\_\_\_ **DATE:** \_\_\_\_\_  
**NAME OF STUDENT (PRINTED)**

\_\_\_\_\_  
**SIGNATURE OF STUDENT**



# REQUEST FOR LIVE SCAN SERVICE

## Applicant Submission

**A1432**

ORI (Code assigned to DOJ)

Authorized Applicant Type

**Dept Mental Health: Volunteer / Contractor / TSE GAIN / Locum Tenen / Other:**

Type of License/Certification/Permit OR Working Title (Maximum 30 characters – if assigned by DOJ, used exact title assigned)

Contributing Agency Information

**COUNTY OF LOS ANGELES DEPT OF MENTAL HEALTH**

Agency Authorizing to Receive Criminal Record Information

**05126**

Mail Code (five-digit code assigned by DOJ)

**550 S Vermont Avenue 9<sup>th</sup> Floor, Room 904**

Street Address pr P.O Box

**Patsy Ayala**

Contact Name (mandatory fir all school submissions)

**Los Angeles**                      **CA**                      **90020**  
City                                      State                      Zip Code

**(213) 738-3641**  
Contact Telephone Number

## Applicant Information:

**Last Name**

Other Name \_\_\_\_\_  
(AKA or Alias) First **Last**

**Sex**     Male     Female

**Date of Birth**

**Height**                      **Weight**                      **Eye Color**                      **Hair Color**

**Place of Birth (state or Country)**                      **Social Security Number**

Home Address **Street Address or P.O. Box**

**First Name**                      **Middle Initial**                      **Suffix**

**First**                      **Suffix**

**Driver License Number**

Billing Number 142410  
(Agency Billing Number)

Misc. Number \_\_\_\_\_  
(Other Identification Number)

**City**                      **State**                      **Zip Code**

Your Number: \_\_\_\_\_  
OCA Number (Agency Identifying Number)

Level of Service:     DOJ     FBI

If re-submission, list original ATI number:  
(Must provide proof of rejection)

Original ATI Number \_\_\_\_\_

Employer (Additional response for agencies specified by statute):

**Employer Name**

Mail Code (five digit code assigned by DOJ)

**Street Address or P.O. Box**

**City**                      **State**                      **Zip Code**

**Telephone Number (optional)**

## Live Scan Transaction Completed By:

Name of Operator \_\_\_\_\_

Date \_\_\_\_\_

LSC – DMH HRB

Transmitting Agency \_\_\_\_\_                      LSID \_\_\_\_\_

ATI Number \_\_\_\_\_                      Amount Collected / Billed \_\_\_\_\_

**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH  
HUMAN RESOURCES BUREAU**

**PHOTO I.D. INFORMATION**  
(please, print legibly)

\_\_\_\_\_  
**WORKSITE (PAY LOCATION NAME)**

\_\_\_\_\_  
**PAY LOC. NO.**

<p>_____ <b>VOLUNTEER NAME</b> <i>First Middle Initial, Last</i></p>
--

<p align="center">I _____ <b>VOLUNTEER ID NUMBER</b> <i>Initials of first and last name and last 4 digits of the SSN# (Example: JD4321)</i></p>	<p align="center"><b>Student Intern</b> _____ <b>TITLE</b></p>
---	--

<p>_____ <b>HEIGHT</b></p>	<p>_____ <b>EYE COLOR</b></p>
<p>_____ <b>HAIR COLOR</b></p>	<p>_____ <b>DATE OF BIRTH</b> <i>Month/Day/Year</i></p>

Please check off one box if you are employed in one of the position titles listed below:

- |   |  |
|---|--|
| <input type="checkbox"/> Volunteer (Non-Intern) | <input checked="" type="checkbox"/> Intern     |
| <input type="checkbox"/> Deputized              | <input type="checkbox"/> TSE/GAIN              |
| <input type="checkbox"/> Contractor             | <input type="checkbox"/> Student Volunteer     |
|   | <input type="checkbox"/> LPS Designated (5150) |

Dear Student:

Effective May 23, 2007, students working within DMH placements who are providing direct clinical services will be required to have a National Provider Identification Number (NPI). This is an outgrowth of HIPAA requirements, and all health care providers must obtain an NPI.

You need to apply for an NPI for the Department of Mental Health to be able to claim/bill your services. Please apply using the NPI web-based application process. For information on how to apply for an NPI, the Centers for Medicare and Medicaid Services (CMS) has available to you an NPI application training Viewlet at the following web site:

<http://www.cms.hhs.gov/apps/mpi/npiviewlet.asp>

The NPI application web site is:

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

When you apply for your NPI please use the taxonomy code "390200000X." This taxonomy is to be utilized by all students.

The web-based application is the link to the National Plan & Provider Enumerator System. When you apply, you will receive confirmation of your registration. The confirmation will be a tracking number. The tracking number is important to keep. This number will be used when contacting the enumerator in the event your NPI is not issued timely. An NPI can be issued the same day you apply or up to 20 days later. When the NPI is issued to you, you will receive an e-mail assigning your number to you. This will be your own unique identification number that you will carry with you no matter when you intern or work.

To be able to update your NPI application data, you must have your user identification and password. Therefore, it is important that you keep this information for later use. Upon receipt of your NPI #, print a copy of the e-mail containing your NPI number.


For complete information regarding the NPI and your responsibilities associated with the NPI, please read the letter of September 25, 2006, addressed to Mental Health Physician/Mental Health Non-Physician Providers, issued by Marvin J. Southard, Director, Los Angeles County Mental Health Department. Also read the Federal Register containing the final rules concerning NPIs.

Thank you for your assistance in this matter.

**You need your National Provider Identification number to complete the Rendering Provider Form in this packet - allowing for billing for services.**



## DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

<b>SUBJECT</b> <b>COMPLIANCE PROGRAM: CODE OF ORGANIZATIONAL CONDUCT, DOCUMENT DISTRIBUTION TO EMPLOYEES AND ATTESTATION</b>	<b>POLICY NO.</b> <p style="text-align: center;"><b>112.2</b></p>	<b>EFFECTIVE DATE</b> <p style="text-align: center;"><b>08/01/04</b></p>	<b>PAGE</b> <p style="text-align: center;"><b>1 of 3</b></p>
<b>APPROVED BY:</b>  <p style="text-align: right;">Director</p>	<b>SUPERSEDES</b>	<b>ORIGINAL ISSUE DATE</b>	<b>DISTRIBUTION LEVEL(S)</b> <p style="text-align: center;"><b>1</b></p>

### PURPOSE

- 1.1 To maintain and promote the highest in ethical and legal conduct consistent with recommendations set forth by the Office of the Inspector General, Department of Health and Human Services for the development of a Compliance Program.
- 1.2 To ensure that all employees of the Department of Mental Health (DMH) have received a copy of the Code of Organizational Conduct.
- 1.3 To ensure that all employees of DMH are aware of their obligation to abide by the principles and standards set forth in the Code of Organizational Conduct.

### DEFINITION

- 2.1 For the purposes of this policy, the term “employees” is used broadly and is defined to mean any permanent or temporary employee, temporary agency or locum tenens employee, persons employed under contract or other type of purchased service agreement, unpaid students, interns and volunteers as well as any other persons who represent the Department in the course of their work duties.

### POLICY

- 3.1 All employees of DMH shall receive a copy of the Code of Organizational Conduct for the County of Los Angeles Department of Mental Health.
- 3.2 All employees shall sign an Attestation Statement (Attachment I) stating they have received a copy of and will abide by the principles and standards set forth in the Code of Organizational Conduct.
- 3.3 Program Managers are responsible to ensure each employee under their management has received a copy of the Code of Organizational Conduct and has signed the attached attestation.
  - 3.3.1 Program Managers are to be available to discuss the Code of Organizational Conduct with their employees and provide or obtain answers to any questions related to the document.



## DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

<b>SUBJECT:</b>  <b>COMPLIANCE PROGRAM: CODE OF ORGANIZATIONAL CONDUCT, DOCUMENT DISTRIBUTION TO EMPLOYEES AND ATTESTATION</b>	<b>POLICY NO.</b>  <b>112.2</b>	<b>EFFECTIVE DATE</b>  <b>08/01/04</b>	<b>PAGE</b> <b>2 of 3</b>
--	---------------------------------------	--	------------------------------

- 3.4 Failure to sign the Attestation Statement may subject the employee to disciplinary measures up to and including discharge.

### **PROCEDURE**

#### 4.1 Initial Distribution of the Code of Organizational Conduct

- 4.1.1 Program Managers are responsible for distributing the Code of Organizational Conduct to employees and obtaining the signature of each employee on the Attestation Statement.
- 4.1.2 Program Managers are required to forward the original signed Attestation Statement to the Bureau of Standards, Practices and Conduct.
- 4.1.3 The Bureau of Standards, Practices and Conduct shall forward the original Attestation Statement to the Human Resources Bureau. The original Attestation Statement form shall then be placed in the employee's official personnel file in the Human Resources Bureau.

#### 4.2 Ongoing Distribution of the Code of Organizational Conduct to New Employees

- 4.2.1 The Human Resources Bureau shall distribute a copy of the Code of Organizational Conduct to each new employee upon commencement of employment and shall ensure that each new employee signs an Attestation Statement.
- 4.2.2 Program Managers are to be available to discuss the Code of Organizational Conduct with their new employees and provide or obtain answers to any questions related to the document.
- 4.2.3 The Attestation Statement shall be placed in the employee's official personnel file.
- 4.2.4 The Human Resources Bureau shall notify the Bureau of Standards, Practices and Conduct upon completion of any new Attestation Statement, including the employee's name, payroll number and date of signature.



**DEPARTMENT OF MENTAL HEALTH  
POLICY/PROCEDURE**

<b>SUBJECT:</b> <b>COMPLIANCE PROGRAM: CODE OF ORGANIZATIONAL CONDUCT, DOCUMENT DISTRIBUTION TO EMPLOYEES AND ATTESTATION</b>	<b>POLICY NO.</b> <b>112.2</b>	<b>EFFECTIVE DATE</b> <b>08/01/04</b>	<b>PAGE</b> <b>3 of 3</b>
--	-----------------------------------	--	------------------------------

**AUTHORITY**

State of California Department of Mental Health contract with the County of Los Angeles Department of Mental Health, Fiscal Year 2003-2004  
 Code of Federal Regulations, Title 42, Section 438.608, Program Integrity Requirements

**REFERENCE**

Code of Organizational Conduct

**ATTACHMENT**

Attachment I            Code of Organizational Conduct Attestation Statement

**RENEWAL DATE**

This policy shall be reviewed two years from the effective date.



**COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH**  
**CODE OF ORGANIZATIONAL CONDUCT**

**I acknowledge that I have received a copy of the Compliance Program document and that I will abide by the principles and standards set forth in the Code of Organizational Conduct.**

---

**Print Name**

---

**Signature**

---

**Employee Number**

---

**Date of Receipt**

**PLEASE INCLUDE THIS SIGNATURE PAGE WHEN RETURNING YOUR APPLICATION**



## DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

SUBJECT <b>SEXUAL HARASSMENT</b>	POLICY NO. <b>605.2</b>	EFFECTIVE DATE <b>01/01/95</b>	PAGE <b>1 of 6</b>
APPROVED BY: <b>original signed by:</b> <b>ARETA CROWELL</b> <div style="text-align: right;">Director</div>	SUPERSEDES  <b>10/1/89</b>	ORIGINAL ISSUE DATE  <b>11/1/81</b>	DISTRIBUTION LEVEL(S)  <b>1</b>

### PURPOSE AND INTRODUCTION

- 1.1 To establish Department of Mental Health (DMH) policy prohibiting sexual harassment in the work place; and to identify DMH procedures for clients, members of the public, examination candidates, prospective employees, and departmental employees to follow to file complaints of sexual harassment against DMH employees.
- 1.2 Sexual harassment in the work place is degrading to all individuals, including those who may not be the targets of such conduct, because it creates a hostile work environment or denies everyone the opportunity to be fairly considered on their individual, job-related merits. Further, sexual harassment is a form of sex discrimination. When it occurs, sexual harassment reflects poorly on the Department and its employees, and impedes goals to provide mental health services to the public in a professional and effective manner.
- 1.3 Sexual harassment can occur between individuals of the same sex or between individuals of opposite sexes. It can occur between superior and subordinate, co-workers, employee and client, and employee and a vendor doing business with the Department.
- 1.4 Managers, supervisors, and employees who have questions regarding the implementation of this policy should contact the DMH Personnel Bureau, Employee Relations/Technical Services Section.

### POLICY

- 2.1 Sexual harassment in the work place or work-related environment, or in the performance of job duties, is prohibited conduct. Sexual harassment is also against State and Federal laws.
- 2.2 Sexual harassment is unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:
  - 2.2.1 submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment, benefits or services received from DMH;
  - 2.2.2 submission to or rejection of such conduct by an individual is used as the basis for any decision on employment, benefits or services affecting such individual;



## DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

<b>SUBJECT:</b> <b>SEXUAL HARASSMENT</b>	<b>POLICY NO.</b> <b>605.2</b>	<b>EFFECTIVE DATE</b> <b>01/01/95</b>	<b>PAGE</b> <b>2 of 6</b>
---	-----------------------------------	--	------------------------------

- 2.2.3 such conduct has the purpose or effect of unreasonably interfering with an individual's work performance, benefits, or services received from the Department; or creating an intimidating, hostile, or offensive work environment.
- 2.3 Sexual harassment also occurs as any of the following conduct when it is done with a sexual intent or connotation or on a sex-determined basis:
- 2.3.1 The conditioning of employment, benefits, or services in exchange for sexual favors, including unwanted sexual advances. Examples of sexual favors are continued requests for dates; any threat of demotion, termination, discipline, loss of pay, benefits, or status, if the requested sexual favors are not given; or propositioning an individual; any threatened denial, termination, or alteration of DMH services, benefits, or diagnoses if the requested sexual favors are not given; making or threatening reprisals after a negative response.
  - 2.3.2 Physical harassment including, but not limited to, assault; blocking movement; or any physical interference with normal work or movement when directed at an individual; touching, pinching, patting, grabbing, brushing against or poking another individual's body; or requiring the individual to wear sexually suggestive clothing.
  - 2.3.3 Verbal harassment including, but not limited to, epithets and derogatory comments or slurs; name-calling; use of patronizing terms; sexually explicit or degrading words to describe an individual; sexually explicit jokes; comments about an employee's anatomy and/or dress; and inquiries about a person's sexual practices.
  - 2.3.4 Visual harassment including displaying or sending sexually derogatory pictures, objects or writings; or physically gesturing in an obscene or sexually oriented manner. Examples include the displaying of sexual photographs, posters or cartoons; sending obscene or unwanted love letters or invitations; leering at or "mooning" an individual.
- 2.4.1 Any DMH manager, supervisor, or employee who is found to have committed an act of sexual harassment is subject to counseling or disciplinary action, including warning, reprimand, suspension, reduction, or discharge.
- Sexual harassment may also render the offender personally, financially liable in civil proceedings.
- 2.5 The Department will also take all reasonable steps to prevent or eliminate sexual harassment of its employees by non-employees, including clients and vendors.



# DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

<b>SUBJECT:</b> <b>SEXUAL HARASSMENT</b>	<b>POLICY NO.</b> <b>605.2</b>	<b>EFFECTIVE DATE</b> <b>01/01/95</b>	<b>PAGE</b> <b>3 of 6</b>
---	-----------------------------------	--	------------------------------

- 2.6 Any of the behavior listed in Sections 2.2 or 2.3 may also constitute violations of other DMH policies or inappropriate behavior warranting counseling, disciplinary action, or other administrative action, even if sexual harassment is not found to have occurred.
- 2.7 No manager, supervisor, or employee may take any retaliatory action against any individual for having filed a sexual harassment complaint; for having opposed sexual harassment; or for having participated in an investigation, proceeding or hearing on allegations of sexual harassment. Such actions by a manager, supervisor, or employee may result in discipline.
  - 2.7.1 Retaliatory action includes, but is not limited to, failing to consider for hire or not hiring a qualified, prospective employee; disciplining an employee; adversely affecting an employee's working condition; or denying any employment benefit to an otherwise qualified employee.
  - 2.7.2 Retaliatory action is also a violation of State and Federal laws.

## **STEPS TO TAKE WHEN CONFRONTED WITH SEXUAL HARASSMENT**

- 3.1 If a DMH client, member of the public seeking services, examination candidate, prospective employee, or DMH employee believes that he or she is or has been the subject of sexual harassment by a DMH employee, any of the following actions should be taken:
  - 3.1.1 When possible, confront the harasser and persuade him or her to stop. Sometimes the individual may not be aware that the particular conduct is offensive. Inform the individual that the conduct is unwelcomed and must stop. Tell the individual of any further steps that will be taken if the harassment continues. Document attempts to have the individual stop the harassment.  
  
Also, document the actual incidents of harassment, identifying the date, place, nature, and any witnesses.
  - 3.1.2 Report the sexual harassment as identified below in Sections 3.2 or 3.3, especially if the individual continues sexual harassment after being told to stop.
- 3.2 To file a complaint of sexual harassment for investigation and/or resolution by the Department, the examination candidate, prospective employee, or DMH employee may take the following actions:
  - 3.2.1 Report the matter to the employee's immediate supervisor or manager. If the allegation is against the immediate supervisor, the employee may report the matter to the next level supervisor or manager.



## DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

<b>SUBJECT:</b> <b>SEXUAL HARASSMENT</b>	<b>POLICY NO.</b> <b>605.2</b>	<b>EFFECTIVE DATE</b> <b>01/01/95</b>	<b>PAGE</b> <b>4 of 6</b>
---	-----------------------------------	--	------------------------------

3.2.2 Report, in writing, to the DMH Personnel Officer or designate, any acts of sexual harassment by DMH employees, including co-workers, supervisors or managers. The report should be made as soon as possible after the incident occurred.

3.2.2.1 The report should identify the alleged harasser, if known; the date, time, place, description of the alleged incident(s); and any witnesses to the alleged incident(s). Also included should be the complainant's work address and work telephone number. If the complainant is not a DMH employee, the complainant's home address and daytime telephone number should be included.

3.2.3 Contact the Los Angeles County Office of Affirmative Action Compliance located at Kenneth Hahn Hall of Administration, Room 780, Los Angeles, California 90012. The telephone number is (213) 974-1251.

3.2.4 File a sexual harassment complaint with the California State Department of Fair Employment and Housing (DFEH) within one year of such an act. DFEH investigates and resolves complaints of unlawful discrimination, including sexual harassment.

To contact DFEH, the complainant should consult the local telephone directory under State Government Offices or ask for directory assistance in Sacramento for the telephone number of DFEH headquarters.

3.2.5 File a sexual harassment complaint with the United States Equal Employment Opportunities Commission (EEOC) within six months of such an act. EEOC is the Federal agency that resolves sexual harassment claims.

To contact EEOC, the complainant should consult the local telephone directory under Federal Government or ask directory assistance in Washington, D.C., for the telephone number of EEOC.

3.2.6 Both DFEH and EEOC have the legal authority to order that a wronged party be hired, restored back pay, promoted, reinstated or granted damages for emotional distress. The agencies also have power to issue "cease and desist" orders to prevent further sexual harassment.

3.3 DMH clients or members of the public seeking services who wish to file a complaint against an employee should contact the manager of the office where the employee works or may contact the Director of the DMH Patients' Rights and Advocacy Section located at 550. S. Vermont Ave., Los Angeles, CA 90020.



## DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

<b>SUBJECT:</b> <b>SEXUAL HARASSMENT</b>	<b>POLICY NO.</b> <b>605.2</b>	<b>EFFECTIVE DATE</b> <b>01/01/95</b>	<b>PAGE</b> <b>5 of 6</b>
---	-----------------------------------	--	------------------------------

- 3.3.1 Managers, supervisors, and Patients' Rights staff who receive such complaints must immediately contact the Personnel Officer or designate before taking any further action.
- 3.4 Any employee, employment candidate, client, or member of the public seeking DMH services who believes that he or she has been subjected to sexual harassment is assured of the right to file a complaint or make a report without fear of reprisal.

### **DMH ACTIONS: INVESTIGATION AND RESOLUTION**

- 4.1.1 A report or complaint received by the Department will be investigated thoroughly, promptly, and confidentially to the extent the allegation permits.
- 4.2 Any manager or supervisor who is aware of sexual harassment by a subordinate or receives an allegation of sexual harassment shall either, depending on the nature of the allegation, investigate and resolve the matter, or consult with the Personnel Officer or his/her designate as soon as possible.
  - 4.2.1 Before taking any investigatory action, managers and supervisors must consult with the Personnel Officer or designate on allegations involving any physical harassment, or repeated harassment of any kind, or sexual favors in exchange for employment, benefits or services received from DMH.
- 4.3 The Department will attempt to conclude any investigation within 60 days; however, failure to complete the investigation within that time does not invalidate any findings or any resulting disciplinary action.
  - 4.3.1 An investigation will include contacting the complainant, witnesses and other individuals who can provide information about the allegations, and the alleged harasser.
  - 4.3.2 In some minor forms of sexual harassment allegations, such as an inappropriate comment, the manager may arrange with the consent of the alleged victim, to meet jointly with the involved individuals to discuss and resolve the issue between them without the need for a formal investigation.
- 4.4 Pending the outcome of any investigation, the work place of either the alleged harasser or the alleged victim, if an employee, may be temporarily relocated as appropriate. The relocation is to help ensure the least disruption of the work environment and is not considered a disciplinary action. Upon completion of the investigation, a determination will be made as to the permanent work location of either individual.
- 4.5 Where sexual harassment has impacted an employment status, benefit, or condition, the DMH will take remedial action. In addition, appropriate administrative action, as provided in Section



## DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

SUBJECT: <b>SEXUAL HARASSMENT</b>	POLICY NO. <b>605.2</b>	EFFECTIVE DATE <b>01/01/95</b>	PAGE <b>6 of 6</b>
--------------------------------------	----------------------------	--------------------------------------	-----------------------

2.5, may be taken even if the sexual harassment did not impact an employment status, benefit, or condition.

### **AUTHORITY**

Los Angeles County Code, Section 5.02.040

California Government Code, Sections 12900 through 12996

California Department of Fair Employment and Housing Regulations (2 CCR 7287.6)

United States Equal Employment Opportunity Commission, Guidelines on Sexual Harassment  
(29 CFR 1604.11)