

## 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

## INSTRUCTIONS FOR COMPLETING THE APPLICATIONS ACCESS FORM

---

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.

## INSTRUCTIONS FOR COMPLETING THE APPLICATIONS ACCESS FORM

---

### **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.

## INSTRUCTIONS FOR COMPLETING THE APPLICATIONS ACCESS FORM

---

**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**

**Revised 04.2014**