



# APPLICATIONS ACCESS FORM

COUNTY OF LOS ANGELES  
DEPARTMENT OF MENTAL HEALTH  
CHIEF INFORMATION OFFICE BUREAU

## REQUEST TYPE

|                                   |                                       |   |                                     |                                      |  |
|-----------------------------------|---------------------------------------|---|-------------------------------------|--------------------------------------|--|
| Effective Date                    | <input type="checkbox"/> Add New User | <input type="checkbox"/> Information Update |                                     |                                      |  |
|                                   | <input type="checkbox"/> Name         | <input type="checkbox"/> Status             | <input type="checkbox"/> Assignment | <input type="checkbox"/> Termination |  |
| <input type="checkbox"/> Transfer | From Location                         | To Location                                 |                                     |                                      |  |

## EMPLOYEE STATUS

|                                    |                                    |                                   |                              |                              |
|------------------------------------|------------------------------------|-----------------------------------|------------------------------|------------------------------|
| <input type="checkbox"/> Permanent | <input type="checkbox"/> Temporary | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> FFS | <input type="checkbox"/> NGA |
|------------------------------------|------------------------------------|-----------------------------------|------------------------------|------------------------------|

## APPLICANT INFORMATION

|   |           |                |                       |                      |
|---|-----------|----------------|-----------------------|----------------------|
| Employee No. (County Only)                                  | Last Name | First Name     | MI                    | Last 4 Digits of SSN |
| Date of Birth MM/DD   | Sex Code  | Ethnicity Code | Handicap Code         | Language Code        |
| Name of Facility / Bureau / FFS Network Provider / Pharmacy |           |                |                       |                      |
| Program Name / Unit   |           | Address        |                       | Suite / FL           |
| City  | State     | Zip Code       | Phone Number<br>( ) - | E-Mail Address       |

|      |  |  |  |  |  |  |  |  |
|------|--|--|--|--|--|--|--|--|
| ROLE |  |  |  |  |  |  |  |  |
|------|--|--|--|--|--|--|--|--|

## SELECT CLASS CODE & AUTHORIZED PROVIDER NO.

|   |  |                                   |  |   |  |
|---|--|-----------------------------------|--|---|--|
| <input type="checkbox"/> DMH Provider No. |  |                                   |  | <input type="checkbox"/> NGA Legal Entity No. |  |
| <input type="checkbox"/> DHS Provider No. |  | <input type="checkbox"/> Pharmacy |  | <input type="checkbox"/> FFS Provider No. (*) |  |

## SELECT APPLICATION ACCESS

|  |  |                               |   |                               |                                 |
|--|--|-------------------------------|---|-------------------------------|---------------------------------|
| Integrated System <input type="checkbox"/>                           | Day Treatment Authorization <input type="checkbox"/> | STAR <input type="checkbox"/> | MAA <input type="checkbox"/>                                      | MEDS <input type="checkbox"/> | LAMHPS <input type="checkbox"/> |
| Oath of Confidentiality on file at Facility <input type="checkbox"/> |  |                               | Original Oath Attached with MEDS Request <input type="checkbox"/> |                               |                                 |

## SIGNATURES

|   |              |                |     |
|---|--------------|----------------|-----|
| Applicant Print Name                          | Signature    | Date Completed | / / |
| Contact Print Name                            | Phone Number | Date Completed | / / |
| Program Head / Authorized Designee Print Name | Signature    | Date Completed | / / |

## FOR CIOB USE ONLY

|              |                  |                |
|--------------|------------------|----------------|
| User ID      | HEAT Call Ticket | Date Received  |
| Processed By | Remarks          | Date Completed |

Having problems filling out this form? call CIO Helpdesk at 213-351-1335

Revised 04/28/2004

Please return to: Department of Mental Health  
CIO - Helpdesk  
3160 W. 6th Street, 2nd Floor  
Los Angeles, CA 90020

This Form may also be accessed at: <http://dmhweb/forms>

(\*) Please use Form MH1003 for additional location.