

## INSTRUCTIONS FOR COMPLETING THE APPLICATIONS ACCESS FORM

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

- **Effective Date:**  
In the 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:** This box would be checked to indicate the user is requesting to have access to a reporting unit not currently assigned.
- **Delete Reporting Unit:** This box would be checked to indicate a user no longer requires access to a reporting unit.
- **Add Role:** This box would be checked to indicate the user is requesting to have access to a role not currently assigned.
- **Delete Role:** This box would be checked to indicate the user is requesting to remove access to a role currently assigned.
- **Termination:** If this box is selected you must **completely** fill out the applicant information portion of this form.

**Contract Providers: if you are terminating staff please enter the person 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** – check 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.

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### EMPLOYEE STATUS.

Check the box that most currently describes the users place of employment.

- DMH Staff check appropriate box to indicate Permanent or Temporary
- Pharmacy Staff
- FFS Staff
- MHSA (DMH Staff ONLY check this box to indicate the item is funded by the Mental Health Service Act)
- NGA (Non Government Agency) or Contract Provider
- DHS

### 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**

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 staffs 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 users 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.

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

### 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. **FFS Staff select IS only.**

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- **Integrated System (IS)** - Used to view, add and/or modify Client Data.
- **Day Treatment Authorization** – Used to enter Service Plans for Clients.
- **STAR (System Treatment Authorization Requests)** – DMH Staff Only
  - STAR is a PC based application developed to provide the ability to create and browse inpatient TARs through remote access using a modem.
  - **Fee-for-Service Inpatient Providers and DMH Central Office staffs only use this application.**
- **MAA - Medi-Cal Administrative Activity** – DMH Staff Only
- **MEDS - Medi-Cal Eligibility Data System**

**Oath of Confidentiality is a requirement for all applications access.**

- **Oath of Confidentiality on file at Facility:** Check this box to indicate a copy of the Oath of Confidentiality form is on file at your facility.
- **Original Oath Attached with MEDS Request:** Check this box if you have attached the Oath of Confidentiality forms to Applications Access forms that are requesting access to MEDS.

### **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 signature designated on the Providers Authorization To Sign CIOB Access Forms for the assigned location. This person must print and sign their name and enter the date the form was signed.
  - For FFS Providers, this is the individual provider, the group provider, administrator, or the organizational provider administrator, program manager or executive Director.

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## FOR CIOB USE ONLY

**DO NOT Write in this section, it is to be used by Chief Information Office Bureau staff only.**

**This form is accessible online at:**

**<http://dmh.lacounty.info/hipaa/index.html> (all providers)**

**<http://dmhweb/forms> (DMH staff only)**

**Please submit the completed form (ORIGINAL ONLY) to:**

**Los Angeles County – DMH  
CIO Bureau/IS-Systems Access Unit  
695 S. Vermont Avenue  
Los Angeles, CA 90005**