



APPLICATIONS ACCESS FORM

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

REQUEST TYPE

Effective Date 2/15/2006	<input checked="" 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

Permanent
 Temporary
 Pharmacy
 FFS
 NGA

APPLICANT INFORMATION

Employee No. (County Only)	Last Name SNOWWHITE	First Name CHILD	MI	Last 4 Digits of SSN 2058	
Date of Birth MM/DD 09/05	Sex Code F	Ethnicity Code 03	Handicap Code 00	Language Code 01	Name of Facility / Bureau / FFS Network Provider / Pharmacy BELOVED MEDICAL CENTER
Program Name / Unit PSYCH EMERGENCY		Address 1234 NEWWAVE BLVD		Suite / FL 901	
City HAPPY CITY	State CA	Zip Code 01234	Phone Number (211) 256-0125	E-Mail Address NOWANDTHEN@SHOP.ORG	

ROLE

SELECT CLASS CODE & AUTHORIZED PROVIDER NO.

<input type="checkbox"/> DMH Provider No.	<input type="text"/>	<input checked="" type="checkbox"/> NGA Legal Entity No.	<input type="text" value="1123"/>
<input type="checkbox"/> DHS Provider No.	<input type="text"/>	<input type="checkbox"/> Pharmacy	<input type="text"/>
<input type="checkbox"/> FFS Provider No. (*)	<input type="text"/>		

SELECT APPLICATION ACCESS

Integrated System <input checked="" 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 checked="" type="checkbox"/>	Original Oath Attached with MEDS Request <input type="checkbox"/>				

SIGNATURES

Applicant Print Name CHILD SNOWWHITE	Signature SIGNATURE REQUIRED	Date Completed <input type="text" value="02/ 01/ 06"/>
Contact Print Name MARY NEWHOUSE	Phone Number 211-256-0123	Date Completed <input type="text" value="02/ 15 / 06"/>
Program Head / Authorized Designee Print Name DR. SALLY BEGONE	Signature SIGNATURE REQUIRED	Date Completed <input type="text" value="02/ 15 / 06"/>

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.