COUNTY OF ORANGE - HEALTH CARE AGENCY (HCA)
BEHAVIORAL HEALTH SERVICES (BHS)
LANTERMAN-PETRIS-SHORT (LPS) OUTPATIENT DESIGNATION AUTHORIZATION APPLICATION

(Please Print Clearly or Type)

TO BE COMPLETED BY APPLICANT & APPLICANT'S SUPERVISOR (Failure to complete all items may result in the application not being processed).

BHS Division:

☐ Adult & Older Adult (AOA) ☐ Children & Youth Services (CYS) ☐ Crisis & Acute Care (CACS) ☐ Forensic & Justice

Please check:

County Programs:

☐ County MHP Outpatient Clinic
☐ County Crisis Assessment Team
☐ CONREP
☐ JCRP

County Contracted MHP Programs:

☐ County Contracted MHP Outpatient Clinic
☐ County Contracted MHP Outpatient FSP
☐ County Contracted MHP Outpatient CRP

Initial Application ☐ Re-Designation Application ☐ Work Location Change ☐

Previous Work Location: Transfer Date:

Applicant's Full Name:		Maiden Name:	

Job Title:

Name of Agency & Program Title:

Work Address			
City		Zip Code	
Work Telephone		Work E-mail	

MCST Credentialing Approval Date: _____

MCST Credentialing Expiration Date: _____

(Must be Credentialed prior to submitting application)

Individual NPI Number:

Number of years' experience as a registered and/or licensed MH professional:

Number of years' working in the MH field:

Start Date with Program: Start Date with Health Care Agency:

Required: Service Chief/Program Director attests that applicant has been trained in Program policies and procedures and is prepared to become an LPS Outpatient Designated staff. Yes ☐ No ☐

Current job description of applicant which requires that he/she be authorized (please check):

☐ LCSW ☐ LMFT ☐ LPCC ☐ PhD/PsyD ☐ PMHNP ☐ RN* ☐ MD****

☐ ASW ☐ AMFT ☐ APCC ☐ Waivered/Registered Psychologist ☐ LVN*** ☐ LPT*** ☐ MHS/MHRS**

BH experience Required* ***Must meet DHCS MHRS criteria* ** Must meet BH experience & DHCS MHRS criteria* ***** CSU MD's only*

License No.		License Expiration Date	

I attest that all statements made in the application are true and correct.

Applicant:

(Must be a wet signature or Adobe time stamped electronic signature)

Signature _____

Date _____

Professional clinically in charge of Program:

(If applicant is clinically in charge, then immediate supervisor must sign)

Print Name _____

Signature _____ Date _____

Email BHPDesignation@ochca.com for application submission and for questions regarding training, Initial & Re-designation LPS Outpatient Applications and LPS Outpatient Authorization Status.

Service Chief/Program Director- Submit this form as an Initial or Re-designation authorization or a change of work location. Form must be completed for each facility at which individual desires LPS Outpatient authorization. QMS IDSS provides training, registration and final LPS Outpatient designation authorization once training has been completed and a passing test score has been registered.

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APPLICANTS ATTESTATION FOR LPS OUTPATIENT DESIGNATION

I attest that all statements made in this application are true and correct. I acknowledge that any false or incomplete statement given here, or an omission of material fact will result in my disqualification.

I attest that I meet the qualifications for LPS designation based on: (Please check the appropriate category)	
☐	Baccalaureate degree and four (4) years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. **Date (MM/DD/YY) degree granted: _____ Number of years' experience: _____**
☐	Master's degree (up to two (2) years of graduate professional education) may be substituted for the experience requirement on a year-for-year basis and minimum of two (2) years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. **Date (MM/DD/YY) degree granted: _____ Number of years' experience: _____**
☐	Associate's Degree (up to two (2) years of post-associate arts clinical experience) may be substituted for the required educational experience and a minimum of four (4) years' experience in a mental health setting. **Date (MM/DD/YY) degree granted: _____ Number of years' experience: _____**

I, the applicant, attest to each statement below by placing my *INITIALS* next to each item:	
	I have met the minimum requirements necessary to be designated.
	I understand that I will be tested on information related to WIC 5150 and WIC 5585 and I will read and review both prior to attending the training.
	I will uphold all applicable legal, ethical, regulatory and reporting principles contained therein and in the standards of my professional license(s).
	I will uphold basic ethical standards essential to the fulfillment of my responsibilities carried out in the application of my authority for involuntary detention, including but not limited to the following:
	I will avoid any participation in a personal arrangement or business transaction which would generate potential or perceived conflict of interest or compromise my ability to provide treatment fairly and objectively.
	I will avoid any circumstances that would hinder my ability to provide or refer to service that is of highest quality and effectiveness.
	I will recognize and avoid any personal situation, habits or behaviors that might impair my ability to provide competent care.
	I will respect and protect client confidential information, in accordance with applicable legal and regulatory standards.
	I will perform all my duties in a manner that demonstrates an understanding of each client's personal dignity.
	I will demonstrate the highest standards of personal integrity in all work-related activities carried out in the application of my authority for involuntary detention.

I acknowledge that if I am given authority for involuntary detention, my failure to comply with the above principles and all laws, policies, by-laws or regulations related to involuntary detention, or with those portions of any policy and procedures related to individuals (including any revisions thereafter adopted), will result in withdrawal of my involuntary detention authority. I acknowledge that involuntary detention authority may also be withdrawn without cause at any time by QMS IDSS on behalf of the HCA BHS Director.

_____ Signature of Applicant
(Must be wet signature or Adobe time stamped)

_____ Print Name

_____ Date

_____ Registration/License No.

_____ Expiration Date

SERVICE CHIEF/PROGRAM DIRECTOR ATTESTATION FOR APPLICANT

I attest that all statements made in this application are true and correct. I acknowledge that any false or incomplete statement given here, or an omission of material fact will result in the denial of the staff's LPS Outpatient Designation application and/or LPS Outpatient Designation privileges.

I attest to each statement by placing my *INITIALS* next to each item below:	
	The applicant has read and reviewed WIC 5150 and WIC 5585 and he/she has read and understood the document and is ready to take the 5150/5585 training and exam.
	The applicant meets the minimum DHCS educational and/or work experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment.
	The applicant is in a position that requires LPS Outpatient Designation.
	I will ensure the applicant will uphold basic ethical standards essential to the fulfillment of their responsibilities carried out in the application for their authority for involuntary detention.
	I have reviewed with the applicant our program's policies and procedures regarding involuntary detentions.
	I have reviewed the steps the applicant must take before, during and after they have completed an involuntary detention.
	I will review each involuntary detention written by the applicant and will provide feedback and further instructions if needed.
	I will provide continued supervision and oversight to applicant regarding involuntary detention.
	I will ensure that the applicant will respect and protect client confidential information, in accordance with applicable legal and regulatory standards.
	I will ensure that the applicant will perform their duties in a manner that demonstrates an understanding of each client's personal dignity.
	I will ensure that the applicant will demonstrate the highest standards of personal integrity in all work-related activities carried out in the application of their authority for involuntary detention.

I acknowledge that, if at any time I feel the applicant should not continue with their LPS Outpatient Designation, I will inform QMS IDSS. I acknowledge that involuntary detention authority may also be withdrawn without cause at any time by QMS IDSS on behalf of the HCA BHS Director.

Signature of Service Chief/Program Director | **Service Chief/Program Director Print Name** | **Date**

Print HCA Program Manager Name | **Print HCA Division Manager or Assistant Deputy Director**