County/Direct Provider Approver Certification

DHCS Approved (DHCS use only)	
Date	**Approver**

For Access to Confidential DHCS Drug Medi-Cal Information Data

County: _____
(County Name and Code)

Direct Provider: _____
(Direct Provider Name and Four Digit DMC Number(s)

To ensure the confidentiality of county/direct provider Drug Medi-Cal (DMC) data, the Department of Health Care Services (DHCS) requests the County AOD Administrator or Direct Provider Executive Officer designate a primary and a secondary contact to be responsible for approving county/direct provider staff requests for access to confidential patient data in the Short-Doyle/Medi-Cal Claims system. Please complete the information below and fax this form to (916) 323-0653. If you have questions about this form, please call (916) 323-2043.

Primary Approver:

First Name: _____ Last Name: _____

Title: _____

Phone Number: (____) _____ Fax Number: : (____) _____

Email Address: _____

Primary Approver's Signature: _____
(Signer acknowledges having read the attached Confidentiality Statement for all DHCS AOD users of the ITWS)

Secondary Approver:

First Name: _____ Last Name: _____

Title: _____

Phone Number: (____) _____ Fax Number: : (____) _____

Email Address: _____

Secondary Approver's Signature: _____
(Signer acknowledges having read the attached Confidentiality Statement for all DHCS AOD users of the ITWS)

Appointed Vendor(s): (If applicable)

The vendor listed below has the authority to receive, send and process the above named county/direct provider's confidential DHCS Drug Medi-Cal information in the Short-Doyle / Medi-Cal Claims system. The vendor will establish its own primary and secondary approving contacts.

Vendor Name: _____

Vendor Contact Name: _____ Phone Number: (____) _____

DHCS AOD Administrator/Executive Officer Certification:

As the AOD Administrator or Executive Officer for _____ (County/Direct Provider), I designate the above individuals and vendor, if applicable, to have independent authority to approve access requests to specific confidential Drug Medi-Cal patient data. DHCS may rely on approvals, denials, and changes made by the above individuals/vendor in its processing of access requests to this county/direct provider's data in the systems listed above. As changes occur to the above approving contacts or vendor information (name, phone, e-mail, or fax), I will sign an updated certification and forward it to DHCS. Also, I acknowledge reading the Confidentiality Statement for all DHCS AOD users of the ITWS.

_____ _____

DHCS AOD Administrator/Executive Officer (signed and printed) Date