State of California — Health and Human Services Agency

Department of Health Care Services
CalOMS
MS 2603
PO Box 997413
Sacramento, CA 95899-7413

CalOMS Tx ITWS Vendor Approver Form

For Granting Access to the CalOMS Treatment Data System

DHCS Approved	
Date	Approver

Vendor (System) Name: _____

To ensure the confidentiality of county/direct provider CalOMS Treatment data, the Department of Health Care Services (DHCS) requires that each designated vendor identify a primary and a secondary contact to be responsible for approving requests for ITWS access to confidential county/direct provider confidential patient data in the CalOMS Treatment data system. Please complete and fax this form to DHCS at (916) 322-7117. If you have questions about this form, please call (916) 327-3010 or e-mail CalOMSHelp@DHCS.ca.gov.

Please print all information

Primary Vendor (User):

First Name: _____ Last Name: _____

Title: _____

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

Email Address: _____

Primary Approver's Signature: _____
(Signer acknowledges having read the Confidentiality Statement to Users of the Information Technology Web Services (ITWS).)

Secondary Vendor (User):

First Name: _____ Last Name: _____

Title: _____

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

Email Address: _____

Secondary Approver's Signature: _____
(Signer acknowledges having read the Confidentiality Statement to Users of the Information Technology Web Services (ITWS).)

Vendor Access for the Following Counties/Direct Providers:

(Please indicate the six digit provider ID for each provider the vendor is requesting access to in order to upload and submit CalOMS Tx data)

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

NOTE: This form is not valid unless the County/Direct Provider has approved vendor access to their data. Form DHCS 5099 should accompany this form.

Vendor Executive Officer Approver:

I hereby certify that this organization is a vendor for the above-named counties/direct providers and designate the individuals identified above to have independent authority to approve ITWS access requests to specific confidential county/direct provider CalOMS Treatment patient data. DHCS may rely on approvals, denials, and changes made by these individuals in its processing of access requests for the above listed counties'/direct providers' data. As changes occur to the above approving contacts (name, phone, e-mail or county/direct provider), I will complete a new certification and fax it to DHCS. Also, I acknowledge reading the attached Confidentiality Statement to Users of the Information Technology Web Services (ITWS).

By: _____ (signed and printed) **Date**: _____

Title: _____