State of California
Health and Human Services Agency

Department of Health Care Services

County Approver Certification & Vendor Appointment Form
For Access to Mental Health **Client and Services Information (CSI)** System

County Name: _____

To ensure the confidentiality of county mental health data, the Department of Health Care Services, requests the county behavioral health director designate two contacts to be responsible for approving county (and vendor, if applicable) staff requests for access to the confidential patient data in the CSI system.

Please complete the information below and email the signed form to MHSData@dhcs.ca.gov. The email must be sent from the signer's (Behavioral Health Director's) email account. If you have any questions, please email to MHSData@dhcs.ca.gov.

Approver I:

First Name: _____ Last Name: _____

Title: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Approver II:

First Name: _____ Last Name: _____

Title: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Appointed Vendor(s): (If applicable)
The vendor listed below has the authority to receive, send and process the above named county's confidential mental health information in the **CSI** system. (The designated county approvers will approve vendor access requests)

Vendor Name: _____

Vendor Contact Name: _____ Contact Email Address: _____

County Behavioral Health Director Certification:
I, the undersigned (check all that apply):

☐ Designate the above county individuals to have independent authority to approve access requests to the CSI system. DHCS may rely on approvals, denials, and changes made by the above individuals in its processing of access requests to this county's data in the CSI system. As changes occur to the above approving contacts or vendor information, I will sign an updated certification and forward it to DHCS.

☐ Appoint the above vendor to have authority to receive, send and process the above named county's confidential mental health information in the CSI system.

_____ _____
County Behavioral Health Director (Signature) Date

_____ _____
County Behavioral Health Director (Print Name) County Behavioral Health Director (E-mail address)