

**County Approver Certification Form**

For Access to the Department of Health Care Services **Short-Doyle Medi-Cal Department of Alcohol and Drug Programs (SDMC-ADP) 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 staff requests for access to the confidential data in SDMC-DMH system.

Please complete the information below and email the signed form to [MedCCC@dhcs.ca.gov](mailto:MedCCC@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 [MedCCC@dhcs.ca.gov](mailto:MedCCC@dhcs.ca.gov).

<b>Approver 1:</b>	
First Name: _____	Last Name: _____
Title: _____	
Phone Number: _____	Fax Number: _____
Email Address: _____	
Signature: _____	Date: _____

<b>Approver 2:</b>	
First Name: _____	Last Name: _____
Title: _____	
Phone Number: _____	Fax Number: _____
Email Address: _____	
Signature: _____	Date: _____

**County Behavioral Health Director Certification:**

I, the undersigned designate the above county individuals to have independent authority to approve access requests to the **Short-Doyle Medi-Cal Department of Alcohol and Drug Programs (SDMC-ADP) 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. As changes occur to the above approving county contacts, I will sign an updated certification and forward it to DHCS.

By submitting this form, any previous approvers will be deleted.

County Behavioral Health Director Signature	Date
County Behavioral Health Director Name	County Behavioral Health Director Email Address