5150/5585 LPS Outpatient Confirmation Form

Completion of this form is required to take the 5150/5585 LPS Outpatient Designation Exam

Initial Designation: ☐ **Re-Designation:** ☐ **County:** ☐ **County-Contracted:** ☐

Division: Please Select

Provider Information

Full Name (Last, First): ______________________ **Maiden Name:** ______________

Job Title: ______________________ **Program Name:** ______________________

Email: ______________________ **Phone:** ______________________

License Type (below): **Lic./Reg.#:** ______________________

- ☐ Associate Clinical Social Worker (ASW)
- ☐ Associate Marriage & Family Therapist (AMFT)
- ☐ Associate Professional Clinical Counselor (APCC)
- ☐ Licensed Clinical Social Worker (LCSW)
- ☐ Licensed Marriage & Family Therapist (LMFT)
- ☐ Licensed Professional Clinical Counselor (LPCC)

☐ Mental Health Rehabilitation Specialist/
Mental Health Specialist (MHS)
Psychiatric/Mental Health Nurse Practitioner
Psychiatrist
Psychologist (PsyD/PhD)
Registered/Waivered Psychologist
Registered Nurse* (RN) *BH Experience Required

Provider Confirmation/Attestation ☐

By checking this box, I attest I have completed the prescribed 5150/5585 LPS Outpatient Designation training to initiate and/or discontinue 5150/5585 involuntary holds as a provider within Orange County Behavioral Health Services on this date: ______________. I understand that if I receive 5150/5585 privileges from the County and terminate employment with the Agency or transfer programs, my 5150/5585 privileges are terminated and I will not have authority to initiate or discontinue 5150/5585 involuntary holds in Orange County and must surrender my designation card to my immediate supervisor.

Provider Signature: ______________________ **Date:** ______________

Service Chief/Program Director/Division Manager Information & Recommendation

Full Name (Last, First): ______________________

Email: ______________________ **Phone:** ______________________

HCA Program Manager Name: ______________________

I recommend ______________________ for 5150/5585 LPS Outpatient Designation privileges. I attest this provider has taken the required 5150/5585 LPS Outpatient Designation training and is ready to take the exam. I understand that I am responsible for providing continued oversight, guidance and monitoring of this provider while they are employed by Orange County Behavioral Health Services.

By checking this box, I attest the individual listed above has shadowed an LPS Outpatient Designated individual for 3 months and is now ready to take the exam. Start Date at Program: ______________. **(For First Time Designation Only)**

By checking this box, I attest the individual listed above was previously designated within the last 30 days. The previous LPS Designation Card has been returned and a copy of the hold has been provided.

Signature/Title: ______________________ **Date:** ______________

Service Chief/Program Director: Please submit a digital passport style photo of the provider, a copy of the provider's employee ID badge, a copy of the Training Certificate of Completion along with this completed/signed form to AQISDesignation@ochca.com