

CALOCUS/LOCUS User Account or Termination Request		
Fill in the following fields on the form below (asterisk (*) means required field.)		
Originator of Request:		
1.* Print Last Name:	2.*Print First Name:	3.Middle:
User Information:		
4.*Last Name:	5.*First Name:	6.Middle:
7. *Telephone Number :()	8. * Job Title:	
9. *Email Address:		
10. *Organization Name:		
11.*Organization Address:		
12.*City:	13. *State:	14. *Zip Code:
* Check all that apply		
15. <input type="checkbox"/> Create Login ID	16. <input type="checkbox"/> Terminate Login ID	
17. <input type="checkbox"/> I request access to LOCUS	18. <input type="checkbox"/> I request access to CALOCUS	
*User: Check the box that applies to your job title:	To be completed by DMH Authority:	
	*Check box for User Access Levels	
	24. <input type="checkbox"/> View Individual Patient Data	
19. <input type="checkbox"/> Clerical Administrative	25. <input type="checkbox"/> Perform Evaluations with an Active Occurrence	
20. <input type="checkbox"/> Clinician/Practitioner	26. <input type="checkbox"/> Perform Evaluations with any Occurrence	
21. <input type="checkbox"/> Supervisor	27. <input type="checkbox"/> Edit Patient Demographic data	
22. <input type="checkbox"/> Program Manager	28. <input type="checkbox"/> Edit Evaluations	
23. <input type="checkbox"/> Clinical Director/CEO	29. <input type="checkbox"/> Edit Patient Files	
30. <input type="checkbox"/> *I By Checking this box certify my signature, and agree to not share my login password or private health information in accordance to HIPAA rules, regulations and privacy.		
----- (Signature) CALOCUS/LOCUS User	----- Date: mm/dd/yyyy	
----- (Signature) Provider Agency Supervisor or Designated Authority	----- Date: mm/dd/yyyy	
----- (Signature) Lead Trainer	----- Date: mm/dd/yyyy	
----- (Signature) DMH Designated Authority	----- Date: mm/dd/yyyy	
Email Request to DMH Provider Relations Representative: Fax Request to: 202-673-4305 joycelyn.alleyne@dc.gov		
SEE BACK OF FORM FOR INSTRUCTIONS.		

INSTRUCTIONS TO FILL OUT CALOCUS/LOCUS FORM

1. Enter Originator of request: Supervisor/Designated Authority last name.
2. Enter Supervisor/Designated Authority first name.
3. Enter Supervisor/Designated Authority middle initial (optional).
4. Enter User last name (the user requesting access to CALOCUS/LOCUS).
5. Enter User first name.
6. Enter User middle initial (optional).
7. Enter User office telephone number.
8. Enter User job title.
9. User Email Address.
10. Enter Name of Agency or Organization.
11. Enter Agency or Organization Street address.
12. Enter Agency or Organization city.
13. Enter Agency or Organization state or district.
14. Enter Agency or Organization zip code.
15. Check box to request a User name and password for access to CALOCUS/LOCUS.
16. Check box to terminate a User name and password.
17. Check box to request access to LOCUS.
18. Check box to request access to CALOCUS.
19. – 23. Check the box that applies to User job title.
24. – 29. CALOCUS/LOCUS Access Levels to be completed by DMH Authority.
30. Check box to certify User signature, and User agreement of HIPAA rules.