APPLICATION TO ACCESS APS PORTAL

Please complete all parts of this application, review Parts E, F, and G, sign and return to the address listed at the end of this application. Upon completion and submission of the attestation form, you may go directly to the Care Connection website at https://c3.apshealthcare.com to access Health Risk Assessments. Please allow at least five (5) days for your application to be processed.

PART A: TYPE OF APPLICATION
☐ New User
☐ Edit Existing User
☐ Delete User

PART B: USER CONTACT INFORMATION		
Last Name:	First Name:	
Organization Name:		
Address:		
City:	State:	Zip Code:
Email Address:		
Phone:		
Fax:		
Desired Username:		

PART C: FACILITY/BUSINESS TYPE
☐ Advocacy Organization
☐ Community Based Adult Services (CBAS)/Adult Day Health Center (ADHC)
☐ Clinician's Office (i.e., PCP, Specialist)
☐ Participating Provider Group, Medical Group, IPA, etc.
☐ Hospital
☐ In Home Supportive Services (IHSS)
☐ Member/Member's Authorized Representative*
☐ Multipurpose Senior Services Program (MSSP)
☐ Nursing Facility
☐ Therapeutic Provider's Office (i.e., Physical, Occupational, Respiratory Therapists, etc.)
☐ Other (please specify):

L.A. Care HEALTH PLAN®

PART D: USER ROLE AT FACILITY/BUSINESS

- ☐ Administrator (i.e., Office Manager, PPG management, etc.)
- ☐ Care Manager
- ☐ Clerical Support Staff
- ☐ Clinician (i.e., PCP, Specialist)
- ☐ Clinical Care Coordinator
- ☐ Discharge Planner
- ☐ Medical Assistant
- ☐ Member/Member's Authorized Representative*
- ☐ Nurse
- ☐ Social Worker
- ☐ Therapeutic Provider (e.g., Physical, Occupational, Respiratory Therapists, etc.)
- ☐ Other (please specify):

PART E: PURPOSE

The APS Portal ("Portal") is provided as a service of L.A. Care Health Plan to Interdisciplinary Care Team (ICT) members for the purpose of providing member care, including conducting quality assessment or improvement activities, case management or care coordination. **Any other use of the Portal is strictly prohibited**.

The Portal is maintained by L.A. Care Health Plan and/or its agents. It may be used for business purposes only. Any other use is strictly prohibited.

PART F: RESTRICTIONS

Submission of this application does not guarantee access approval. Access is subject to review and approval of this application by L.A. Care. The Care Connection website is the sole property of APS Healthcare Bethesda, Inc., which provides administrative services to L.A. Care.

Use of the Portal is limited to the user noted on this application, for the purpose noted in Part E above, and is subject to all of the terms and conditions established by L.A. Care Health Plan. Only an ICT member should use the Portal.

Users may not share usernames and passwords with any other person or entity. Access may be revoked at any time, including for violation of any of the terms and conditions governing use of the Portal, the Purpose and Attestation contained within this application, or any other requirement established by L.A. Care Health Plan.

Users are restricted to accessing and sharing only the amount of information needed to perform a permitted treatment, payment, or health care operations activity.

Users or their agents must notify L.A. Care Health Plan or L.A. Care Health Plan's agent within 24 hours after which access is no longer needed, including changes related to employment termination or role change. Accounts will be disabled after 30 days of inactivity.

The information provided via this Portal may **not** contain all information related to the diagnosis or treatment provided to a member. Due to state and federal privacy and confidentiality laws, certain information has been excluded from this Portal. In order to obtain the most recent and comprehensive information related to a member's health, users or the member's provider should speak with the member, i.e., the patient, to ensure that all relevant information is considered when rendering care.

Prior to submitting this form, the organization (i.e., agency, hospital, facility, etc.) must determine who may make requests via the Portal. The decision should be made by the appropriate agent within the user's organization. It is not the responsibility of L.A. Care or its agent to verify that the user has the appropriate authority. Submission of this form will imply that the user has the authority to act on behalf of the organization.

Please review the attestation on Page 4 (Part G) and sign and date the signature block noted in Part H.

PART G: ATTESTATION
I certify that the information provided on this application is accurate. I am an authorized member of an ICT and am requesting access for the purposes outlined in Part E above. I understand that inappropriate access to, or disclosure of, this information may be a violation of federal or state law and may be subject to disciplinary action by both L.A. Care and federal or state authorities, including but not limited to, termination of Portal access. I understand and acknowledge that L.A. Care Health Plan and its agents may monitor any activity on the Portal. I also understand L.A. Care Health Plan and its agents may retrieve any information stored within the Portal. By registering and using the Portal, I am expressly and knowingly giving my consent to monitor my activity on the Portal. I also give my consent to retrieve any information stored on the Portal. I, individually, and as an authorized representative of aforementioned organization, agree that I will access and use the information available through the Portal only for the purpose outlined in Part E above. I will use reasonable precautions with respect to protecting the security of unique logins and the privacy and security of the data within the Portal. By signing this request, I agree to adhere to all security and privacy regulations (as mandated by HIPAA and other applicable state and federal requirements) when using the Portal. I understand and acknowledge that any use of the Portal other than as specifically described herein will be reported to L.A. Care Health Plan and may result in termination of my rights to use the Care Connection website. By signing below and using the Portal, I am certifying that I agree to the Portal's privacy policy and terms and conditions, and all other conditions delineated herein or established by law, regulation or L.A. Care Health Plan governing the Portal or use or disclosure of L.A. Care member information.

PART H: SIGNATURE
Today's Date
Signature:
*If signed by the member's authorized representative, please provide relationship to member and include documentation of authority (e.g., Power of Attorney, guardianship, etc.) with this application:

RETURN APPLICATIONS TO THE ADDRESS BELOW

Return completed and signed applications to:
L.A. Care Health Plan
Provider Portal Oversight
Fax #: 213-438-5792
E-mail: ppo@lacare.org