

MACOMB COUNTY COMMUNITY MENTAL HEALTH
FOCUS SOFTWARE SYSTEM

ACCESS REQUEST **Enrollment, Change, Dis-enrollment**

Note: All requests for FOCUS Access must be submitted by an authorized supervisor

SYSTEM ACCESS REQUESTED FOR:

First Name:		Last Name:	
Phone:	Fax:		
E-Mail Address:			
Job Title:		Date of Hire	

Agency Name and Department/ unit (Be specific as to contract working unit)

Functions: Please place "X" in one or more boxes as needed:

(Administrative [] Billing [] Clerical [] Clinical [] Clinical (without need for FOCUS user id) [] Supervisor [])

Applicable to CLINICAL STAFF only:

Degree and Date of Graduation (Required):

State of MI License(s)
(If no License please report years of post degree experience)

NPI number (required for all Licensed staff)	DEA number (Physicians only)
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The Organization/Responsible person MUST notify MCCMH immediately once the staff person's need to access FOCUS changes. This includes but is not limited to:

Employment status: termination, temporary leave, change in duties, transfer of Dept or (units)
Contact information: Change in phone number, fax number or e-mail or location address
License status change / Expiration
Name Change

REQUESTING SUPERVISOR, Title and Department:

Name:	
Phone:	Fax:

Supervisor Signature: _____ Date: _____

My Signature attests that all information above is accurate and complete to the best of my knowledge.

Please submit to FOCUSAccessRequest@mccmh.net or Fax at 586-469-7958