MACOMB COUNTY COMMUNITY MENTAL HEALTH
FOCUS SOFTWARE SYSTEM
ACCESS REQUEST

REQUIRED: ☐ Enrollment ☐ Change ☐ Disenrollment

SYSTEM ACCESS REQUESTED FOR:
Note: All requests for FOCUS Access must be submitted by an authorized supervisor

First Name: **REQUIRED**	Last Name: **REQUIRED**	
Email Address: **REQUIRED**	Phone: **REQUIRED**	Fax:
Job Title: **REQUIRED**	Date of Hire: **REQUIRED**	Date of Termination: **REQUIRED IF MARKED BELOW*)**

Functions: Please place an "X" in one box: **REQUIRED**
(1) Billing: Only staff who will submit bills through FOCUS
(2) Clerical: Non-clinical staff who will enter authorizations, admissions/discharges, insurance policies, etc.
(3) Clinical: All medical and clinical staff who you will bill for, AND will enter/view data in FOCUS
(4) Clinical (without need for FOCUS user id): All medical and clinical staff who you will bill for, but will NOT enter/view any data in FOCUS
(5) Supervisor: Not used by MCOSA

Agency Name & All Locations/Provider IDs
REQUIRED (AGENCY NAME & COMPLETE ADDRESS WHERE SERVICES WILL BE PROVIDED)

Clinical Staff ONLY:

Degree (Required): **n/a**	**Graduation Date (Required); (Month/Date/Year): n/a**

State of MI License(s) – name and number, Issue Date and Expiration Date(s): Clinical staff without a license must report years of post-degree experience
REQUIRED FOR ALL CLINICAL AND MEDICAL STAFF: LICENSE NUMBER, ISSUE DATE, EXPIRATION DATE

NPI number (if applicable): **REQUIRED FOR MD/DO, NP, PA**	**DEA number** **(Physicians only)**
SUD Credential (Required): **REQUIRED IF STAFF HAS CAADC OR OTHER**	**Expiration Date (Required); (Month/Date/Year):** **REQUIRED IF STAFF HAS CAADC OR OTHER**

The responsible supervisor MUST notify MCOSA immediately when a staff person's FOCUS profile needs updating. These updates include the following:

Change in Employment Status:
☐ Termination* – date required above if applicable
☐ Temporary leave **n/a**
☐ Change in duties **n/a**
☐ Transfer of Location

Contact Updates:
☐ Change in phone number **n/a**
☐ Fax number **n/a**
☐ E-mail
☐ License status change / Expiration
☐ Name Change (include previous name)

Requesting Supervisor's Name:
REQUIRED

Title & Department: **REQUIRED**	**Phone:** **REQUIRED**	**Fax:**

Supervisor Email Address:
REQUIRED

My Signature attests that all information above is accurate and complete to the best of my knowledge.
Supervisor Signature: REQUIRED **Date: REQUIRED**

SUD: Please submit to mcosa@mccmh.net or Fax at 586-469-5568