

**MACOMB COUNTY COMMUNITY MENTAL HEALTH  
FOCUS SOFTWARE SYSTEM  
RECOVERY SERVICES ACCESS REQUEST**

**Enrollment**       **Change**       **Disenrollment**

**SYSTEM ACCESS REQUESTED FOR:**

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

First Name:	Last Name:	
Email Address:	Phone:	Fax:
Job Title:	Date of Hire:	Date of Termination:

**Staff Listing (check all that apply):**

- Directly providing service (Peer, Case Manager, House Monitor, etc.)
- Data entry (clerical/administrative)

**“X” Agency Location:**

- |   |   |
|---|---|
| <input type="checkbox"/> CARE – Peer Recovery<br><input type="checkbox"/> CARE – Case Management<br><input type="checkbox"/> CARE – IPS<br><input type="checkbox"/> CARE – Older Adult<br><input type="checkbox"/> Eastland House<br><input type="checkbox"/> Else-Willard ¾ Living | <input type="checkbox"/> Grace Recovery House<br><input type="checkbox"/> Hollywood House<br><input type="checkbox"/> Kim K Just 4 Today Stay<br><input type="checkbox"/> Live-Rite Properties<br><input type="checkbox"/> Peake Recovery<br><input type="checkbox"/> _____ |
|---|---|

**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/resignation
- Temporary leave

**Contact Updates:**

- Change in phone number
- Fax number
- E-mail
- Name Change (include previous name)

**Requesting Supervisor’s Name:**

Title:	Phone:	Fax:
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**Supervisor Email Address:**

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

**Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

Please submit to [mcosa@mccmh.net](mailto:mcosa@mccmh.net) or Fax at 586-469-5568; **ALL REQUESTS MUST BE IN WRITING.**