MACOMB COUNTY COMMUNITY MENTAL HEALTH - MCOSA
FOCUS SOFTWARE SYSTEMACCESS 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****

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

1. **Billing:** Staff who will submit claims through FOCUS.
2. **Clerical**: Non-clinical staff who will enter/view authorizations, admissions/discharges, insurance policies, etc.
3. **Clinical:** All medical and clinical staff who you will bill for their services, 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 their services so need listed in the system, but will NOT enter/view data in FOCUS.
5. **Case Manager:** Case Manager that you will bill for their services, but will not enter/view data in FOCUS.
6. **Peer:** Peer Coach that you will bill for their services and will enter/view data in FOCUS.
7. **Peer (without need for FOCUS user ID):** Peer Coach that you will bill for their services, so need listed in the system, but will not enter/view data in FOCUS.
8. **Recovery Home:** Any Home staff who will enter/view data in FOCUS.

Agency Name & All Locations/FOCUS 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/Development Plan: **REQUIRED WHEN APPLICABLE**	**Expiration Date (Required); (Month/Date/Year):** **REQUIRED WHEN APPLICABLE**

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**
☐ Transfer of Location ***this would be a "change" request**

Contact Updates:
☐ 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. ***ALL REQUESTS MUST BE IN WRITING!***