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| MACOMB COUNTY COMMUNITY MENTAL HEALTH - MCOSAFOCUS SOFTWARE SYSTEM 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: |
| **Functions: Please place an “X” in one or more boxes as needed**: [ ] Billing [ ] Clerical [ ] Clinical [ ] Clinical **(without need for FOCUS user id)**  [ ]  Case Manager [ ]  Recovery Home [ ] Peer [ ] Peer **(without need for FOCUS user id)** |
| **Agency Name & All Site Locations:** |
| **Clinical Staff ONLY:**  |
| **Degree:** | **Graduation Date (Month/Date/Year):**  |
| **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 |
| **NPI number (if applicable):**  | **DEA number (Physicians only)** |
| **SUD Credential and/or Development Plan:** | **Expiration Date(s) (Month/Date/Year):** |
| **The responsible supervisor MUST notify MCOSA immediately when a staff person’s FOCUS profile needs updating/ended. These updates include the following:**  |
| **Change in Employment Status:** [ ] Termination [ ] Transfer of Location | **Contact Updates:** [ ] E-mail [ ] License status change / Expiration[ ] Name Change (include previous name) |
| **Requesting Supervisor’s Name:** |
| **Title & Department:**  | **Phone:** | **Fax:** |
| **Supervisor Email Address:**  |
| **My Signature attests that all information above is accurate and complete to the best of my knowledge.****Supervisor Signature: Date:**  |
| SUD: Please submit to mcosa@mccmh.net. ***ALL REQUESTS MUST BE IN WRITING!*** |