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| MACOMB COUNTY COMMUNITY MENTAL HEALTH - MCOSA  FOCUS 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](mailto:mcosa@mccmh.net). ***ALL REQUESTS MUST BE IN WRITING!*** | | | | | | |