MACOMB COUNTY COMMUNITY MENTAL HEALTH
FOCUS ACCESS REQUEST

TYPE OF REQUEST (select one): ◯ **Enrollment** ◯ **Change** ◯ **Disenrollment**

Is this request for clinical access *without* a FOCUS ID? (e.g., for billing purposes) ◯ **Yes** ◯ **No**

Note: All requests must include a Job Description for the Requested User

① FOCUS USER INFORMATION:

User Type: [ ] MCCMH Direct Operated [ ] Contract Network Provider [ ] MCCMH Business Associate
[ ] Other (please describe):
NOTE: Please refer to instructions for a description of required supporting documentation

First Name:	Last Name:
Phone:	Fax:
E-Mail Address:	
Job Title: Job Description Attached: [ ] Yes [ ] No **NOTE**: requests will not be processed without a job description	② **Effective Date of Access Change** (Hire / Transfer / Location Change / Disenrollment):

③ AGENCY NAME AND PROVIDER ID:

④ PROFESSIONAL CREDENTIALS (Required for CLINICAL STAFF only):

Degree and **Date** of Graduation [**MM/DD/YYYY**]:

State of MI License(s)

NPI number **(required for all Masters Level Providers)**	DEA number (Physicians only)

⑤ CREDENTIALING AND PRIVILEGING (C&P): (please select the applicable level)

[ ] Direct Staff / Interns (excl. volunteers) C&P required prior to obtaining FOCUS access

[ ] Peer Support – Part 1 Limited, predominantly "read only" access; C&P required prior to obtaining access

[ ] Peer Support – Part 2 Full clinical access & ability to bill; Part 1 training complete

[ ] Crisis Center Volunteers Background check and volunteer training complete

[ ] Contract Network Provider

Has the applicable credentialing/privileging process completed? **[ ] Yes [ ]No**

⑥ AUTHORIZED REQUESTER
Name:_____ Title and Department: _____

Phone:	Fax:

⑦ FOCUS SUPERVISOR:

⑧ AUTHORIZED REQUESTOR ATTESTATION:

- I am an Authorized Requestor with respect to the Requested User;
- This form requests "Appropriate Access" to EPHI for the Requested User, which means that it is the amount of access which is minimally necessary to perform their job responsibilities, and is consistent with MCCMH policy;
- The Requested User has received appropriate HIPAA training;
- The Requested User will have adequate supervision to ensure that their access is consistent with that which has been deemed "Appropriate Access," and ensure that unauthorized access to EPHI is avoided;
- I have obtained any required approval from the Deputy Director and/or the Office of Compliance; ***AND***
- ***I have attached the appropriate supporting documentation to this Access Authorization Form***:
  - ***Job description (MCCMH Staff & Providers; Contract Network Providers)***
  - ***Business Associate Agreement / Contract / Work Order (as appropriate and/or requested)***

Authorized Requester Signature: Date:

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

⑨ FOCUS USER ACKNOWLEDGEMENT:
Signature:_____ Date: _____

Please submit requests to FOCUSAccessRequest@mccmh.net
Please indicate the type of request in the email or fax cover sheet subject line (see instructions for examples)

⑩ NOTES: (attach additional pages, if necessary)

MACOMB COUNTY COMMUNITY MENTAL HEALTH
FOCUS SOFTWARE SYSTEM
ACCESS REQUEST FORM INSTRUCTIONS
please allow at least 2-weeks for processing

General Instructions:

- When Required: This form must be completed in full and submitted for processing in any of the following events:
  - New FOCUS access required (new hire, change in position, etc.)
  - Access level modification (more or less access needed due to change in position, change in location, etc.)
  - User demographic information change (name, phone number, email, other contact information)
  - License status change / expiration (clinical staff)
  - Employment status change (termination, temporary leave, return from leave)
- How to Send: All requests should be forwarded via email to FOCUSAccessRequest@mccmh.net.
  - The subject line of the email or the fax cover sheet should indicate the type of request (e.g., "NEW ACCESS", "ACCESS CHANGE", "USER DEMOGRAPHIC CHANGE", "DISENROLLMENT REQUEST", "RE-ENROLLMENT REQUEST", etc.)

① **FOCUS User Information**.
Please provide complete information regarding the requested FOCUS User that is the subject of the request.
Supporting Documentation Requirements:

- Job Description required with all FOCUS access requests
- Business Associate Agreements and underlying contract/job order required for business associates
- "Other" requests will require written support requested by the MCCMH Office of Compliance

Consistent with MCCMH policy, all access requests for business associates or other third-party (non-MCCMH, non-Contract Network Provider entities) will require approval from the MCCMH Office of Compliance.

② **Effective Date of New Access / Access Change.**
Please provide the effective date of the requested access change. For example: (i) the effective date for a new non-provider MCCMH employee would be the hire date; (ii) the effective date for a new provider MCCMH employee would be the date of the credentialing and privileging approval (iii) the effective date for a contract network provider would be the date this form is submitted; (iv) the effective date of changed access based on a transfer to a new department or a change in job functions would be the effective date that the transfer or change in job functions actually occurred.

③ **Entity Name and Provider ID**.
Please provide the entity name and provider ID - please be specific as to contract working unit**.**

④ **Professional Credentials**.
Clinical staff (MCCMH Direct Operated and Contract Network Providers) must provide the requested details concerning their professional credentials.

⑤ **Credentialing and Privileging**.
Please select the level of privileging and credentialing required for the requested FOCUS User, and verify that the C&P process is complete. Note that requests will not be processed until credentialing and privileging is completed. If the process is not complete at the time of submission of this form, it is the Authorized Requestor's responsibility to send notification email to FOCUSAccessRequest@mccmh.net with "[Requested FOCUS User's Name] - C&P Complete" in the subject line.

⑥ **Authorized Requester Information**.
Authorized Requesters are only those individuals who have been designated as such, pursuant to MCCMH Policy. For guidelines on "Authorized Requesters", please refer to MCCMH MCO Policy 10-442 for Direct Operated Program Management (including MCCMH staff, providers, business associates, etc.), and to MCCMH MCO Policy 3-016 for Contract Network Providers. **Requests will not be processed unless they are submitted by the appropriate Authorized Requester**.

⑦ **FOCUS Supervisor**.
Please identify the individual who, after this request is processed, will be listed in FOCUS under the User Record as the requested FOCUS User's supervisor.

⑧ **Authorized Requester Attestation**.
Authorized Requesters are required to sign the Access Request Form, and attest to the accuracy and completeness of the form, as well as to their agreement with the points articulated in this section. False attestations violate MCCMH policy, and will subject the requesting individual to investigation and potential corrective or disciplinary action, as appropriate and consistent with MCCMH policy.

⑨ **FOCUS User Acknowledgement**.
The individual who is obtaining new or changed FOCUS access must sign to acknowledge the request.

⑩ **Notes**.
Please provide any additional information necessary to accurately process the request, attaching any helpful or required information or documentation.

INCOMPLETE REQUESTS WILL NOT BE PROCESSED