MACOMB COUNTY CMH - SUBSTANCE USE DEPARTMENT FOCUS SOFTWARE SYSTEM ACCESS REQUEST **Enrollment** (new staff; add *new/additional* location) **Disenrollment** (remove staff) – must provide last date of employment. Change (change locations, function, license) – must indicate the change in section D. A. System Access Requested For: First Name: Last Name: Email Address: Phone: Fax: Job Title: Date of Hire: Date of Disenrollment: B. Functions: Please place an "X" in the appropriate box(es) as applicable (you must select at least one): Claims Mgmt. staff Peer Coach Clinical/Medical (without User ID) Clerical staff Peer Coach (without User ID) Clinical/Medical staff ☐ Intern (must have LMSW as Supervisor) Recovery Home Clinical with ASAM permission* Clinical with GAIN permission* SUDHH staff Supervisor name: Intern (without need for User ID) SUDHH (without User ID) *must include Certificate of Completion Supervisor name: Agency Name & All Site Locations You Are Requesting Access For: C. Clinical/Medical Staff ONLY **Highest 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 MCBAP Development Plan: **Expiration Date(s) (Month/Date/Year):** D. The responsible supervisor MUST notify MCCMH-SUD immediately when a staff person's FOCUS profile needs updating/ended. These updates include the following: **Change in Employment Status: Contact Updates:** ☐ Termination/Resignation ☐ E-mail Transfer of Location License/MCBAP status change/Expiration Change in Staff Role (from/to Name Change (include previous name) Requestor/Supervisor Name: Title: Phone: Email: My Signature attests that all information above is accurate and complete to the best of my knowledge. Signature: SUD: Please submit form to mcosa@mccmh.net. ALL REQUESTS MUST BE IN WRITING!