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
☐ Clerical staff
☐ Recovery Home
☐ SUDHH Staff
☐ Peer Coach
☐ Peer Coach **(without need for User ID)**
☐ Intern (must have LMSW as Supervisor)
Supervisor name: _____
☐ Clinical/Medical **(without need for User ID)**
☐ Clinical/Medical staff
☐ Clinical with ASAM permission*
☐ Clinical with GAIN permission*
**must include Certificate of Completion*

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 MCOSA immediately when a staff person's FOCUS profile needs updating/ended. These updates include the following:

Change in Employment Status:
☐ Termination/Resignation
☐ Transfer of Location
☐ Change in Staff Role (from/to_____)

Contact Updates:
☐ E-mail
☐ License/MCBAP status change/Expiration
☐ 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: **Date:**

SUD: Please submit form to **mcosa@mccmh.net.** ***ALL REQUESTS MUST BE IN WRITING!***