# County of Santa Cruz - Behavioral Health

# New Hires, Changes and/or Deactivated Employees – MHE 10

**Supervisor / designee must provide NPI# & Hire Date on form before any processing can be started**

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| Section 1: General Information |
| [ ]  New Hire;       Date of Hire (Complete Section 1& 2) [ ]  Change       Date of Change (Complete Section 1& 2)  Briefly explain reason for the change:      [ ]  **Deactivate** **Date** (**Complete Section 1)**; Be sure you fill-in 9, 9a. & 9b. and briefly explain deactivation:       |
| **(All questions must be answered in the far right column with Yes / No / NA / or written Answer)** |
| 1. Team or Division  |  |
| 2. Individual **NPI #** (National Provider Identifier) *can be obtained via their website: nppes.cms.hhs.gov* |  |
| 3. Individual NPI **Taxonomy,** such as Psychiatry - 2084P0800X; Clinical Social Worker - 1041C0700X; Counselor MH 101YM0800X |  |
| 4. Employee First Name |  |
| 5. Employee Last Name  |  |
| 6. Employee Middle Name or Initial *(optional)* |  |
| 7. Email Address (work email address) |       |
| 8. Access to MH, SUD or Both |  |
| 9. County Job Description |  |
| 9a. Supervisor of other staff*? If YES, list first and last name of all staff this person supervises here:*  | NO [ ]  YES [ ]   |
| 9b. If this is a **deactivate request for a supervisor,** provide the first and last name of the Avatar user who will now supervise the staff listed above in 9a.  |  |
| 10. Name of another Employee who does same job |  |
| 11. Any Specialty Access Required? *i.e. reports, document scanning, transcribing, access to agency calendars, ability to reset user passwords, etc.* | **[ ]  Yes [ ]  No**  |
| 12. Name of Supervisor |  |
| 13. Practitioner? (Yes or No) *Answer Yes, if seeing clients, writing progress notes & assessments in Avatar.* | **[ ]  Yes** **[ ]  No** |
| **If “no” to Practitioner skip Section 2 and go to Section 3.** **If “yes” to Practitioner complete Section 2 before going to Section 3.** |
| **Section 2: Practitioner Information** |
| 1. Using calendar(s)? [ ]  No [ ]  Yes If yes, allow practitioner to see other practitioner calendars? [ ]  No [ ]  Yes |
| 2. Gender |  |
| 3. Date of Birth |  |
| 4. Office Address, City, Zip Code |  |
| 5. Office Phone Number |  |
| 6a. Ethnicity 6b. Languages Spoken *(other than English)* |  |
| 7. Social Security Number *(required for DHCS Compliance/Auditing)* |  |
| 8. Practitioner Licensed, Certified or Registered? (yes or no) **If YES,** attach copies of all that applies and complete **Items 11 – 16**. **If NO,** skip to #15and then complete **#15 & #16.** |  |
| 9. Practitioner Category for Coverage |  |
| 10. License / Certification / Registration Authority ***(if other than State of California)*** |  |
| 11. **License# or Certification#,** or **Registration#** |  |
| 12. Effective Date for License, Certification, or Registration *(from date)* |  |
| 13. Expiration Date for License, Certification, Registration |  |
| Section 2 (continued): Practitioner Information |
| 14. Is the Practitioner a Prescriber? Yes [ ]  No [ ]  If yes, complete all information on next line: DEA Number       Expiration Date       Degree       Year of Degree      **15**. Does Employee need a waiver form? [ ]  YES [ ]  NO If yes, choose, which type of license waiver & provide the BBS# below)License Waiver  **Number w/BBS**:       OR License Waiver for Psychologist [ ]  **Number**:       Does employee need application to apply for a **Mental Health Rehabilitation Specialist**? **Yes [ ]  No [ ]** **License Waiver forms & MHRS application may be obtained from the Quality Improvement Division of MHSAS by calling 454-4971**

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| **16**. Program Association **#1** (refer to list of Programs for your Team/Reporting Unit; specify “All Programs” for your Team/Reporting Unit (if applicable.) |             |
|  Program Association **#2** |       |
|  Program Association **#3** |       |
|  Program Association **#4** |       |
|  Program Association **#5** |       |
|  Program Association **#6**  |       |
|  *If more than 6 individual Programs, list the rest of them here and separate with commas* |       |

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| Section 3: CoMPUTER APPLICATION ACCESS |
| **[ ]** AVATAR **[ ]** EPIC [ ]  Order Connect [ ]  SCHIE **[ ]** OWA [ ]  HSD Server [ ]  MEDS Default Network Printer Name       County Network Shared Drives:MHCLINSHR [ ]  SUBSTANCE ABUSE **[ ]** MHCLERSHR [ ]  MHQASHR **[ ]** Other or Additional shared areas/configuration requests:       **Budget Index:**        |
| Sections 1- 3 Completed By:       Date Completed:      **Notes/Comments:**       |
| Section 4: CoMPleted by County MHSAS DATA PROCESSING COORDINATORS |
| Avatar Practitioner ID#:       Avatar Username:       User Roles Assigned:       Date Entered:       Entered By:       Copy Routed to QI:       Hiring Supervisor Notified:      Notes/Comments:       |