# 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**   |  |  | | --- | --- | | **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* |  | | |
| 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: | |