# County of Santa Cruz - Behavioral Health

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

**Submit to HSA\_BHCredenetialing@santacruzcountyca.gov**

**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 (Complete Section 1 & 2); Date of Hire        Practitioner (*check Practitioner* if *seeing clients, writing progress notes & assessments in Avatar)* Complete Sections 1,2,3  Change       Date of Change (Complete Section 1 & 2) Briefly explain reason for the change:  Deactivate       Date (Complete Section 1); Be sure 9, 9a. & 9b. are filled-out and briefly explain deactivation: | | |
| **(All questions must be answered in the far right column with Yes / No / NA / or written Answer)** | | |
| 1. Employee First Name | |  |
| 2. Employee Last Name | |  |
| 3. Employee Middle Name or Initial *(optional)* | |  |
| 4. Date of Birth | |  |
| 5. Individual **NPI #** (National Provider Identifier) *can be obtained via their website: nppes.cms.hhs.gov* | |  |
| 6. Individual NPI **Taxonomy** [Find Your Taxonomy Code | CMS](https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/health-care-taxonomy) | |  |
| 7. Team or Division | |  |
| 8. Access to BH, 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 | |  |
| **If not a Practitioner skip Section 2 and complete Section 3**  **If yes a Practitioner complete Section 2 and Section 3** | | |
| **Section 2: Practitioner Information** | | |
| 1. Using calendar(s)?  No  Yes If yes, allow practitioner to see other practitioner calendars?  No  Yes | | |
| 2. Email Address (work email address) | |  |
| 3. Social Security Number *(required for DHCS Compliance/Auditing)* | |  |
| 4. Gender | |  |
| 5a. Ethnicity 5b. Languages Spoken *(other than English)* | |  |
| 6. Office Address, City, Zip Code | |  |
| 7. Office Phone Number | |  |
| 8. Is Practitioner Licensed, Certified or Registered? (yes or no – NOTE that “registered” includes ASW, AMFT & APCC candidates who have applied for their Associates # with the BBS) **If YES, attach copies of all documents that apply – for Associates with application on file with BBS, attach the Associate’s application** | | **Yes  No** |
| 9. Practitioner is a Clinical Trainee (unlicensed / non-waivered enrolled in graduate degree program working towards LPHA licensure post graduation) | | **Yes  No** |
| 9a. Clinical Trainee Name of Supervising LPHA: | | |
| 9b. Clinical Trainee Graduate School / Program: | | |
| 10. Practitioner Category for Coverage |  | |
| 11. License / Certification / Registration Authority ***(if other than State of California)*** | |  |
| 12. **Provide** **License, Certification** or **Registration Number A**ttach copy to the MHE 10 | |  |
| 13. Effective Date for License, Certification, or Registration *(from date)* | |  |
| 14. Expiration Date for License, Certification, Registration | |  |
| Section 2 (continued): Practitioner Information | | |
| 15. Is the Practitioner a Prescriber? Yes  No  If yes, complete all information on next line:DEA Number       Expiration Date       Degree       Year of Degree **16**. 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 BH by calling 454-4468**   |  |  | | --- | --- | | **17**. 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 hsA-BH DATA PROCESSING COORDINATORS | | |
| Avatar Practitioner ID#:       Avatar Username:  User Roles Assigned:  Date Entered:       Entered By:       Copy Routed to QI:  Hiring Supervisor Notified:  Notes/Comments: | | |