# 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**

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| **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* |       |

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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 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:       |