**County of Santa Cruz Behavioral Health Department**

Contracting Agency Avatar User-Practitioner Request Form MHE 87

Submit this form and required documents with an email to [HSA\_BHCredentialing@santacruzcounty.us](mailto:HSA_BHCredentialing@santacruzcounty.us)

For detailed instructions on how to fill out this form, follow the link below, or go to the [Santa Cruz County Avatar Webpage](http://www.santacruzhealth.org/hsahome/hsadivisions/behavioralhealth/avatarresources.aspx). Link to instructions: [**http://www.santacruzhealth.org/Portals/7/Pdfs/Avatar/MHE87Instructions.pdf**](http://www.santacruzhealth.org/Portals/7/Pdfs/Avatar/MHE87Instructions.pdf)

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| Section 1: General Information | |
| New Hire Date of Hire:       (Complete Sections 1-3)  Practitioner (C*heck if Practitioner is* *seeing clients, writing progress notes & assessments in Avatar.)*  Change Date:      (Complete Sections 1 & 2) Briefly explain reason for the change(renewal, location, lic, new supervisor):  Deactivate Date:      (Complete Section 1); Be sure 9, 9a. & 9b. are filled-out and briefly explain deactivation: | |
| **(All questions in applicable sections must be answered in the far right column with Yes / No / NA / or written Answer)** | |
| 1. Contract Employee First Name |  |
| 2. Contract Employee Last Name |  |
| 3. Contract Employee Middle Name or Initial *(optional; if user has a common name, please try to add a middle name to avoid confusion with other Avatar users)* |  |
| 4. Date of Birth |  |
| **If user is a practitioner, do not submit form unless user has an NPI number and an ACCURATE Taxonomy code. Verify NPI/Taxonomy at:** <https://npiregistry.cms.hhs.gov/>. **Create an NPI or Update Taxonomy at:** <https://nppes.cms.hhs.gov/#/> | |
| 5. Individual **NPI Number** |  |
| 6. Individual NPI **Taxonomy** |  |
| 7. Agency, Team and/or Division |  |
| 8. Access to BH, SUDS or Both |  |
| 9. 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**  **Other:** |
| 12. Name of Supervisor(s) |  |
| 13. Email Address (work email address) |  |
| **Section 2: Practitioner Information** | |
| 1. Using Avatar calendar(s)?  No  Yes If yes, allow practitioner to see other practitioner calendars?  No  Yes | |
| 2. Social Security Number *(required for DHCS Compliance/Auditing)* |  |
| 3. Gender |  |
| 4. Ethnicity |  |
| 5. 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) **If YES, attach copies of all that apply. Form will not be processed without these.** | **Yes  No** |
| 9. Practitioner Category for Coverage |  |
| 10. License / Certification / Registration Authority (e.g. California BBS or CCAPP) |  |
| 11. **Provide** **License, Certification,** or **Registration Number Attach copy to your email** |  |
| 12. Effective Date for License, Certification, or Registration *(initial date of licensure)* |  |
| 13. Expiration Date for License, Certification, Registration |  |
| 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 contract-provider staff need Waiver Application?**  **NO**  **YES**  **If YES check one from below. The appropriate waiver form will be sent to you as soon as possible:**  AMFT  ASW  APCC  Psychologist Assoc.  Other: | **16.** **Is an application for Mental Health Rehabilitation Specialist (MHRS) needed?**  NO  YES  If yes, one will be sent via email. | | | **17**. Program Association **#1** (Refer to the list of Programs for your Team/Programs) | |  | | 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**  **Other:** | |
| MHE 87 Completed By:       Ph. No. of person completing form:       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:  Date Hiring Supervisor Notified:  Notes/Comments: | |