YOLO COUNTY ALCOHOL, DRUG & MENTAL HEALTH DEPARTMENT

AVATAR Account Request Form

*This form is used to request activation, modification or deactivation of an AVATAR account for the ADMH MIS system. It must be filled out completely by a **Supervisor or Manager.***

DATE OF REQUEST: _____

Type of Action: ☐ Activate (Add) ☐ Modify ☐ Deactivate Effective Date: _____

User Type: *(Select only One)*

☐ Intern *(if ADMH intern, check this box too ➔➔)* ☐ Yolo Co. ADMH Employee *(Permanent or Extra-Help)*

☐ Provider *(CBO, Managed Care, Institutional)* ☐ Contractors/Temps *(Contractors providing in-house services, e.g., Kelly Services.)*

Name of Person Submitting Request: _____ **Signature:** _____

Agency/Organization Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone No.:** _____

User's Name: *(Last Name, First Name, MI)* _____ **Phone No.:** _____

Primary Office Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Registration Date: _____ **Deactivation Date:** _____ **Reason:** _____

Job Function(s):

☐ **Billing**
☐ **Support Staff**
☐ **Quality Management**
☐ **Nurse/Physician**
☐ **Intern**

☐ **Clinician** ***(Choose type of Clinician below)***
- ☐ Alcohol & Drug
- ☐ Mental Health
- ☐ Both

☐ **Supervisor** ***(Choose type of Supervisor below)***
- ☐ Clinical
- ☐ Billing
- ☐ DUI
- ☐ Other (Specify) _____

Clinician Availability: *Please indicate your work location(s), circle the days, show the hours that you are scheduled to work at the location(s)*

Location: _____ **M T W Th F Hours—From:** _____ ☐ AM ☐ PM **to** _____ ☐ AM ☐ PM
Location: _____ **M T W Th F Hours—From:** _____ ☐ AM ☐ PM **to** _____ ☐ AM ☐ PM
Location: _____ **M T W Th F Hours—From:** _____ ☐ AM ☐ PM **to** _____ ☐ AM ☐ PM
Location: _____ **M T W Th F Hours—From:** _____ ☐ AM ☐ PM **to** _____ ☐ AM ☐ PM

PC Tag Number: _____ *(MHE-xxx) This number is on a sticker somewhere on your computer CPU*

* CalOMS Providers Only

☐ CalOMS – Cache Creek ☐ CalOMS – CommuniCare ☐ CalOMS – Progress House ☐ CalOMS – Walter's House

** These roles are only for Outside Provider personnel entering CalOMS information.*

Does User Provide Direct or Indirect Services? ☐ **Yes** ☐ **No**

If **Yes,** please provide **Practitioner ID Number:** _____

Note: If user provides direct or indirect services, but does not have a Practitioner ID number, please also complete **"AVATAR Practitioner ID Request form"**.

Is Practitioner an Intern or Temporary Employee? ☐ **Yes** ☐ **No**

If **YES**, please enter **Deactivation Date:** _____

Note: If no Deactivation Date is entered, temporary activation will be limited to sixty (60) days as default.

ADMH Use Only

Required ADMH HIPAA Training Completed: _____ _____

DATE QUALITY MANAGEMENT STAFF SIGNATURE: