ANASAZI REQUEST FORM (ARF) – MENTAL HEALTH PROGRAMS

MENTAL HEALTH MANAGEMENT INFORMATION SYSTEM (MHMIS)

FAX FORM TO MHMIS UNIT: 858-467-0411 or

SCAN AND EMAIL TO BHS-AccountRequest.HHSA@sdcounty.ca.gov

ALL FORMS MUST BE COMPLETE AND TYPED OR THEY WILL BE RETURNED.

[1] USER TYPE REQUEST

☐ New User ☐ Modify Current User*(see [8] below)

Anasazi Staff ID#

Citrix Staff ID

☐ Terminate User; Termination Date:

Anasazi Staff ID#

Citrix Staff ID

[2] PROGRAM INFORMATION

☐ County Staff ☐ Non-County Staff

Program Name:

LE/Parent Org:

User Job Title:

Employment Start Date:

[3] USER INFORMATION

* If Name Change, please use new name below and enter previous name here:

First Name: MI: Last Name: Work Phone: Ext:

Primary Work Street Address: Last 5 of SSN:

City: State: Zip: User Work Email:

[4] MENU GROUP None

Will this user need to complete or view Client Plans? ☐ Yes ☐ No

Will this user need to complete or view Progress Notes? ☐ Yes ☐ No

Will this user need other types of access? ☐ Yes ☐ No If yes, specify:

[5] UNIT/SUBUNIT ACCESS (LIST ALL UNITS AND SUBUNITS TO WHICH USER REQUIRES ACCESS)

Unit:	Subunit(s):	Unit:	Subunit(s):
Unit:	Subunit(s):	Unit:	Subunit(s):
Unit:	Subunit(s):	Unit:	Subunit(s):

[6] CREDENTIAL & CERTIFICATION INFORMATION

☐ No Credential – Administrative Staff

OR Select Credential: Unlicensed Blank OR Select Credential: Licensed Blank

License or Registration # state of issuance NPI # TAXONOMY #

If User is a Medicare certified provider, provide PTAN and effective date:

[7] LANGUAGES SPOKEN

Language #1: Language #2: Language #3: Language #4 :

[8] *COMMENTS (what is changing?):

[9] PROGRAM CONTACT INFORMATION (FOR MHMIS QUESTIONS)

First Name: Last Name: Work Email: Phone:

[10] USER ACCESS AUTHORIZATION

User Signature: _____

First Name: Last Name: Date:

Pursuant to the contractual agreement on file with the County of San Diego and as designated by my corporate office, I am authorizing access as noted above and affirm that I have personally reviewed the County's Summary of Policies with the above user.

Authorizing Program Manager Signature: _____

First Name: Last Name: Date:

MHMIS Unit Only: ☐ Anasazi ☐ CSRF ☐ NPI ☐ SESA EFFECTIVE DATE: Staff ID: