CMHCM **CIGMMO** Access Request

User name: _____

Provider: _____

Supervisor: _____

Type of access requested - select one:

Billing *Select this option for billing access.* *Phone training to be provided by Payables team.*	**Clinical** *Select this option if the user is a licensed provider staff who enters documentation for services directly into CIGMMO, even if they are a supervisor. Training required and scheduled once credentials verified.*
PCP/Chart View *Select this option if the user views consumer charts, trains on person-centered plans (PCP), and/or uploads documents. No formal training provided or required.*	**Clinical Supervisor** *Select this option if the user is a clinical supervisor of provider staff and will only view consumer charts and enter consultation notes in CIGMMO. Training required and scheduled once credentials verified.*
Home Manager *Select this option if the user enters and manages Specialized Residential documentation and reports in CIGMMO. No formal training provided or required.*	**Direct Care Worker** *Select this option if the user will be entering Specialized Residential documentation in CIGMMO. No formal training provided or required.*

ABA Transcription *Select this option if the user will be data entering autism forms to be signed by an ABA clinician.*

A signed CMHCM Computer Use Agreement MUST accompany <u>all</u> access requests

Please complete the following information for **_Clinical staff_** requesting access:

Start Date: _____

Professional License: _____

Other Credentials (QBHP, CMHP, QMHP, QIDP): _____

NPI: _____

Degree: *(highest achieved – check one)*

Physician Medical	Bachelor's Degree
Doctorate	Associate's Degree
Master's Degree	High School Diploma

Please send completed form and signed CMHCM computer use agreement to:
CMHCM Provider Network Team providernetwork@cmhcm.org