

## CMHCM CIGMMO Access Request

User name: \_\_\_\_\_

Provider: \_\_\_\_\_

Supervisor: \_\_\_\_\_

### Type of access requested - select one:

<p><b>Billing</b></p> <p style="text-align: center;"><i>Select this option for billing access. Phone training to be provided by Payables team.</i></p>	<p><b>Clinical</b></p> <p style="text-align: center;"><i>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.</i></p>
<p><b>PCP/Chart View</b></p> <p style="text-align: center;"><i>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.</i></p>	<p><b>Clinical Supervisor</b></p> <p style="text-align: center;"><i>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.</i></p>
<p><b>Home Manager</b></p> <p style="text-align: center;"><i>Select this option if the user enters and manages Specialized Residential documentation and reports in CIGMMO. No formal training provided or required.</i></p>	<p><b>Direct Care Worker</b></p> <p style="text-align: center;"><i>Select this option if the user will be entering Specialized Residential documentation in CIGMMO. No formal training provided or required.</i></p>
<p><b>ABA Transcription</b></p> <p style="text-align: center;"><i>Select this option if the user will be data entering autism forms to be signed by an ABA clinician.</i></p>	<p><b>Autism Administration</b></p> <p style="text-align: center;"><i>Select this option if the user needs access to everything in the PCP/Chart View plus the ability to add non-billable notes.</i></p>

**\*\*A signed CMHCM Computer Use Agreement MUST accompany all 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 | <input type="checkbox"/> | Bachelor's Degree   | <input type="checkbox"/> |
| Doctorate         | <input type="checkbox"/> | Associate's Degree  | <input type="checkbox"/> |
| Master's Degree   | <input type="checkbox"/> | High School Diploma | <input type="checkbox"/> |

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