AVATAR

COUNTY OF SOLANO
USER AUTHORIZATION REQUEST

Date of Request: _____

County Staff Billing ID #: _____

Please check all that apply:

- ☐ Contract Staff
- ☐ County Staff
- ☐ Initial Authorization
- ☐ Training (UAT System)
- ☐ Change/Update Authorization
- ☐ Deactivate Account
- ☐ Reactivate Account
- ☐ Citrix Remote Access Required

Last Name: _____ First Name: _____ Middle Initial: _____

Program Name (where staff works): _____ Phone: _____ - _____ - _____ Ext: _____

Program Address (include city & zip): _____

Company/Work E-mail: _____

Supervisor's Name: _____ Phone: _____ - _____ - _____ Ext: _____

Supervisor's Email: _____

Add Reporting Units	
Remove Reporting Units	
County Staff: List Programs for Calendar Access	

Please check appropriate box(es) below:

OUTSIDE CONTRACT AGENCIES	
☐ Mental Health	Support Staff: ☐ Yes ☐ No Practitioner: ☐ Yes ☐ No
☐ Substance Abuse	Enter Program Name: _____ (Corp. Office Name)

COUNTY AGENCIES (*ONLY* County Employees Below This Line)					
Mental Health Roles					
☐	MH CLERICAL, *LIST PROGRAM(S):*			**ADD-ON ROLES**	
☐	MH CLINICAL LICENSED	☐	MH MA ICC (FF, VJO and VV)	☐	MH ADMINISTRATOR
☐	MH CLINICAL REGISTERED	☐	MH MANAGER/SUPERVISOR	☐	MH INPATIENT
☐	MH CLINICAL TRAINEE	☐	MH MEDICAL	☐	HOSPITAL LIASION
☐	MH CLINICAL UNLICENSED	☐	MH MEDICAL ICC	☐	KTA MGMT
				☐	MH MSO (BATCH CLOSING)
Substance Abuse Roles					
☐	SA CLERICAL	☐	SA CLINICAL	☐	SA MANAGER/SUPERVISOR
☐	SA MSO	☐	SA HR360	☐	SA AUTHS
Managed Care Roles					
☐	MSO CLAIMING	☐	MSO CLERICAL	☐	MSO CLINICAL
☐	MSO PROVIDER RELATIONS	☐	MH MANAGED CARE (MSO)		
Billing / Fiscal / MHICC / Quality Improvement Roles					
☐	BILLING	☐	FISCAL	☐	MH ICC (FHS ICC)
☐	QI CLERICAL	☐	QI CLINICAL	☐	QI TXPLANOVERRIDE

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COMPUTER SECURITY AGREEMENT

1. I understand that as part of my job assignment I will be accessing Avatar using a password that I create. I further understand that the data I access is confidential and will be handled in compliance with all applicable regulations including HIPAA and the California Welfare & Institution § Code 5328 and that I must lock my computer or use a secured screen saver while away from my workstation.
2. I understand that my password is confidential and that I am not authorized to reveal it to anyone or to put it in writing. I understand that breaching this confidentiality may result in disciplinary action.
3. I understand that this password is part of my "electronic signature" and that any system actions taken using it will be presumed to have been entered with my authorization. I further understand that I will be held responsible for these actions. They will be used in evaluating my job performance and may be used as evidence in any disciplinary or legal actions that the County may choose to take if it is determined that my password has been utilized to fraudulently access confidential data.
4. I understand that I have the responsibility to change my password at any time if I suspect that the confidentiality of my current one may have been compromised. I will notify my supervisor/manager in writing if I suspect my password has been compromised.

Employee Signature: _____ Date: _____

*** **Remember to attach copy of Acceptable Use Policy and EHR Confidentiality Agreement** ***

Need Avatar installed?	□ Yes	□ No
Program Supervisor:	□ Approved	□ Denied

Program Supervisor Signature: _____ Date:_____

County QI/Manager Authorization Level:	□ Approved	□ Denied	
Audit:	□ Silent Audit OK	□ Full Audit	
Data Warehouse Access	□ Yes	□ No	
System Code:	□ MH	□ SA	□ Both
Workflow – Notification Users	□ Yes	□ No	

Choose one category if Workflow Notification is Yes:

□ Provider Authorization Request -(SA) SA Authorizers
□ MH Users that Cosign - (MH) MH Clinician License
□ MH Provider Authorization Request - (MH) QI

Is Acceptable Use Policy Signed?	□ Yes	□ No (access denied)
Is EHR Confidentiality Agreement Signed?	□ Yes	□ No (access denied)
Need Avatar installed?	□ Yes	□ No

County QI/Manager Signature: _____ Date:_____

*** **NETWORK AND CITRIX ACCESS** ***

□ QI Create county network account and grant access to Citrix Desktop for Avatar

Date: _____

ISD Ticket #_____

Send Original MHS Request Form(s) to:
Mental Health Quality Improvement Unit
Attn: Sheila Roberts
275 Beck Avenue, MS 5-250
Fairfield, CA 94533

Send Original DAS Request Form(s) to:
Substance Abuse Support Staff
Substance Abuse Division
2101 Courage Drive, MS 10-100
Fairfield, CA 94533

User Name:_____ System Code: _____ User role:_____

User, Supervisor & QI Notified ☐ **YES** ☐ **NO**

Citrix Requested ☐ **YES** ☐ **NO**

Date: / /

IT Tech Initials Verifying Setup Completed: _____

Rev. 9/12/2014e