St. Clair County Community Mental Health Authority

Request to Create, Modify or Delete a Form

Date: _____

Person, Department or Committee Requesting Change: _____

Type of Request *(Please list only 1 form per form):*

☐ New Form *(Attach draft of form, preferably word document)*

☐ Temporary Form

☐ Annual Review

☐ Modify Form Form #: _____ Form Name: _____

☐ Delete Form Form #: _____ Form Name: _____

Purpose of Request *(Check all that apply):*

☐ New Program, Project, Initiative ☐ Policy or Process Change

☐ New/Updated Language *(i.e., CARF, Legal, MDHHS, etc.)*

Additional Information/Comments:

Requested Time Frame:

☐ ASAP (24 hours) ☐ High (48-72 hours) ☐ Medium (1 week) ☐ Low (2-3 weeks)

Date Needed by: _____

Please email completed request to "Forms Committee" email group (FormsCommittee@scccmh.org)

Forms Committee Use Only

☐ Approved ☐ Denied Date of Decision: _____ Decision Made By: _____

Explanation if Denied/Modified:

Can the requested form be made into an OASIS module? ☐ Yes ☐ No
Document has been added to the EHR Scan Guide Document? ☐ Yes ☐ No