

Application to Be an OWITS EHR User

Application and Program Details

If you are interested in applying to become a user of the Oregon Web Infrastructure for Treatment Services (OWITS) behavioral health Electronic Health Record (EHR), please complete the application form below.

Return completed applications to:

By Mail:

Health Systems Division
Oregon Health Authority
Attn: Justin King
500 Summer St. NE, E86
Salem, OR 97301-1118

By Email:

owits.support@state.or.us

By Fax:

(503) 945-6199

This application will be reviewed within one month of receipt.

Approved providers will be trained on the use of the OWITS EHR.

If this application is approved, Health Systems Division (HSD) staff will send an acceptance notification by email.

If this application is not approved, HSD staff will send a letter with an explanation regarding any unmet requirements within one month of application receipt. Additional guidance will be made available to help the agency become qualified for OWITS EHR use.

For additional information, visit

<http://www.oregon.gov/oha/amh/mots/Pages/owits.aspx> or email us at the address above.

Thank you for your interest in this program. We look forward to working with you in our collaborative efforts to build a healthier Oregon.

Sincerely,

The OWITS Team



www.oregon.gov/OHA

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Agency and Staff Information

Name of Agency: _____

Number of Facilities or Locations: _____

List Cities and/or Counties in which Facilities are Located:

Applicant Name: _____ Role: _____
(Person filling out application) (Clinician, Director, Staff, etc.)

Applicant Phone: () - Applicant Fax: () -

Applicant Email: _____

Contact Name: _____ Role: _____
(Primary contact for OWITS EHR) (Clinician, Director, Staff, etc.)

Contact Phone: () - Contact Fax: () -

Contact Email: _____

Preferred Communication Method(s)

Phone Fax Email
Best Time to Call: _____

Approximate Number of Users Requiring OWITS Access: _____

Average number of clients served monthly _____

Agreement and Signature

I understand that this application is subject to approval and that it does not constitute a contract. I agree that the business and technical requirements (on Page 5) will be met by or before the time that the agency will participate in formal OWITS training.

Applicant Signature: _____ Date: ____ / ____ / ____
(A typed signature is acceptable.) MM DD YY

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Provider Services List

What services are provided by this agency? Check all that apply.
(This data is requested for survey purposes. Detailed service information will be collected later.)

<input type="checkbox"/>	—	Alcohol or Drug Abuse Prevention Programs (Expected to be included Winter 2014)
<input type="checkbox"/>	—	Alcohol or Drug Addiction Treatment – Outpatient <input type="checkbox"/> Children <input type="checkbox"/> Adolescents <input type="checkbox"/> Adults <input type="checkbox"/> Seniors
<input type="checkbox"/>	—	Alcohol or Drug Addiction Treatment – Residential / Inpatient <input type="checkbox"/> Children <input type="checkbox"/> Adolescents <input type="checkbox"/> Adults <input type="checkbox"/> Seniors
<input type="checkbox"/>	—	ATR (Access to Recovery)
<input type="checkbox"/>	—	Detoxification
<input type="checkbox"/>	—	DUII Information / Education / Treatment Programs
<input type="checkbox"/>	—	Mental Health Involuntary Commitments
<input type="checkbox"/>	—	Mental Health Crisis Services
<input type="checkbox"/>	—	Mental Health Treatment – Outpatient <input type="checkbox"/> Children <input type="checkbox"/> Adolescents <input type="checkbox"/> Adults <input type="checkbox"/> Seniors
<input type="checkbox"/>	—	Mental Health Treatment – Residential / Inpatient <input type="checkbox"/> Children <input type="checkbox"/> Adolescents <input type="checkbox"/> Adults <input type="checkbox"/> Seniors
<input type="checkbox"/>	—	Methadone Maintenance
<input type="checkbox"/>	—	Other (please specify): _____

Additional Agency Information

Please check all that apply.

This provider agency is...	
<input type="checkbox"/>	— ...currently submitting MOTS data to HSD.
<input type="checkbox"/>	— ...currently receiving behavioral health funds directly from AMH, via a Local Mental Health Authority (LMHA), or from a Community Mental Health Program (CMHP).
<input type="checkbox"/>	— ...licensed and/or certified by HSD to provide behavioral health services.

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OWITS Requirements

Please verify that your agency can meet the following requirements.

Business Requirements

Use of OWITS will involve dedicated time and effort from staff members.

Agencies using OWITS will be required to:

- Assign a Program Director to support the agency staff members who will be using OWITS.
- Assign at least one person plus one backup to maintain contact with OWITS Support and MOTS Support staff.
- Commit to provide Addictions & Mental Health (HSD) with input regarding agency business and reporting needs.
- Commit at least two (or 20%, whichever is greater) of proposed initial OWITS users with adequate computer skills (primarily data entry and web navigation) to “train-the-trainer” instruction.
- Commit the “train-the-trainer” participants to share the instruction with the rest of the agency/facility proposed OWITS users.
- Commit at least one staff member with adequate computer skills (beyond basic data entry and web navigation) plus one backup to serve as the agency’s OWITS system administrator. This may require additional training time.
- Dedicate at least 15% of one clinical staff member’s time over a 1-3 month period for system setup, business process documentation, and additional training as needed.

Technical Requirements

To use OWITS, at least one computer must be available with the following specifications:

- Microsoft Internet Explorer, version 10 or better, or other modern web browser such as Chrome, Firefox, Safari, or Opera.
- Broadband Internet access (cable, DSL, T1, etc.)
- 1GB RAM or more
- Monitor with a resolution of 1024x768 or better