

GEORGIA COLLABORATIVE ASO STAFF UPDATE FORM
Only to be completed by approved DBHDD providers requesting a Staff Update

This form is used to make modifications to provider information maintained by the Georgia Collaborative ASO (Collaborative) for the Department of Behavioral Health and Developmental Disabilities (DBHDD) provider system. This form must be submitted along with the additional documentation listed below:

1. **Clinical Director:** Current resume and copy of professional license
2. **Developmental Disabilities Director (DD):** Current resume and [IDD Director Attestation](#) form which can be found on the GA Collaborative ASO website at www.georgiacollaborative.com under forms.
3. **Developmental Disabilities Professional (DDP):** Current resume and [IDD Professional Attestation](#) form which can be found on the GA Collaborative ASO website at www.georgiacollaborative.com under forms.
4. **Behavioral Support Consultant (BSC) and/or Behavioral Support Specialist (BSS):** Current resume, evidence of specialized training/education and professional license/certificate
5. **Registered Nurse (RN):** Copy of professional license
6. **Chief Executive Officer:** Copy of Secretary of State (SOS) registration that indicates current CEO name
7. **Clinical Services Supervisor:** Current resume

This form must be signed and dated by an authorized representative of the agency attesting to and authorizing the requested changes. Return this form with any necessary attachments via e-mail to GA_enrollment@beaconhealthoptions.com or mail to:

GA Collaborative Enrollment
P.O. Box 56324
Atlanta, GA 30343

Provider Information (Required)			
Agency Name:		Taxpayer ID#:	
Address:			
Update Employee Information (Check the one that applies) Add Delete (Please complete additional form if requesting both changes)			
Chief Executive Officer	Georgia Owner	Corporate Owner	Site Contact Person
Behavioral Health Clinical Director	Clinical Services Supervisor	Developmental Disabilities Director	Developmental Disabilities Professional
Developmental Disabilities Agency Nurse	Agency Contact Person	Behavioral Support Consultant	Behavioral Support Specialist
New Name:			
Phone Number:		Email Address:	
Attestation Statement (Required)			
I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of material information may subject me to liability under civil and criminal law.			
Authorized Representative's Name (print):		Title:	
Authorized Representative's Signature:		Date:	
Phone Number:		Email Address:	