Department of Mental Health
Contract Provider Access Request Form

Updated: 10/26/2009

☐ New ☐ Change ☐ Revoke User ID

PART 1 User Information (please print clearly)

Fields marked with an asterisk (*) must be completed.

*Last Name ____________________ *First Name ____________________ Mid Initial ______

*SSN ____________________ User ID ____________________ (User ID Required for Change or Revoke)

*Email Address ____

*Provider Name ____

*Phone # ____________________

*Provider Number(s) ____________________ (Primary Provider) ____________________ ____________________

____________________ ____________________ ____________________

Division (check all that apply)

☐ ADA ☐ CPS ☐ DD

PART 2 Confidentiality Statement

I, the undersigned, a designated representative of the provider named above, understand that the approval and assignment of the requested ID or change enables me to access the Department of Mental Health Information Systems. I understand that Federal and State laws require confidentiality of the Department of Mental Health information and provide penalties for unauthorized access, use, or disclosure of this information. I agree to keep confidential all information made available to me through this access. I also agree not to divulge or share my password with anyone.

I agree to use the information obtained through these systems for purposes directly connected with the administration of a federal/state assisted program which provides assistance in cash or in kind, or services, directly to individuals on the basis of need. I further agree to comply with the policies and procedures established by the Department of Mental Health further governing the access and use of this information.

Violations or disclosures on my part may result in loss of access to the information systems, civil court action, or cancellation of the provider contract with the Missouri Department of Mental Health.

User Signature ____________________ Date __________

Local Security Coordinator ____________________ Date __________

Central Office Use Only

Request Completed by ____________________ Date __________

Send completed form to OIS Security Coordinator, DMH Central Office.

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Name ________________________

PART 3 Production Systems Information

Check all system accesses required and indicate whether access should be Added or Removed.

Add	Remove	System Name	Purpose
		POS - Purchase of Service	payments
		CIMOR – Consumer Information Management, Outcomes & Reporting (complete Part 4) Training	
		CAFAS - Child & Adolescent Functional Assessment Scale (complete Part 5)	

PART 4 CIMOR Training______

PART 5 CAFAS___________

ADDITIONAL DATA REQUEST

Department of Mental Health
Contract Provider Access Request Form

Updated: 10/26/2009

Name ________________________

Instructions for Completing Form

Type of Request

- New = no previous access requested
- Change = current User ID requires name, level, division, or provider change, additional system(s) access or remove system(s) access
- Revoke = current User ID no longer needs access to DMH systems

Part 1 User Information

New Request

- Complete full Name and SSN.
- Check which type of employer
- Complete Provider Name and 7-digit Primary Provider Number for access.
- If access is needed to additional Providers, indicate other Provider Numbers required.
- Check which Division is appropriate for your access.
- SDC Netname must be completed by the local Security Coordinator.

Change Request

- Complete full Name, SSN, and User ID.
- Complete Provider information to be changed, if appropriate.
- Complete Division if changed.

Revoke Request

- Complete full Name, SSN, and User ID of user accesses to be revoked.

Part 2 Confidentiality Statement

- Complete the entire form, read the confidentiality statement, sign the form, and forward it to the local provider or division Security Coordinator for approval.
- Division or Provider Security Coordinator must send the completed form to the DMH Central Office, OIS Security Coordinator.
- Upon completion of the access request, the OIS Security Coordinator will sign and date the form.

Part 3 Production Systems Information

Complete this section if access to production systems is being requested. Note that some data accesses require approval from another source prior to OIS approval. The OIS Security Coordinator will verify that proper sources have given approval prior to processing the request.

New Request

- Indicate all system accesses required by checking in the Add column.

Change Request

- Indicate system accesses to be Added or Removed by checking in the appropriate column.

Part 4 CIMOR Training

Complete this section if requesting CIMOR Training.

Part 5 CAFAS

Complete this section if requesting CAFAS.

Department Central Office Security Coordinators

ADA	Jodi Haupt
CPS	Tom Rehak
MRDD	Gary Schanzmeyer
Admin	Mike Clark, Rick Klebba
ITSD	Michelle Yahnig

Additional Data Request