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| --- | --- |
| **Full Name:** | |
| **Position Title:** | |
| **Organization:** | |
| **Address:** | **Telephone Number:** |
| **E-mail address:** | |

|  |  |  |
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| **New User**   **Change in Access**  **Termination of Access** | | |
| **Service Population(s):** | **Developmental Services**  **Brain Injury (BI)**  **Other Related Conditions** **(ORC)** | **Mental Health Services**  **Children’s Services** |
| **EIS Profile needed**  ***Please check all that apply*** | **Community Case Manager**  **Reportable Event Entry**  **Provider Authorization (SAS)**  **Employment Data**  **PCP (Person Centered Plan)** | **Care Coordinator (BI/ORC)**  **Home Support (BI/ORC)**  **Other** |
| **Confidentiality Statement:**  *By signing this form, you agree that to the extent that the Provider seeks to use, access, maintain, or disclose information in the EIS system that actually or reasonably could identify an individual or consumer receiving benefits or services from or through the Department (“Protected Information”), the Provider agrees to a) maintain the confidentiality and security of such Protected Information as required by applicable state and federal laws, rules, regulations and Department policy, b) contact the Department within 24 hours of a privacy or security incident that actually or potentially could be a breach of Protected Information and c) cooperate with the Department in its investigation and any required reporting and notification of individuals regarding such incident involving Protected Information.*  **Specially-Protected Categories of Individual or Consumer Information**: *To the extent that the Provider has access to or views Substance Use Disorder information protected by 42 CFR 2, HIV status or test results, or behavioral health information, related to an individual or consumer, Provider agrees to comply with all federal and state confidentiality mandates applicable to the access, maintenance, use or disclosure of such information.* | | |

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| --- | --- | --- |
| **Is the user a supervisor?  Yes  No** | **If yes, please list name(s) of staff member(s) user supervises:** | |
| **User (Print Name)** | **Date** | **User (Signature)** |
| **Supervisor (Print Name)** | **Date** | **Supervisor (Signature)** |

**Please fax request to:**

**Lorraine Curtis**

**Office of Aging and Disability Services**

**(207) 493-4173**

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| --- | --- | --- |
| Access Security Coordinator: | Access granted as above? | Yes  No |
|  | | |
| Signature: | | Date: |