

**Department of Mental Health
Contract Provider Access Request Form**

Updated: 3/6/2012

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 : _____

*City: _____

*Provider Name _____

*Phone # _____

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 _____

Supervisor Signature _____ Date _____

Local Security Coordinator _____ Date _____

DMH Central Office Use Only

Request Completed by _____ Date _____

**Send completed form to: User Provisioning-ITSD/DMH,
Truman State Office Bldg, 301 West High St, Rm 270, Jefferson City, MO. 65101
FAX: 573-526-6033**

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Name _____

PART 3: Mortality Review – available to DD Providers only (Not TCM)

This system is currently in the pilot phase.

Add	Remove	Role	Description
		Provider Access	This role, scoped to Application Level (Access Users Own Records Only), includes View/Write access to the following sections: Provider Part 1 & 2

Part 4: Consumer Referrals – available to DD Providers only (Not TCM)

Add	Remove	Role	Description
		Provider Access	The Provider role allows a provider agency to receive and view referrals as well as maintain their 'Provider Profile', including e-mail addresses and the link to a county served. Scoped by Provider Agency.

Consumer Referrals – available to TCM Providers (Not DD Providers)

Add	Remove	Regional Office Facility Code	Role	Description
			Oversight (SB40 staff through the regional office)	Allows read-only access to all referrals at each facility listed in the scope as well as incoming referrals to the same facility. this is typically provided to administrators and service coordinators.

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Name _____

Part 5: TCM Logging Monitoring Tool – available to DD Providers only

Development Testing Production

Add	Remove	Role	Scope (Facility Code(s))	Description
		DataEntry		Allows read/write access to TCM Monitoring Tool Survey. Scoped to Facility Level.
		Reviewer		Administrative Staff Only: Review and edit surveys entered by DataEntry Staff. Scoped to Facility Level.
		Oversight		Read access to TCM Monitoring Tool Survey. Scoped to Facility Level.

ADDITIONAL DATA REQUEST

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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, SSN and email address
- Complete provider name, phone number and provider number for the primary provider. If access is needed to additional providers, indicate additional provider numbers.
- Check which division is appropriate for your access

Change Request

- Complete full name, SSN, email and User ID
- If necessary, complete provider information to be changed.
- Complete division, if changed

Revoke Request

- Complete full name and User ID of user needing access revoked.

Part 2: Confidentiality Statement

- Read the confidentiality statement
- After completing the form, sign where indicated. Have you supervisor sign the form and forward to you Local Security Coordinator.
- The Local Security Coordinator will then sign the form and forward it to the DMH Central Office ITSD Security Coordinator.

Parts 3-5:

Complete this section to request access to the following applications. Forward the form to the Local Security Coordinator at your Regional Office.

- Mortality Review
- Consumer Referrals
- TCM Logging Monitoring Tool

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

Additional Data Request

Complete this section to request additional data not listed in previous sections. Written justification is needed.