Department of Mental Health
Contract Provider Access Request Form
Updated: 04/10/2017

☐ New ☐ Change ☐ Revoke User ID

PART 1: User Information (please print clearly)
*Required

*Last Name _____ *First Name _____ Initial: _____

*SSN XXX-XX- _____ *Phone _____ User ID (Req. for Change or Revoke) _____

*Email _____

*City _____

*Provider _____

*Title _____

Division: **Behavioral Health (ADA/CPS)** ☐ **DD TCM Provider** ☐ **DD Service Provider** ☐

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 _____

Behavioral Health Providers - Fax completed form to: Account Provisioning - 573-526-6033

***For DD Providers: Fax Completed Form to the Provider Relations Office or TAC Office at Your REGIONAL OFFICE.**

See Page Two (2) for Regional Office Fax Numbers

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

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 RESIDENTIAL Providers only (Not TCM Providers)

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/SB40 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.

Part 5: APTS (For SB40 and Private TCM Only)

Add	Remove	Role	Description
		Private TCM	The Private TCM role provides access for SB40 and Private TCM Entities to input and view their information entered in to Apts by them for each Corresponding Regional Office.

REGIONAL OFFICE FAX NUMBERS.
(DD PROVIDERS SHOULD FAX DOCUMENTATION TO THEIR APPROPRIATE REGIONAL OFFICE)

Albany Regional Office 816-387-2219 (Fax)	**Central MO Regional Office** 573-884-4294 (Fax)	**Hannibal Regional Office** 573-248-2408 (Fax)
Joplin Regional Office 417-629-3026 (Fax)	**Kansas City Regional Office** 816-889-3325 (Fax)	**Kirksville Regional Office** 660-785-2520 (Fax)
Poplar Bluff Regional Office 573-840-9311 (Fax)	**Rolla Regional Office** 573-368-2206 (Fax)	**Sikeston Regional Office** 573-472-5308 (Fax)
Springfield Regional Office 417-895-7412 (Fax)	**St. Louis Regional Office St. Louis County** 314-877-3051 (Fax)	**St. Louis Regional Office Tri-County** 314-244-8804 (Fax)

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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, last four digits of 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, last four digits of 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 and forward to your Local Security Coordinator.
- The Local Security Coordinator will then sign the form and forward it to User Provisioning. (For DD, the request should be faxed to Provider Relations at your Regional Office).

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
- Action Plan Tracking System

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