

CT Department of Mental Health and Addiction Services
SYSTEM ACCESS REQUEST FORM

Instructions:

- If you need help completing this form, contact the DMHAS Help Desk at (860) 418-6644.
- TYPE or PRINT** clearly and **DO NOT** use abbreviations for your agency. **Complete sections 1- 3.** Required items are marked with an asterisk (*). **Training must be completed to receive some access.** For class schedules, please go to the DMHAS webpage at <http://www.ct.gov/dmhas>, click on Divisions, Information Systems Division and then Computer Training. To sign-up for training, mental health providers should contact their state LMHA training coordinator; substance abuse providers should contact the DMHAS/ISD Training Coordinator at Christine.Farrelly@po.state.ct.us
- # 4 must be signed by your agency's administrator or designee, and include their telephone #, to indicate approval of your request.**
- Carefully read # 5,** the Confidentiality Pledge, and sign to indicate your agreement.
- Fax completed form to (860) 418-6896. Allow 5 business days for processing. UserIDs will be given only to the users themselves, either at a required class or by telephone.

1. User Information:

*Last Name:		*First Name:		MI:	
*Agency Name:		*Agency Address:			
E-mail:		*Phone #:		Ext:	
Does your agency currently have a RNAS/token at your site?	Y / N	If yes, to whom is this registered?			
Name of Training Completed:		Date Completed:			

2. Access: (insert a check mark for each type of access requested/required)

*Consumer Survey Sys (CSS)	()	NO training required
Web Reports	() SA and /or () MH	Indicate whether access is for S A and/or M H program(s)
DPAS-Reports ONLY	() SA and /or () MH	
DPAS-Full Rights	() SA and /or () MH	MUST Complete "DPAS" training to get access
DPAS-Jail Diversion		MUST Complete "DPAS" training to get access
DPAS-Crisis		MUST Complete "DPAS" training to get access
DPAS-Off. Of Court Eval.		MUST Complete "DPAS" training to get access
DPAS-PTIP		MUST Complete "DPAS" training to get access
DPAS-UM Screening		MUST Complete "DPAS" training to get access

3. Reactivate Access: (Y / N) If Y, please indicate in #2 (above) what reactivation access is being requested.

4. Provider Approval:

* Provider Approval (must be CEO or designee)		*Phone #:		*Date	
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5. *CONFIDENTIALITY PLEDGE / *NOT APPLICABLE FOR CSS USERS

I, _____, understand that DMHAS Web Reports and the DMHAS Provider Access System (DPAS) application will allow me to access client level information that my agency has submitted to The Department of Mental Health & Addiction Services as a business Associate of The Department. I agree to ensure the protection of this information as appropriate under HIPAA and other State of Connecticut and Federal privacy regulations. I understand that access to this information is protected through my information system logins and passwords; I agree that these will not be shared by me with any other person.

Signature _____ Date _____ Facility _____

For DMHAS Use ONLY:

DMHAS approval (Healthcare Systems)		Phone ext.		Date	
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For DMHAS/ISD Use ONLY:

Help Desk	Initials & Date	Citrix DPAS/SATIS/Interface	User ID Password	Applicant Notified	Initials & Date

Checklist:

Citrix	SATIS/Interface/DPAS	RNAS Tag	SAS Web Maint.
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