* For help completing this form contact, Chrishaun Jackson at [Chrishaun.Jackson@ct.gov](mailto:Chrishaun.Jackson@ct.gov) or 860-418-6912
* **FAX completed form to:** Chrishaun Jackson at 860-418-6896 **HANDWRITTEN, incomplete, out of date, or Emailed forms will not be accepted.**
* For questions regarding the VPN token, contact DMHAS Information Technology Help Desk at[**MHA-DMHAS-Helpdesk@ct.gov**](mailto:MHA-DMHAS-Helpdesk@ct.gov) **or 860-262-5058**

1. **User Information**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date:** | | | | |
| **Name First MI Last**: | | | | |
| **Agency Name (not Program Name):** | | | | |
| **Work Site Address**: **Street 1:**  **Street 2:** | | | | **City:** |
| **State:**    **Zip:** |
| **Work Site Email Address:** | | **Work Site Phone # : (****)**   **-**     **Ext:** | | |
| **Does this user work at a DMHAS site:  No** | **Yes,** **Site:** | | **Title:** | |

1. **VPN Token Information**: (A token is a device that will allow you to connect to the secure network. If you need one, it will be mailed to you at the address above.

|  |  |
| --- | --- |
| N/A or Already Have Token  Token was lost. Requesting a new one  First time Request for a Token | Change a Name on an existing token Serial # :  Current User Name:  \*New name will be the one listed above |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Access Request** | **New** | **Additional** | **Replace** | **Deactivate** |
| 1. **User Role(s):** | **PNP User** | **File Submission** | **Consumer Survey** | |

1. **Program Access** Program Type: all programs for your agency **OR** Program Code and Name but**, not both**.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Program Type** | Full Access | Reports  Only | **OR** | **Program Code and Name**  **EX:** L761302462 - ABC House | Full Access | Report  Only |
| **Mental Health** |  |  |  |  |  |
| **Addiction** |  |  |  |  |  |
| **Forensic – MH (JD)** |  |  |  |  |  |
| **Forensic – SA (PTIP)** |  |  |  |  |  |
| **All Programs** |  |  |  |  |  |

1. **Reports Access**: (check all that apply :)

|  |  |  |  |
| --- | --- | --- | --- |
| Client Reports | Fiscal - PNP | Outcome Measures | Reports Documentation |
| Data Quality | Forensic Services | Provider and Program Profile |  |

|  |
| --- |
| **Notes:** |

**For DMHAS Use only**

|  |  |  |
| --- | --- | --- |
| DMHAS – Help Desk Sign off: | Initials: | Date: |

**Confidentiality Pledge**

|  |  |
| --- | --- |
| Name: | Date: |
| Agency: | Title: |
| DMHAS Site: | Email: |

**I** of  , pledge that any Department of Mental Health and Addiction Services “Confidential or Restricted State Data” [[1]](#endnote-1) or ”Protected Health Information”[[2]](#endnote-2) to which I have access through a Clinical Information System and / or any other information I may gain access to as a result of the granting of this request will be shared only with appropriate, authorized personal, and is prohibited from being stored on any mobile computing device, including but not limited to, portable devices such as laptops, thumb drives , flash drives, PDAs, portable memory devices, smartphones, tablets, or any other type of electronic storage or storage media equipment without proper encryption using methods authorized by the State of Connecticut or Federal Guidelines, and is prohibited from being sent to DMHAS email accounts / other electronic transmission formats unless encrypted as specified above. I further pledge that I will not reveal my passwords, unique security IDs/codes/keys or like information to any other person.

I understand that Laws pertaining to confidentiality of patient/client records also apply to information stored electronically and I understand that violation of patient/client confidentiality is potential grounds for civil suit and substantial fines. Additionally, I understand that violation of this pledge may be grounds for disciplinary action, potentially including termination of employment.

**My signature confirms that I have received, agree to, and will adhere to policies as detailed above.**

**All signatures are required**

|  |  |
| --- | --- |
| Signature of Requester: | |
| Typed Name: | Date: |

|  |  |
| --- | --- |
| Signature of Requester’s Supervisor: | |
| Typed Name: | Date: |

|  |  |
| --- | --- |
| Signature of the DMHAS Business Designee: | |
| Typed Name: | Date: |

1. Confidential or Restricted State Data includes but is not limited to:

   Personally identifiable information that is not the public domain add if improperly disclosed could be used to steal an individual’s identity, violate the individual’s right to privacy or otherwise harm the individual.

   Organizational information that is not in the public domain and if improperly disclosed might cause a significant or severe degradation in mission capability: result in significant or major damage to organizational assets: result in significant or major financial loss , or result in significant, severe or catastrophic harm to individuals [↑](#endnote-ref-1)
2. Protected Health Information (PHI) data includes but is not limited to:

   Health information that could reveal the identity of a person.

   Under HIPAA, PHI identifiers include Name , Street, address, City, County, Precinct, Zip Code, Dates (except year) that directly relate to a person (including, Social Security number, birth date, admission date, Medical record number, Health plan beneficiary number, discharge date, date of death, and all ages over.

   Telephone numbers, Fax numbers, E-mail addresses, Account number, Certificate/ license number,, Vehicle identifiers and serial numbers including license plate numbers, Device identifiers and serial numbers Web Universal Resource Locator (URL) , internet protocol (IP) address number, Biometric identifiers (for example, finger or voice prints), Full face photographs or similar images and any unique identifying number, characteristic or code. [↑](#endnote-ref-2)