Oklahoma Department of Mental Health and Substance Abuse Services

ACCESS APPLICATIONS REQUEST

Section A: **ACCESS PRIVILIEGES ACTION REQUESTED**

☐ Assign Access Privileges ☐ Cancel Access Privileges

HELP DESK CASE #: ☐

Section B: **REQUESTER INFORMATION** **(Please BLOCK Print (ABCDEFGHIJKLMNOPQRSTUVWXYZ) Information)**

AGENCY NAME _____ AGENCY NUMBER ☐☐☐

FIRST NAME _____ LAST NAME _____

JOB TITLE _____ TELEPHONE _____ EXT _____

ADDRESS _____ E-MAIL _____

STATE EMPLOYEE ID ☐☐☐☐☐☐ **PLEASE, DON'T OVERWRITE NUMBERS.**

YOUR CURRENT ODMHSAS ACCESS CONTROL USER-ID: EU0_ ☐☐☐☐☐

LAST 5 NUMBERS OF SSN (Keyword) ☐☐☐☐☐

Section C: **ACCESS APPLICATIONS REQUESTED:** **(Only One applications per request form.)**

☐ BED UTILIZATION

☐ CASE MANAGEMENT (017)

☐ COURIER (003)

DATA RETRIEVAL:

☐ ISI INTEGRATED SCREENING TOOL (004)

☐ COMPETENCY EVALUATION DATA SHEET (016)

☐ eCRW

☐ NAMESCHECK (check all that apply) (018)

- ☐ DOC Global InQuiry
- ☐ CLEET
- ☐ OSBI
- ☐ OHFA

☐ INVOICE APPROVAL

☐ OPM-92

☐ PACT (09)

- ☐ READ
- ☐ WRITE
- ☐ MODIFY

☐ VIDEO CHECKOUT

☐ YIS (015)

Section D: **REQUESTER ACKNOWLEDGMENT**

I, the undersigned, understand that the information, which this user identification enables me to access, is to be utilized only in the performance of my assigned duties as an employee of or contractor of services with the Department of Mental Health and Substance Abuse Services. I, therefore, agree to make no inquiry or updates which are not required for the performance of these duties. I am aware that there are Federal statutes and statutes of the State of Oklahoma making information confidential and that these statutes carry penalty provisions. Therefore, I will keep confidential any information made available to me.

In addition, I agree not to divulge or share my terminal access information with anyone. I understand that my failure to comply with security procedures may result in my termination of employment with DMHSAS or the termination of this facility's contract with DMHSAS.

Requester _____ Date ____/____/____

Section E: **FACILITY AUTHORIATION APPROVAL SIGNATURE**

Approval Authority (Print) _____ (Sign) _____

Job Title _____ Tel _____ Date ____/____/____

E-Mail _____

Section F: **DMHSAS AUTHORIZATION APPROVAL SIGNATURE**

Approval Authority (Print) _____ (Sign) _____

Job Title _____ Tel _____ Date ____/____/____

All above fields are REQUIRED to be filled out for assignment of UserID or access to other links.

(ODMHSAS Personnel Only)

UserID/Password: _____ Phone: ☐ E-Mail: ☐

Setup By: _____ Date ____/____/____

Disabled: Date ____/____/____ By: _____