Oklahoma Department of Mental Health and Substance Abuse Services

ATR/ICIS USER LOGON ACCESS REQUEST

Section A: **USERID AND PASSWORD ACTION REQUESTED** **HELP DESK CASE #:**

☐ Assign User Identification ☐ Change User Identification ☐ *Change ICIS Links Privileges** ☐ Cancel User Identification

Section B: **EMPLOYEE INFORMATION** **(PLEASE PRINT (ABCDEFGHIJKLMNOPQRSTUVWXYZ) INFORMATION)**

AGENCY NAME _____ AGENCY NUMBER ☐☐☐

FIRST NAME **(Print)** _____ M.I. _____ LAST NAME **(Print)** _____

SEX (M/F) ☐ BIRTH YEAR ☐☐ Highest Educational Level Attained: _____

JOB TITLE _____ TEL _____ EXT _____

E-MAIL **(Print)** _____

SSN ☐☐☐☐☐☐☐☐☐

YOUR CURRENT ODMHSAS SECURE ACCESS USER-ID: EU00_ ☐☐☐☐☐

Section C: **ATR ACCESS** (Check All That Apply) ☐ **Change OATR Rights**

ASSESSOR ☐ TREATMENT PROVIDER ☐ SUPPORT PROVIDER ☐

Section D: **ICIS LINKS PRIVILEGES GRANTED**

Contacts	Client Data Core Transactions	Services
Agency Information	Staff Profile	SSN Change
Change Client ID	Client Information	Fee For Service Reports
	ICIS Reports	PI Reports
	SSN Look Up	

Section E: **EMPLOYEE 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.

Employee: _____ Date ___/___/_____

Section F: **ATR AGENCY APPROVAL SIGNATURE**

Approval Authority **(Print)** _____ (Sign) _____

Job Title _____ Tel _____ Date ___/___/_____

E-Mail _____

Section G: **ODMHSAS ATR PROGRAM APPROVAL SIGNATURE**

Approval Authority (Print) _____ (Sign) _____

Job Title _____ Tel _____ Date ___/___/_____

E-Mail _____

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

(ODMHSAS Personnel Only)

UserID/Password: _____ AC User Key: _____ Tested: ☐ Phone: ☐ E_Mail: ☐

Setup By: _____ Date ___/___/_____

Disabled: Date ___/___/_____ By: _____