By completing this form, you are providing the requested information to HHS Enterprise Identity & Access Management/Provisioning in order to gain access to secured systems. This information will not be shared in any manner or for any reason not permitted by the laws of the State of Texas. You may, in writing, request copies of this information at any time and may request that any information in error be corrected.

HHS ENTERPRISE IDENTITY & ACCESS MANAGEMENT APPLICATION ACCESS REQUEST	CACTS ID		CRS-CWS
CLIENT RECORDS SYSTEM-CLINICIAN WORKSTATION ACCESS REQUEST IS035B	HHSAS Employee ID		
COMPUTER SECURITY AGREEMENT and FORM INSTRUCTIONS found on Page 2 [Go to Page 2] [Clear Form]	CRS ID#:		
SUPERVISOR'S NAME:	COMPONENT CODE:	MAINFRAME ID NUMBER:	
SUPERVISOR'S PHONE: Ext.	LAST NAME:		
	FIRST NAME:	MIDDLE INITIAL:	
	JOB TITLE:		
DATE OF THIS REQUEST: (mm/dd/yyyy)	WORK PHONE: Ext.		
USER'S MONTH & DAY OF BIRTH: (mm/dd)	WORK E-MAIL:		

This form consists of three pages. All pages require signatures by either the user or the various approvers.
Any form received by HHS Enterprise Identity & Access Management/Provisioning without all the required pages and signatures will be returned to the manager to be resubmitted with corrections and may delay receiving access to the application.

COMPONENT NAME:	
DEPARTMENT:	
MAILING ADDRESS:	ZIP CODE:
PHONE NUMBER:	

TIMS ID#: ☐☐☐☐☐☐☐

USER ROLES - Check ONE option ONLY

ROLE	ADD	DELETE	CACTS
Chaplain			29
Dentist			30
Dietitian			31
Habilitation Therapies			32
Inquiry Reports Only			33
Medical Records			34
Nurse - LVN			35
Nurse - RN			36
Physician			37
Progress Notes			38

Facility Defined Roles: (For Facility Use Only)			45
	✔	Describe Role:	
1			
2			
3			
4			
5			

ROLE	ADD	DELETE	CACTS
Psychiatrist			39
Psychologist			40
QMRP			41
Rehabilitation Therapies			42
Site Manager			43
Social Worker			44
MHMR Series			46
*DSS Database Access (see below)			47
Business Objects			48
*Order Entry (see below)			49

Facility Defined Roles: (For Facility Use Only)			45
	✔	Describe Role:	
6			
7			
8			
9			
10			

***NOTES:** **#47- If you have already obtained DSS Database Access via the CRS-BHIS Access Request Form (IS035A), you do NOT need to request DSS Database Access on this form. #48- User Role [one of #29 through #46] MUST be checked in order to obtain this access.**

NOTE:	***All changes or alterations to information filled in on this form must be done in ink, initialed and dated, and must NOT totally obscure the original entry.***

PRINT NAME OF FACILITY CRS COORDINATOR	TITLE OF FACILITY CRS COORDINATOR
SIGNATURE OF FACILITY CRS COORDINATOR	DATE SIGNED

AFTER OBTAINING SIGNATURES, MAIL TO:
HHS Enterprise Identity & Access Management/Provisioning
Texas Health andHuman Services Commission
701 West 51st Street, C720, Austin, Texas 78751

Enterprise Identity & Access Management Use Only

Enterprise Identity & Access Management Authorizing Signature

Date

DATE IN:

DATE FILED:

Go to Page 1 | Go to Page 3 | Clear Form

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HHS Enterprise Identity & Access Management - INSTRUCTIONS FOR COMPLETING FORM

Access is either ADD or DELETE. Contact the application owner or coordinator to determine the appropriate level of access.

Forms that are incomplete, incorrect, or outdated will be returned to the sending party without being processed.

This form MUST be signed by the person Authorized to grant user access, or it will be returned unprocessed.

All forms are multi-page. Remember to complete and sign ALL pages.

The Computer Security Agreement (below) MUST be signed by the user.

Computer Security Agreement - User MUST also complete the HHS Acceptable Use Agreement (AUA)

I acknowledge that I have been assigned an individual identification code (USERID) and password to use to access HHS Enterprise applications. I understand that I will be held personally accountable for any activity performed under my USERID. Under no circumstances will I allow my confidential USERID to be used by any other individual, nor will I use one belonging to someone else. I will not enter any unauthorized data, make any unauthorized changes to data, or disclose any data without proper authorization. Unauthorized access to a data system, allowing another party unauthorized access to a data system, altering data without proper authorization, or maliciously causing a computer malfunction are violations under Chapter 33 of the Texas Penal Code ("Computer Crime Law") and are punishable by fines, jail time, or both. I understand that if I violate any of these standards I may be subjected to disciplinary action and/or prosecution under one or more applicable statutes. *(NOTE: AUA forms need not be completed **if previously submitted** to HHS Enterprise Identity & Access Management.)*

USER'S NAME - PRINT:

USER'S SIGNATURE:

DATE SIGNED BY USER:

REQUIRED INFORMATION FOR ALL HHS Enterprise Identity & Access Management ACCESS AUTHORIZATION FORMS

COMPLETE ALL APPLICABLE PAGES AND SPACES. OBTAIN ALL REQUIRED SIGNATURES FROM AN AUTHORIZED SIGNER.

1. CACTS ID - Current/Existing Security ID assigned to you by Enterprise Security Management. DO NOT FILL IN IF THIS IS A REQUEST FOR A NEW USER.
2. HHSAS Employee ID - Your 11 digit State of Texas employee ID assigned to you by HHSAS. Include Leading Zeroes.
3. CRS ID - Your AVATAR PM-BHIS (CRS) ID assigned by your Facility AVATAR-PM Coordinator.
4. COMPONENT CODE - The facility code by which you are employed - call a supervisor if you do not know it.
5. MAINFRAME ID NUMBER - Your IBM (Legacy MHMR) Mainframe ID Number. Example: F551234
6. LAST NAME - Your LAST name.
7. FIRST NAME/MIDDLE INITIAL - Your FIRST name and MIDDLE INITIAL.
8. JOB TITLE - Your current job title.
9. WORK PHONE - Your phone number, including the area code and extension (if applicable).
10. WORK E-MAIL - Your e-mail address at work, example: first.last@hhsc.state.tx.us
11. SUPERVISOR NAME - Your immediate supervisor's full name.
12. SUPERVISOR PHONE - The phone number of your immediate supervisor, including area code and extension (if applicable).
13. (intentionally blank)
14. DATE OF THIS REQUEST- The date you completed this form. (mm/dd/yy)
15. USER'S MONTH & DAY OF BIRTH (mm/dd)
16. COMPONENT NAME - The name of the facility at which you are located.
17. DEPARTMENT - The name of the department in which you work.
18. MAILING ADDRESS - Your complete mailing address at work, including city and zip code. ZIP CODE IS REQUIRED.
19. PHONE NUMBER - The number of the facility's main switchboard.
20. TINS#

Agreement to Comply with System and Password Policies

This is an agreement to strictly comply with system and password policies and procedures regarding the use of the authentication application in the Clinical Record System at _____, currently available through the Medical Record/Health Information department.

I have received the training material from the Health Information/Medical Record Department, and have gone through a personal training session to educate users on how to correctly:

- Logon to the system
- Change my password
- Review documents
- Edit documents
- Attach my name to finalize and authenticate documents in the Clinical Record System

I also recognize that I alone may use my user identification and password to review and authenticate documentation, and that under no circumstances shall I share my user identification and password with anyone, including any other hospital or office employee. I also understand that failure to comply with this policy could result in disciplinary action, including dismissal.

By signing this form I am promising to comply with all of the above instructions, as well as the guidelines, standards and policies relating to the use of the authentication of documents in the Clinical Record System.

_____(Print name)

_____(Signature)

_____(Date)
(mm/dd/yyyy)