User ID and System Access Request Form (External)

Section 1 - User Information

Agency Name: _____ OPWDD Agency ID: _____

First Name: _____ Mi: ____ Last Name: _____

Title: _____ Work Telephone: _____

Work Address: _____

Street , City, State Zip

User's Agency E-Mail, if known: _____

Section 2 - OPWDD User ID & Access Requests

OPWDD User ID: _____

(In above box enter UserID for all requests except Open*).

Additional USER ID Required for Multiple Agency Use: ☐ Yes ☐ No

OPWDD User ID request (if required): ☐ Open* ☐ Close ** ☐ Reset Password

** Close will delete all access to all applications

Application Access request: ☐ Grant ☐ Revoke *** ☐ Modify Role Select from drop down or type in the access you need grar

*** Revoke will remove access to just this one application

Section 3 - Statement of Use

(To be read and signed by User agreeing to the statement of use)

Use is limited to conducting official business involving OPWDD. Any use, authorized or not, constitutes express consent for authorized personnel to monitor, intercept, record, read, copy, access or capture such information for use or disclosure in any manner without additional prior notice. Users have no legitimate expectation of privacy during any use of OPWDD systems. Unauthorized use or attempted unauthorized use is not permitted and may constitute a federal or state crime. Such use may subject you to appropriate disciplinary and/or criminal action. Clinical information, including records that identify or tend to identify individuals served or proposed to be served by OPWDD and its certified providers, is confidential and can only be disclosed in accordance with Mental Hygiene Law Sec. 33.13, HIPAA, and OCS.

I have read and understand the above Statement of Use.

_____ _____

User Signature Date

Section 4 - Executive Approval

(To be read and signed by Executive Director or designee agreeing to the statement)

When an employee's employment with a Provider Agency is terminated, the Executive Director, the OPWDD "sponsor," or the Application Owner or designee is responsible for completion and submission of this form to close the individual's account.

_____ _____

Executive Director Signature Date

_____

Type Executive Director Name

Section 5 - Secure Application Authorizer Approval (if required, *see below instructions for submission)

_____ _____

Application Authorizer Signature Date

Select from drop down OPWDD Application Authorizer Name, if required

Select or type Application Authorizer Name

***Note - Section 5 Signature requirement- forward to an OPWDD Application authorizer for approval before submission to OPWDD IMS.**

Scan and send completed forms to OPWDD IMS via e-mail @ external.account.provisioning@opwdd.ny.gov or fax to 518-381-2191.

Requests for Fingerprinting Authorization must be faxed directly to 518-474-1328.

Requests for all IRMA applications must be emailed directly to incident.management@opwdd.ny.gov

Clear Form Print Form