Confidentiality Agreement and Application to Request Access to DHHS Information Technology (IT) Assets

For purposes of this application, the Nebraska Department of Health and Human Services (hereafter DHHS) refers to all Divisions within DHHS; Children and Family Services, Behavioral Health, Developmental Disabilities, Medicaid and Long Term Care, Public Health and Veteran's Homes. IT Assets refer to any DHHS business software system, network access, e-mail system, or computer hardware owned or supported by DHHS.

For the purposes of this application the Applicant refers to the external organization submitting the request to access DHHS assets as defined in the paragraph above.

In the event this Application is approved by DHHS, the applicant agrees to comply with all DHHS IT Security Policies, Procedures and Standards, and all applicable state and federal laws governing information or access they may receive. Any information disclosed to the applicant may be used solely to facilitate services for which the applicant is under contract or for which they have been given specific authorization. Approved applications will be good for a maximum two years or except when business needs or contract changes terminate the need for access. Each application will be reviewed prior to the end of the two-year approval period to determine if access should be extended. DHHS may revoke access at any time without prior notification if a violation of any policy, procedure, or standard is detected.

Applicant Contact Information

DHHS Sponsor: **Department of Health and Human Services, Division of Medicaid & Long-Term Care**

Name of agency/business: _____

Address: _____

Name of contact person: _____

Contact Telephone: _____

Contact E-mail address: _____

Application Request Information

1. Please complete an outline of the specific service your agency plans to offer. Attach a copy of any contract that supports your request for access.

   Nebraska Medicaid Provider access to verify Medicaid client eligibility and claim status.

2. Outline what specific information your agency needs in order to offer these services and include the computer application or database you are requesting access to.

   ___ Medicaid Client Eligibility Verification (RFS6)
   ___ Medicaid Claim Status Inquiry (MCCS)

3. List type of organization: corporation - nonprofit corporation - government – partnership – limited liability corporation – limited liability partnership – professional corporation – sole proprietorship – other.

_____

4. If an out of state entity, is the applicant registered to do business in Nebraska? _____

5. State of incorporation_____

6. List (by name, title and location) each individual in your agency who will have access to this information and the approximate number of hours of access each individual would need weekly. **NOTE: Each individual in your agency who will have access must sign the DHHS External Access Confidentiality Statement.**

_____

_____

7. Please indicate the period for which access is requested: **While Nebraska Medicaid Provider Number is active.**

8. Who in your organization will be responsible for providing updates and staff changes or security requests?

   Name: _____

   Telephone No. _____

   Email Address: _____

9. Please outline the process to be followed should your agency or DHHS observe an incident of information misuse or security violation. **Attach copy of your agency policy and procedures for such an occurrence.**

10. Please identify how you intend to electronically access the DHHS systems referred to in this request (i.e., what company/organization owns and maintains the computer equipment and network you will be using for the proposed access). **Internet**

11. List your 11-digit Nebraska Medicaid Provider Number(s): _____

_____

COSTS (Note: This section does not apply to Medicaid Provider access to Medicaid eligibility and claim status internet access)

Access costs and fees may be assessed to the Applicant agency. These costs will be determined by the Information Systems and Technology division with the approval of the External Access Committee or at the discretion of the DHHS Policy Cabinet Directors.

- DHHS assumes that the applicant has or will obtain an Internet Provider and encryption software if determined necessary for protected access.
- Applicant may be required to pay the cost of technical support necessary to allow NFOCUS access if necessary.
- Applicant may be required to pay the cost of hardware/software or browser and Internet Service Provider costs if necessary to allow access.
- Applicant may be required to pay a monthly access fee, which shall include support functions (including HHS Help Desk and bulletin boards).

- Applicant may be required to pay cost of mandatory training for their staff before access is granted - including training for additional staff added at a later date or remedial training for on going staff.
- Applicant may be required to pay costs of network installation and monthly lease costs.
- Applicant may be required to pay segment cost.
- Full costs will be established at a monthly or yearly rate and identified prior to the approval of this application.

ACCESS Requirements

This reference and all their terms and conditions incorporate all DHHS Policies, Procedures, Standards and all governing state and federal laws, apply to the applicant.

Applicants shall agree that no staff is to be given access until they complete any DHHS mandated training.

All staff who have completed any DHHS mandated training must complete a "Confidentially Statement" (see attached). The confidentiality statement states that they have been informed of their obligation to use the information as intended and understand that misuse will result in their immediate loss of access and may result in legal action being taken as a result in their misuse.

No access will be given to any applicant until signed confidentiality statements have been received by DHHS for *ALL* individuals listed in item 6 above.

A Service Level Agreement (SLA) will be negotiated with the applicant prior to final approval can be given to this application. No access will be given until a signed SLA is received by DHHS.

Your signature indicates your agreement that under no circumstances shall your staff use the information for any other purpose than that outlined in the application, even purposed which the applicant feels is critical to another part of their business operation.

Your signature indicates that you are aware that this information is the property of or under the guardianship of DHHS and access can be withdrawn immediately.

Cancellation

Either party hereto may cancel this contract for any reason upon thirty-(30) days written notice to the other party. Notification should be sent to HHSS IT Security Administrator Finance and Support, P.O. Box 95026, Lincoln, NE 68509-5026. Payment arrangements for services provided to the date of termination will be based on a per diem adjustment to the monthly rates.

By signing and submitting this application, you agree to comply with all the provisions of the application.

Organization Legal Name: _____

BY: _____

ITS AUTHORIZED REPRESENTATIVE

Title: _____

Date: _____

Office Use Only:

Initial Approval Date: _____ Review Date _____

Approval Extension Date: _____ Review Date _____

Approval Extension Date: _____ Review Date _____