CALIFORNIA HEALTH CARE OPTIONS
SECURE DATA EXCHANGE SERVICES
Account Request or Access Change Request Form

All entities requesting access to the California Health Care Options Secure Data Exchange Services (SDES) must complete an Account Request or Access Change Request Form. A separate form is required for ***each* person requesting access.** To ensure expedited processing of your form, please take care to provide all requested information. The form ***must be signed by the individual*** *requesting access or a change in access,* ***and an authorized representative*** of the entity that is making the request.

The California Department of Health Care Services (DHCS) has the sole authority to grant or revoke access to the SDES. The site itself is managed by Maximus.

If you require assistance with completing the form, please e-mail your questions to CAHCO_IS_SDES@maximus.com

Please complete and submit the form using one of the following methods:

Scan & Email To:	**Fax To:**	**Mail To:**
CAHCO_IS_SDES@maximus.com	ATTN: CA HCO SDES (916) 364-0289	ATTN: CA HCO ISO 11050 Olson Drive, Suite 100 Rancho Cordova, CA 95670

SECURITY NOTICE

Authority to use this system is granted by the California Department of Health Care Services (DHCS) and may be revoked at any time. Only authorized personnel may use this system. Users of this site are bound to the following:

1. Utilize any data obtained for its intended purposes only.
2. Users shall not share their Secure Data Exchange Services password.
3. If the data contains e-PHI and/or PI as defined by the HIPAA/ARRA/HITECH acts and California Privacy and Security Laws, the user must ensure the confidentiality and security of data obtained adheres to the appropriate guidelines.
4. Acknowledge that inappropriate usage of the Secure Date Exchange Services may, at a minimum, result in privilege revocation by DHCS to utilize these services.
5. Submit new SDES request form if changes to the account are needed, such as delete, add, or suspend user access or IP address changes.

Use of this system is always monitored. Anyone using this system expressly consents to such monitoring and is advised that if such monitoring reveals possible evidence of criminal activity, system personnel may provide evidence of such monitoring to law enforcement officials

Plan's Information Security Officer/Security Official (Name) ____________________ Title ____________________

Signature ____________________ Date ____________________

You must sign this form to acknowledge you have read the above Security Notice and agree to abide by it. No access will be granted without receipt of a signed acknowledgement.

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New Account/Access Change/Deactivation Request Form

*Place "X" in applicable boxes** **Request Date:** ___________________

* Request Type: New Individual Access New Service Account Deactivate Access

* **Business Name of Entity:** ____

e.g., Acme Health Plan of Sunshine County

* **HCP #(s):** ____________________ * **County(ies):** ____________________

* Account Requestor (Name): ____________________ *Title: ____________________

* Phone Number: ____________________ Ext.: ____________________

* **Login** E-mail Address: ____________________ ** Requestor Signature: ____________________

****Signature indicates that requestor will comply with Security Notice on Page 1 of this form**

User Login Email to Mirror (if applicable): ____________________________________

Request Type Details:

Service Account SSH Key (optional): ____________________________________

Access Change description: ____________________________________

Deactivate Access Employee Name to deactivate: ____________________________________

* **Requested Folder Access:**

Weekly Health or Dental Plan Files (WPF) Weekly MET/HIF Files (MET/HIF discontinued as of 1/15/19)

Provider Data File (PPD/PIN) SEP/SPEP Files

Other: ____________________________________

* **Requested File Access Levels:**

Read-only (can only see & download files) ***Delete*** (can see & delete files-must have Read-only access)

Read/Write (upload & download files only-no delete) ***List*** (only see folders & files-no file download/upload/delete)

Notifications:

Notified of new file uploads? **Notification Email** if different than above: ____________________

PLEASE HAVE YOUR SUPERVISOR COMPLETE THE FIELDS BELOW

* **Outward facing** IP or IP range from which logon or SFTP requests will originate (obtain from your I.S. dept.):

____

* Authorized Representative (Name):____________________ * Title:____________________

* Phone Number: (   ) ____________________ Ext.: ____________________

* E-mail Address: ____________________ * Signature: ____________________

It is the express responsibility of the Authorized Representative to notify MAXIMUS within 24 hours of the termination or change in duties of an employee who has been granted access to the SDES

------------------------------------- MAXIMUS INTERNAL USE ONLY -------------------------------------

CA HCO ISO ⇨	**DHCS**
Name: ____________________	Name: ____________________
Sign: ____________________	Sign: ____________________
Date: ____________________	Date: ____________________

* ***Indicates required fields. Use one form per individual***