**INSTRUCTIONS:**

* For help completing this form contact, Chrishaun Jackson at [Chrishaun.Jackson@ct.gov](mailto:Chrishaun.Jackson@ct.gov) or 860-418-6912 **FAX the completed form to:** Chrishaun Jackson 860-418-6896 **HANDWRITTEN, incomplete, out of date, or Emailed forms will not be accepted.**
* For questions regarding the VPN token, contact the DMHAS Information Technology Help Desk at: [**MHA-DMHAS-Helpdesk@ct.gov**](mailto:MHA-DMHAS-Helpdesk@ct.gov) **or 860-262-5058**

* + 1. **User Information**: Enter all user information, including your complete **Facility Name**, Address, Email and Phone Number.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: First MI Last: | | | | | |
| Facility Name: | | | | | |
| Address: Street 1: | City: | | | | |
| Street 2: | State |  | Zip: |  | |
| Email Address: | | | Phone # : **(****)**   **-** | | Ext: |

1. **VPN Token**: A token is a device that will allow you to connect to the DMHAS secure network. If you need one, it will be mailed to you at the address above. Review the options listed and select the one that applies to you. *If you are a DDaP user or VATS user, you can use your existing token or if you are a State Operator, you do not need a token; select ‘N/A or Already Have Token’.*

|  |  |
| --- | --- |
| N/A or Already Have Token  First time Request for a Token  Token was lost. Requesting a new one | Change a Name on an existing token Serial # :  Current User Name:  \*New name will be the one listed above |

1. **Access Request**: If this is a first time request for access to CI, select ‘NEW’. If you had prior access and need to reactivate, select ‘Reactivate’. If you already have access, but need additional access (i.e., additional provider access), select Additional Access.

**NEW**  **Reactivate**   **Additional Access**

1. **Additional Facilities:** If you need CI access to more thanone facility, enter the name(s) of the facilities below.

|  |  |
| --- | --- |
| **Facility Name** *(If requesting more than 6 facilities, attached additional facility names in a separate word document.)* | |
| **1.** | **4.** |
| **2.** | **5.** |
| **3.** | **6.** |

1. **Facility Approval & Confidentiality Pledge**: Once you have completed the information above, print the form. Obtain a signature from your CEO or Designee and include Phone # and Date. Enter your name for the Confidentiality Pledge, sign the pledge and include the date and your agency name.

**CONFIDENTIALITY PLEDGE**

I,  **,** understand that DMHAS CI Reports and the Critical Incident (CI) application will allow me to access client level information that my agency has submitted to The Department of Mental Health & Addiction Services as a business Associate of The Department. I agree to ensure the protection of this information as appropriate under HIPAA and other State of Connecticut and Federal privacy regulations. I understand that access to this information is protected through my information system logins and passwords; I agree that these will not be shared by me with any other person.

**All signatures are required**

|  |  |
| --- | --- |
| **Signature of Requester:** | |
| **Typed Name:** | **Date:** |

|  |  |
| --- | --- |
| **Facility CEO or Designee Signature:** | |
| **Typed Name:** | **Date:** |
| **Phone #:** |  |

**DMHAS Use Only:**

|  |  |
| --- | --- |
| **DMHAS Approval Signature :** | **Date:** |