Rhode Island Community Supports Management User ID Request

This form will not be processed without the user's signature on the Confidentiality Acknowledgment page.

Add New User ☐ Change ☐ Delete ☐

Date Request Needed By:_____

Please allow 7-10 business days to process your request

User Information (please print): (all fields are required to process the request)

Last Name:_____ First Name: _____ Middle Initial: ___

Email Address:_____

Phone Number: _____

Provider or Agency Name: _____

Supervisor Name: _____

Please check one:

Group Access CSM		***For Admin Use Only***
Community Mental Health Center Provider	☐	
Connect Care Program	☐	
DCYF CANS User	☐	
DEA Case Management	☐	
Home Health Provider	☐	
Hospice Provider	☐	
Hospital Provider	☐	
HP Operations	☐	
LTC Manager/Supervisor	☐	
LTC Worker	☐	
Nursing Home Provider	☐	
OMR Reviewer	☐	
OMR/ OCP/ DEA Support	☐	
Office of Community Programs	☐	
PASRR MI Office	☐	
PASRR MI Resident Review	☐	
PASRR MR/DD Office	☐	
State Manager	☐	
View-Only (Report Developers)	☐	

Access to DCYF CANS Admin ☐

DCYF Approval: _____

State of Rhode Island
Exeutive Office of Health & Human Services

Rhode Island Community Supports Management System

Confidentiality Acknowledgment

As a user of the Rhode Island Community Supports Management System (CSM), I may have access to Protected Health Information (PHI). PHI means any individually identifiable information relating to the past, present or future physical or mental health or condition of an individual, or the past, present or future payment for health care provided to an individual.

By signing below, I acknowledge the following:

EOHHS policies and procedures, Rhode Island law, and federal law prohibit the unauthorized use or disclosure of PHI.

I will not share PHI with other state or provider workforce members or any other individuals unless doing so is necessary to do my job and EOHHS policies or procedures permit the use or disclosure.

I will not attempt to access or look at PHI other than what is required to perform my job.

I will not remove PHI from the CSM or secure areas within my work premises unless doing so is necessary to perform my job.

I will abide by all EOHHS policies and procedures relating to PHI.

Upon leaving the workforce of the state of Rhode Island or its business associates, my access will be terminated. The business associate organization will notify the appropriate personnel to end access.

After I leave the workforce of the state of Rhode Island or its business associates, I will continue to observe EOHHS policies and procedures with regard to PHI that I had access to while a workforce Member.

I understand that if I violate EOHHS polices or procedures relating to PHI, I may be subject to employment or contractual sanctions, up to and including the termination of state employment or contract, and also may be subject to civil liability or criminal prosecution.

_____ _____
User Signature Date

_____
Printed Name

_____
Title

Authorized by(EOHHS Use Only): _____ Date:_____

Submit this form to:

RI Community Supports Management System
c/o Nelson Aguiar, Gainwell Technologies
301 Metro Center Boulevard
Third Floor
Warwick, RI 02886