

Section 1: Web User Information (Please type or print clearly)			
First Name	MI	Last Name	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Preferred User Name	Email Address		Phone Number
<input type="text"/>	<input type="text"/>		<input type="text"/>
Preferred User Name will be used unless another user already has an account with that user name			
Security Question and Answer will be used in the event the password needs reset or the account is locked.			
Security Question	<input type="text"/>		
Security Answer	<input type="text"/>		
Is this user already affiliated with another CareConnection(c) user account? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If so, what username is already established? <input type="text"/>			

Section 2: Web User Requested User Access (Select <input checked="" type="checkbox"/> the type of access the user requires)			
ADMIN*	<input type="checkbox"/> Provider Super Admin*	<input type="checkbox"/> Provider Administrator	<input type="checkbox"/> Provider Super Admin Read Only*
SC	<input type="checkbox"/> Read/Write/Submit	<input type="checkbox"/> Read/Write	<input type="checkbox"/> Read Only
MECA	<input type="checkbox"/> PCA Admin	<input type="checkbox"/> PCA	<input type="checkbox"/> IPN
F/EA	<input type="checkbox"/> Provider Administrator	<input type="checkbox"/> Fiscal/Employer Agent	
BMS	<input type="checkbox"/> BMS (only applicable to staff of designees of the Bureau for Medical Services)		
All ADMIN and SC User Roles must be affiliated with a provider, as indicated in Section 3.			

Section 3: Web User Provider Affiliation (Provider for which this user is requesting access) (Section is only applicable to ADMIN and SC Web User Requests)			
*Provider Super Admin & Provider Super Admin Read-Only may indicate multiple locations-use additional pages as necessary.			
Must match information submitted on Provider Registration Form	Provider Name (include location if applicable)		Behavioral Health License #
	<input type="text"/>		<input type="text"/>
	Address		
	<input type="text"/>		
	City	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Section 4: Web User Agreement
I, individually and as an authorized web user, agree that I will access and use the information available through the kepro Intellectual/Developmental Disability Waiver web site only for treatment and healthcare operations purposes (as those terms are defined in the HIPAA Privacy Rule). I will use all reasonable precautions with respect to protecting the security of my unique login and the privacy and security of the data within this web site.
User's Signature _____ Date _____

Section 5: Provider Authorization
ADMIN, MECA and F/EA User requests must be authorized by the company's or provider's executive leadership. SC User requests may be authorized by an established Web User Admin or executive leadership. BMS User requests must be authorized by the Program Director.
I authorize the action indicated above for the specified User. I agree to promptly deactivate a User account or notify Kepro, when a User no longer has a business purpose to access the information available within the web site.
Admin, Director or CEO's Printed Name _____ Admin, Director or CEO's Signature _____ Date _____