

# ORGANIZATION USER APPLICATION

## FOR ACCESS TO STATE OF ARIZONA HEALTH-E-ARIZONA PLUS

Please identify all of the individuals for whom you are requesting Health-e-Arizona Plus (HEAplus) user account access, including:

- Employees of your organization
- Employees of organizations you contract with to provide application assistance at your facilities
- Volunteers

Each person you list on this form must also complete and sign an Individual User Application.

### 1. ORGANIZATION INFORMATION

Name of Legal Entity Name and, if applicable, the Doing Business As name
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### 2. PERSON COMPLETING THIS REQUEST

Legal First and Last Name	Title
Date of Birth	Social Security Number
Office Telephone <i>(include Extension)</i>	E-Mail Address

### 3. HEAplus USERS

I am requesting that the persons listed below be either added as a user in HEAplus in conjunction with this organization’s Community Partner Agreement or removed as a HEAplus user for this organization. ***(Please ensure that HEAplus accounts have been deactivated for persons you are removing.)***

- **Note:** If the user will be a Site Administrator for your organization, this will need to be indicated in the “Add or Remove” column as follows: “Add-SA”

Legal First and Last Name	Date of Birth	Social Security Number	Work Address	Phone Number	Email	Employee, Contractor or Volunteer?	Add or Remove?
Kathy Sponagle			1234 W Example St. Phx. AZ. 85033	602-417-4246	Example.Example@E xample.com	Employee	Add

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## **SECURITY REQUIREMENTS FOR USERS OF THE STATE OF ARIZONA HEALTH-E-ARIZONA PLUS**

The State of Arizona Health-e-Arizona Plus system contains sensitive information to carry out its mission. Sensitive information is any information, which the loss, misuse, or unauthorized access to, or modification of could adversely affect the privacy to which individuals are entitled. Arizona records all access to its computer systems and conducts routine reviews for unauthorized access to and/or illegal activity.

Anyone with access to the State of Arizona's Health-e-Arizona Plus system containing sensitive information must abide by the following:

- **Do not disclose or lend your IDENTIFICATION NUMBER AND/OR PASSWORD to someone else. They are for your use only and serve as your electronic signature. This means that you may be held responsible for the consequences of unauthorized or illegal transactions.**
- **Do not browse or use Arizona data files for unauthorized or illegal purposes.**
- **Do not use Arizona data files for private gain or to misrepresent yourself or Arizona.**
- **Do not make any disclosure of Arizona data that is not specifically authorized.**
- **Do not duplicate Arizona data files, create sub-files of such records, remove or transmit data unless you have been specifically authorized to do so.**
- **Do not change, delete, or otherwise alter Arizona data files unless you have been specifically authorized to do so.**
- **Do not make copies of data files, with identifiable data, or data that would allow individual identities to be deduced unless you have been specifically authorized to do so.**
- **Do not intentionally cause corruption or disruption of Arizona data files.**
- **Complete Annual HEAplus Security Training.**

A violation of these security requirements could result in termination of systems access privileges and/or disciplinary/ adverse action, depending upon the seriousness of the offense. In addition, Federal, State, and/or local laws may provide criminal penalties for any person illegally accessing or using a Government-owned or operated computer system illegally.

If you become aware of any violation of these security requirements or suspect that your identification number or password may have been used by someone else, immediately report that information.

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**ORGANIZATION'S RESPONSIBILITY FOR USERS**

The HEAplus Community Partner organization is responsible for and assumes all liability for each user's use of the HEAplus system.

**SIGNATURE**

By signing this form on behalf of my organization, I am declaring that I have read and understand the requirements related to the use of Health-e-Arizona Plus and penalties for violations of these requirements. As the undersigned, I attest that I am the authorized representative of the enrolling entity and have the authority to sign this application. I affirm under penalty of law that the information I have provided on this form is true, accurate, and complete to the best of my knowledge.

I understand that in the future I must submit this document to request any changes in the persons for whom I am requesting access to Health-e-Arizona Plus under my organization's HEAplus Agreement.

Printed Legal Name
Signature

**After signing the form, you will be asked to save a copy for your records.**

**Once saved, click the Submit by email button and the form should automatically ask you to send via an email option, if not please send your saved copy to: [CP-AOOperationsTeam@azahcccs.gov](mailto:CP-AOOperationsTeam@azahcccs.gov)**

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