Area Agency on Aging 1-B

My Health 360 ACCESS REQUEST

TYPE OF REQUEST (select one):☐ **Enrollment** ☐ **Change** ☐**Disenrollment**

Is this request for access *without* an ID? (e.g., for billing purposes) ☐ **Yes** ☐ **No**

Note: All requests must include a Job Description for the Requested User

User Information	
User Type: ☐AAA 1-B Staff: Indicate (Mi Choice Pod, Program, Dept): ☐ Provider Network Vendor ☐Other:	
First Name:	Last Name:
Phone:	Email:
Job Title: Note: Requests will not be processed without a job description.	Effective date of Access Change: ☐Hire _____ ☐Transfer _____ ☐Disenrollment _____
Agency Name & Provider ID:	
Professional Credentials:	
State of Michigan License(s)	
NPI Number (If applicable, Masters Level Providers and higher)	
Authorized Requester	
Name:	
Title & Department:	
Phone:	

AUTHORIZED REQUESTOR ATTESTATION:

- I am an Authorized Requestor with respect to the Requested User;
- This form requests "Appropriate Access" to EPHI for the Requested User, which means that it is the amount of access which is minimally necessary to perform their job responsibilities, and is consistent with AAA 1-B policy;
- The Requested User has received appropriate HIPAA training;
- The Requested User will have adequate supervision to ensure that their access is consistent with that which has been deemed "Appropriate Access," and ensure that unauthorized access to EPHI is avoided;
- I have obtained any required approval from the CEO and/or the Office of Compliance; AND
- I have attached the appropriate supporting documentation to this Access Authorization Form:
- ☐Job description (AAA 1-B Staff & Providers; Contract Providers)
- ☐Business Associate Agreement / Contract / Work Order (as appropriate and/or requested)

Signature:

Date:

Please submit completed forms to myhealth360help@aaa1b.org

Area Agency on Aging 1-B
My Health 360 SOFTWARE SYSTEM
ACCESS REQUEST FORM INSTRUCTIONS
please allow at least 2-weeks for processing

General Instructions:

When Required: This form must be completed in full and submitted for processing in any of the following events:

- New My Health 360 access required (new hire, change in position, etc.)
- Access level modification (more or less access needed due to change in position, change in location, etc.) User demographic information change (name, phone number, email, other contact information)
- License status change / expiration (clinical staff)
- Employment status change (termination, temporary leave, return from leave)

How to Send: Type responses into the PDF fillable form, print and sign. All signed and completed requests are to be scanned and emailed to myhealth360help@aaa1b.org. The subject line of the email or the fax cover sheet should indicate the type of request (e.g., "NEW ACCESS", "ACCESS CHANGE", "USER DEMOGRAPHIC CHANGE", "DISENROLLMENT REQUEST", "RE-ENROLLMENT REQUEST", etc.)

User Information.
Please provide complete information regarding the requested User that is the subject of the request.
Supporting Documentation Requirements:

- Job Description required with all access requests
- Business Associate Agreements and underlying contract/job order required for business associates
- "Other" requests will require written support requested by the AAA 1-B Office of Compliance

Consistent with AAA 1-B policy, all access requests for business associates or other third-party (non-AAA 1-B, non-Contract Network Provider entities) will require approval from the AAA 1-B Office of Compliance.

Effective Date of New Access / Access Change.
Please provide the effective date of the requested access change. For example: (i) the effective date for a new non-provider AAA 1-B employee would be the hire date; (ii) the effective date for a new provider AAA 1-B employee would be the date of the credentialing and privileging approval, if applicable (iii) the effective date for a contract network provider would be the date this form is submitted; (iv) the effective date of changed access based on a transfer to a new department or a change in job functions would be the effective date that the transfer or change in job functions actually occurred.

Entity Name and Provider ID.
Please provide the entity name and provider ID - please be specific as to contract working unit.

Professional Credentials.
Clinical staff (AAA 1-B Staff and Providers) must provide the requested details concerning their professional credentials.

Authorized Requester Information.
Authorized Requesters are only those individuals who have been designated as such, pursuant to AAA 1-B Policy. For guidelines on "Authorized Requesters", please refer to AAA 1-B Policy for Internal staff and to AAA 1-B Policy for Contract Network Providers. **Requests will not be processed unless they are submitted by the appropriate Authorized Requester**.

Supervisor.
Please identify the individual who, after this request is processed, will be listed in My Health 360 under the User Record as the requested My Health 360 User's supervisor.

Authorized Requester Attestation.
Authorized Requesters are required to sign the Access Request Form, and attest to the accuracy and completeness of the form, as well as to their agreement with the points articulated in this section. False attestations violate AAA 1-B policy, and will subject the requesting individual to investigation and potential corrective or disciplinary action, as appropriate and consistent with AAA 1-B policy.

User Acknowledgement.
The individual who is obtaining new or changed access must sign to acknowledge the request.

INCOMPLETE REQUESTS WILL NOT BE PROCESSED