

Idaho WITS Treatment Provider Agency Security Access Form

If you have any questions about this form, please e-mail the WITS Help Desk at:
dbhwitshd@dhw.idaho.gov or call 208-332-7316.

According to HIPAA guidelines, a person should only have enough access necessary to perform his/her job.

Please check one of the following: **New User** **Edit Permissions** **Revoke Permissions**

Date: 11/25/13 Agency Name: XYZ Counseling Center

Physical Address: 1234 Main Street

City: Utopia State: ID Zip: 83702 Mountain Time Zone Pacific Time Zone

First Name: John Last Name: Smith

Phone Number: 208 123-4567 User Email: johnsmith@XYZCounselingCenter.com

Job Title: Counselor Supervisor: Jill Smith

Check here if individual is to have access to all facilities under the agency. Otherwise, please list the facilities the individual will need access to: Regions 1 and 2 only

The Individual will need the following permissions (please select one):

	Job Description	Standard Job Function Roles	Standard Role Attributes <i>(In addition to Job Function Roles)</i>
<input type="checkbox"/>	Agency WITS Administrator	To be assigned by IDHW WITS Administrators	
<input type="checkbox"/>	Billing Staff (non-clinical)	Agency Invoicing (Full Access) Agency Reporting Billing Encounter List Clinical (Read-Only) Create Agency Claim Batch	Agency Billing Authorization (Full Access) Client Payments (Full Access) Client Profile (Full Access) Contract Management (Read Only) Non-Treatment Team Access Release to billing
<input checked="" type="checkbox"/>	Clinical Staff and/or Clinical Supervisor and/or Case Manager	Clinical (Full Access)	Authorization (Full Access) Client Diagnosis Create Scheduler Encounter Manage staff schedules (Read-Only) Release to billing
<input type="checkbox"/>	Non-Clinical Staff (Office staff)	Clinical (Read-Only)	Authorization (Read-Only) Client Profile (Full Access) Intake (Full Access) Manage staff schedules Non-Treatment Team Access Notes (Full Access)
<input type="checkbox"/>	Staff Accepting Referrals and Authorizations	Clinical (Full Access) Clinical Supervisor	Authorization (Full Access) Manage staff schedules (Read-Only)

Additional Job Function Roles and Role Attributes outside of standard role access must be approved by the IDHW WITS Administrators.

Additional Role Attributes

- Admission (Full Access) – Access to enter admission information.
- Agency Reporting – Access and run agency-wide reports under Reports.
- Billing Encounter List – Access to the encounter list screen under agency/billing.
- Client Diagnosis – Access to enter a diagnosis on the admission screen.
- Create Scheduler Encounter – Access to create or view an encounter for scheduled appointments.
- Consent (Full Access) – Access for non-clinical staff to accept/reject consented information from other agencies.
- Contract Management (Read-Only) – Access to view contract management under Agency/Contract Management.
- Drug Testing (Full Access) – Access to enter drug testing results.
- Drug Testing (Read-Only) – Access to view drug testing results.
- *Group Notes – (Add Group) – Access to enter new groups.
- Human Resources (Full Access) – Access to enter staff profiles and staff information.
- Human Resources (Read-Only) – Access to view staff profiles and staff information.
- Manage Staff Schedules – Access to enter and view appointments for all active agency staff.
- Manage Staff Schedules (Read-Only) – Access to view appointments for all active agency staff.
- Notes (Full Access) – Access to enter and view miscellaneous notes.
- Referrals (Full Access) – Access to accept/reject referrals from other agencies in WITS.
- Release to Billing – Access to release encounter notes.
- Reset Logon – Access to enable accounts, reset passwords and pins, and unlock staff accounts.
- TxEncounter (Full Access) – Access to enter encounter notes (billable notes).
- Vital Signs (Full Access) – Access to enter vital signs.

*** Staff that will create the Group Types and set-up the initial Group Profiles should be granted Group Notes (Add Group).**

GAIN Access

Please submit a copy of GAIN Certification or IDHW GAIN Trainee Form*. Supporting documentation of QP Status must be on file at DHW for individuals at DHW Treatment Agencies and will be verified before permissions will be granted.

- GAIN-I  If this box is marked, also submit the GAIN ABS User Information form, the GAIN Usage Agreement form, and a copy of the user's GAIN-I certificate.
- GAIN Data Manager

***IDHW GAIN Trainee's must achieve GAIN Certification within six months of the date of the training. Access to the GAIN site will be revoked if not certified within this timeframe.**

Justification: _____

The signature below serves as a record that I have reviewed this request and approve of the requested WITS security access.

Awesome Administrator
Agency WITS Administrator Signature/Other Appropriate Staff

11/25/13
Date

**Submit the completed form(s) to the WITS Help Desk:
via Support Ticket in WITS, or email dbhwitshd@dhw.idaho.gov, or fax 208-332-7305.**

IDAHO WITS USER AGREEMENT

Substance Use Disorders Program

I, John Smith, employed by XYZ Counseling Center (*agency name*), understand that all information on the Idaho WITS database is confidential and I agree not to disclose any information regarding persons who have applied for, have received or who are receiving substance use disorders services to any unauthorized persons.

I understand that I may only use the information in the performance of activities of the Idaho WITS system for which I have been authorized. I understand that use or disclosure of any information concerning a recipient of assistance or service for any purpose other than the activities of Idaho WITS is prohibited except on written consent of the recipient.

I understand that I may only use the Idaho WITS site for those specific functions for which I am authorized. I understand that I will only be given access to information for which I have a legitimate need to know to complete my job functions.

I understand that my Idaho WITS Password and PIN are confidential and must be protected from unauthorized access. They are to be used only by me and I am prohibited from sharing my individual security information. Therefore, I agree to (a) limit unauthorized physical access to computer systems, displays, networks and health-care records; (b) position monitors and keyboards so they are not easily seen by anyone other than myself; (c) where appropriate, program workstations to display password protected screen savers if left idle for a specified period of time.

I understand that Help Desk service for Idaho WITS will be provided through the Idaho Department of Health and Welfare as a free service for users. I acknowledge and accept that Help Desk service is provided without representation or warranty of any kind, and as such no liability will be taken for advice and assistance given to me where I or my representatives deem that advice to be inappropriate or incorrect. I am welcome to use the Idaho WITS Help Desk to help resolve WITS issues; however the Department and WITS Help Desk accepts no responsibility for any loss that may be suffered by any user who relies totally or partially on information imparted by the Idaho WITS Help Desk to make the service workable in the providers' environment. The Department and WITS Help Desk will not be liable to you or any other persons or entity with respect to any liability, loss or damage caused or alleged to be caused either directly or indirectly by WITS or the WITS Help Desk. The Department reserves the right to protect our Help Desk staff from any form of abuse by withdrawing the Help Desk service from the customer at any time deemed fit by Department management.

By signing below, I am indicating that I have read this entire nondisclosure agreement and agree to abide by it. I also understand that any violation of this agreement may result in the revocation of my access to Idaho WITS. Furthermore, I understand that criminal prosecution may be undertaken if I knowingly and intentionally disclose the information to anyone who is unauthorized, or use the data for fraudulent purposes.

John Smith
Print Name

John Smith
Signature

11/25/13
Date

Chestnut Health Systems
Modified for use in Idaho

GAIN ABS USER INFORMATION

Mail this completed form to the WITS Coordinator per the check list.

If you have any questions about this form, please e-mail the WITS Helpdesk at DBHWITSHD@dhw.idaho.gov or call 208-332-7316.

Today's Date: 11/25/13

USER INFORMATION

Agency name: XYZ Counseling Center

GAIN ABS User First Name: John

GAIN ABS User Last Name: Smith

Phone number: (208) 123-4567

E-mail address: johnsmith@XYZCounselingCenter.com

Address: 1234 Main Street

City: Utopia

State: ID

Zip code: 83702

Staff ID: *To be assigned by SUD*

Does the USPS package (addressed to Denise) include a completed GAIN Usage Agreement for this user? Yes No

PERMISSIONS

(Please select the permissions for this user. According to HIPAA guidelines, a person should only have enough access necessary to perform his or her job. Also, the number of users that have permission to delete assessments, transfer assessments, and receive assessments should be limited.)

Create assessments

Edit assessments (If this GAIN ABS user will be completing assessments in more than one session, he or she must have this permission.)

Read/review assessments

Generate/edit GAIN Recommendation and Referral Summaries (G-RRS)

Read/review GAIN Recommendation and Referral Summaries (G-RRS)

Generate/edit Quick Recommendation and Referral Summaries (Q-RRS)

Read/review Quick Recommendation and Referral Summaries (Q-RRS)

Generate Personalized Feedback Reports (PFR)

Generate full assessment reports (full list of items and responses)

Generate Validity Reports

GAIN Usage Agreement
(Last updated By GAIN June 20, 2007)

By signing below I am agreeing to:

- use the GAIN only if I (or my agency) have a valid GAIN license agreement.
- represent the GAIN only as a tool for research or program evaluation and, if used clinically, as one of several sources of information that should be combined with clinical judgment in making diagnosis, placement and other clinical decisions.
- not train others to use the GAIN until I have been certified, or not otherwise misrepresent my certification level to others.

Name: John Smith _____

Agency: XYZ Counseling Center _____

Address: 1234 Main Street _____

Utopia, ID 83702 _____

Phone: (208) 123-4567 _____

Fax: _____

E-mail: johnsmith@XYZCounselingCenter.com _____

Grant Program (if applicable): Not Applicable _____

Grant # (if applicable): Not Applicable _____

Sponsor/Funder (if applicable): Not Applicable _____

GAIN License #: Idaho Project License

John Smith
Trainee Signature

11, 25, 2013
Date (MM/DD/YYYY)

John Smith
Print Trainee's Name

Joe Trainer
GAIN Certified Trainer

11, 25, 2013
Date (MM/DD/YYYY)

Joe Trainer
Print Trainer's Name

Trainer, Please initial All that apply:

GAIN Coursework Certificate

GAIN Administration Certification