DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Medicaid Services
F-02118 (09/2022)

AUTHORIZED SUBMITTER DESIGNATION FOR ACCESS TO Program Participation System (PPS) and Functional Screen Information Access (FSIA)

Agency Name and Module

	Authorized Submitter	Additional Authorized Submitter	Additional Authorized Submitter
Full Name (include middle initial)			
Job Title			
Telephone Number			
Fax Number			
Email Address			

I have read the client confidentiality regulations covered by state policy and federal/state statutes and understand their relationships to authorizing access to client information and will ensure such confidentiality in accordance with Wis. Stats §§ 49.81 and 49.83.

I have a legal and ethical responsibility to protect the confidentially and security of all protected data and information to which I have access via the Wisconsin Department of Health Services (DHS) system application(s). Confidential information may include but is not limited to: financial information, client/patient identifiable information, or protected health information. This information is protected by state and federal laws.

I agree to the following:

- I will not in any way access, use, divulge, copy, release, sell, loan, review, alter, or destroy any confidential information except as properly and clearly authorized within the scope of my job and all applicable policies and laws. I will not re-disclose any information I have accessed unless needed to complete my authorized task and as allowed by law.
- I acknowledge that my WAMS ID password is the equivalent of my signature and I am responsible for its use. I will not use or request to be informed of anyone else's password.
- I acknowledge that when I submit an access request form as the Authorized Submitter, I am certifying that the applicant has a business need for the access and is qualified to have it.
- If I know of an actual or attempted privacy or security violation or inappropriate use or disclosure of this data, I will notify DHS.
- It is my responsibility to inform my supervisor and the State Security Officer, in writing, when I am leaving employment. When my association ends, I will no longer access confidential information and will not take any confidential information with me.
- It is also my responsibility to notify DHS when anyone affiliated with my agency no longer needs access to FSIA or PPS and request the revocation of such access.

I understand that my actions in this system may be intercepted, monitored, recorded, copied, audited, inspected, and disclosed to authorized personnel. Any improper use or unauthorized access of this system may result in administrative disciplinary action and civil and criminal penalties. By signing this form and continuing to use DHS system(s), I consent to these terms and conditions.

After signing, please scan the completed and signed form and email to: DHSSOSHelp@dhs.wisconsin.gov.

SIGNATURE – Authorized Submitter	Date Signed
SIGNATURE – Additional Authorized Submitter	Date Signed
SIGNATURE – Additional Authorized Submitter	Date Signed

SIGNATURE – Agency Director	Date Signed	Type or Print Name