



STATE OF MISSOURI  
DEPARTMENT OF SOCIAL SERVICES  
ACCESS REQUEST

**I. IDENTIFYING INFORMATION SECTION**

SOCIAL SECURITY NUMBER	USERID
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NAME (LAST, FIRST, MI)			
		CONTRACTING AGENCY'S NAME	
DEPARTMENT DHSS		DIVISION Senior Services and Regulation	
COUNTY NAME		SECTION/UNIT EDL IVR	
WORK ADDRESS	CITY	STATE	ZIP CODE
WORK TELEPHONE NUMBER		JOB TITLE	

**II. ACTION SECTION**

ACTION REQUESTED

<input type="radio"/> ADD USERID	<input type="radio"/> ADD ADDITIONAL USERID	<input type="radio"/> DELETE ACCESS
<input type="radio"/> ADD ACCESS	<input type="radio"/> REPLACE ACCESS	<input type="radio"/> DELETE USERID

EFFECTIVE DATE OF ACTION (MONTH/DAY/YEAR)

CHANGE IDENTIFYING INFORMATION

PREVIOUS	NEW
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**III. ACCESS SECTION**

E-MAIL

COMMENTS-

DOA\$P066

**IV. CONFIDENTIALITY/SIGNATURE SECTION**

I, the undersigned, an employee or authorized contract representative of the State of Missouri, understand that approval and assignment of the requested ID or approval of the requested change enables me to access the resources, which by law, must be utilized only in the performance of my assigned duties. Therefore, I agree to make no inquiries or updates except in the performance of my official duties. I understand that state and federal statutes require confidentiality of information and provide penalties for unauthorized access, use, and/or disclosure of information. Violations or disclosures on my part may result in disciplinary action that may include one or all of the following: (1) suspension, (2) civil court action and (3) dismissal. I agree to keep confidential all information made available to me in the performance of my official duties. In addition, I agree not to divulge or share my password with anyone.

REQUESTOR (SIGNATURE)	DATE
SUPERVISOR/SECURITY COORDINATOR (SIGNATURE)	DATE
DIVISIONAL SECURITY OFFICER(S) (SIGNATURE)	DATE