MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
Bureau of Community Food and Nutrition Assistance
P.O. Box 570, Jefferson City, MO 65102-0570

NETWORK USER ACCESS REQUEST (CACFP)

HELP DESK LOG #
(Assigned by ITSD)

SOCIAL SECURITY NUMBER	OFFICE TELEPHONE
NAME (Last Name, First Name, MI)	ORGANIZATION NAME (Must Match CACFP Application)
DIVISION DCPH/BCFNA – Child and Adult Care Food Program (CACFP) 800-733-6251	OWNER/AUTHORIZED REPRESENTATIVE (Must Match CACFP Application)
EMAIL ADDRESS OF REQUESTOR	COUNTY
ADDRESS (PO Box/Street, City, State, ZIP)	

SOFTWARE ACTION REQUESTED

ACTION REQUESTED: ☒ ADD ACCESS ☐ DELETE ACCESS

☒ CACFP web-based system for application updates and claim submission.

COMMENTS

NOTES

Failure to log in to the system for any six-month period will cause your access to be deleted.

Keep a copy of the signed form for your records.

Submit a separate form for each individual needing access. (Make copies as needed.)
Access may be limited for independent centers.

Submit the completed, signed form by fax to 573-526-3679 *OR* by mail to CACFP, PO Box 570, Jefferson City, MO 65102.

I, the undersigned, understand that individual user IDs and passwords may not be transferred to others or shared. The individual user or the owner or authorized representative must contact the Missouri Department of Health and Senior Services-Bureau of Community Food and Nutrition Assistance (MDHSS-BCFNA) in writing if the user is leaving employment or changing job duties so that access may be revoked immediately. I understand that state and federal statutes require confidentiality of information and provide penalties for unauthorized access, use and/or disclosure of information. In addition, I agree not to divulge or share my passwords with anyone. I understand that misuse of another individual's user ID and password will not be tolerated. Access will be revoked immediately, and may only be restored by submitting a corrective action plan to MDHSS-BCFNA detailing how individual passwords will be protected and not shared. Claims for reimbursement submitted through misuse of another individual's user ID and password will be considered invalid, and must be repaid in full to the MDHSS-BCFNA.

USER SIGNATURE *(Required)* ➢	**DATE**
OWNER/AUTHORIZED REPRESENTATIVE SIGNATURE (Must match CACFP application) *(Required)* ➢	**DATE**
MDHSS-BCFNA APPROVAL SIGNATURE ➢	**DATE**

FOR INFORMATION TECHNOLOGY SERVICES DIVISION (ITSD) USE ONLY

DATE RECEIVED: