



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
 P.O. Box 570, Jefferson City, MO 65102-0570

MDHSS-BCFNA USE ONLY

**NETWORK USER ACCESS REQUEST
(SFSP)**

SOCIAL SECURITY NUMBER	OFFICE TELEPHONE
NAME (Last Name, First Name, MI)	ORGANIZATION NAME (Must Match SFSP Application)
DIVISION DCPH/BCFNA – Summer Food Service Program (SFSP) 888-435-1464	AUTHORIZED REPRESENTATIVE (Must Match SFSP Application)
ADDRESS (PO Box/Street, City, State, ZIP)	COUNTY
	EMAIL ADDRESS OF REQUESTOR

SOFTWARE ACTION REQUESTED

ACTION REQUESTED: ADD ACCESS DELETE ACCESS

SFSP web-based system for application updates and claim submission.

COMMENTS

NOTES

Keep a copy of the signed form for your records.

*Submit a separate form for each individual needing access. (Copies can be made if needed.)
 Access is limited to two users per sponsor.*

Submit the completed, signed form by fax to 573-526-3679 OR by mail to SFSP, 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 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.

MDHSS BCFNA USE ONLY

DATE RECEIVED:

USER SIGNATURE (Required) ➤	DATE
AUTHORIZED REPRESENTATIVE SIGNATURE (Must match SFSP application) (Required) ➤	DATE
MDHSS-BCFNA APPROVAL SIGNATURE ➤	DATE