Individual User Application for Access to State of Arizona Health-e-Arizona Plus (HEAplus)

An Individual User Application must be submitted by every individual who is requesting access to the Health-e-Arizona Plus (HEAplus) system as an authorized employee or volunteer with a Community Partner Assistor Organization (CP-AO). A CP-AO must have an active agreement with AHCCCS (CP-AO Agreement) and a designated Site Administrator prior to the submission of any Individual User Applications. Individual user access to HEAplus through a CP-AO organization account is granted pursuant to the terms of the CP-AO Agreement. Individual user access will be deactivated upon termination or cancellation of the CP-AO Agreement with AHCCCS.

To request access to the HEAplus system through a CP-AO organization account, an individual user must complete this application and email it to CP-AOOperationsTeam@azahcccs.gov.

All questions and fields must be completed:

- Incomplete applications will be returned and will not be processed until corrected and resubmitted.
- AHCCCS may request additional information from the applicant to process a request for access to the HEAplus system.
- Failure to provide information or correct an incomplete application will constitute a withdrawal of the request for access by the applicant.

A copy of this application must be retained by all parties for their records.

Community Partner Assistor Organization Information
Name of the CP-AO:
DBA, if applicable:
Is the organization an AHCCCS registered provider? ☐ YES ☐ NO If yes, what is the AHCCCS Provider ID?
URL for the organization's website:

Individual User's Information		
First Name:	**MI:**	**Last Name**:
Date of Birth:	**Social Security Number:**	
Home Address:	**City and State:**	**ZIP Code**:
Phone Number:	**Email Address**:	
Select one: ☐ **I am a volunteer and do not receive payment for my services to the CP-AO.** ☐ **I am a paid employee or otherwise receive payment for my services to the CP-AO.**		

Conditions for Access to HEAplus

As a condition of initial and ongoing authorization to access the HEAplus system through a CP-AO organization account, I agree to the following:

I will not disclose or lend my CP-AO organization account username or password to someone else. These credentials are for my use only and serve as my electronic signature. I understand that I may be held responsible for the consequences of unauthorized or illegal transactions.

I will not browse or use State of Arizona data files for unauthorized or illegal purposes.

I will not use State of Arizona data files for private gain or to misrepresent myself or the State of Arizona.

I will not make any disclosure of State of Arizona data that is not specifically authorized by the CP- AO site administrator.

I will not duplicate State of Arizona data files, create sub-files of such records, remove, or transmit data unless I have been specifically authorized to do so by the CP-AO site administrator.

I will not change, delete, or otherwise alter State of Arizona data files unless I have been specifically authorized to do so by the CP-AO site administrator.

I will not use HEAplus as a look-up tool unless I have been specifically authorized to do by the individual I am assisting for the purpose of assisting them with benefit eligibility.

I will not make copies of data files, with identifiable data, or data that would allow individual identities to be deduced unless I have been specifically authorized to do so by the CP-AO site administrator.

I will not intentionally cause corruption or disruption of State of Arizona data files.

I will complete all required training, including the Annual HEAplus Security Training.

I will immediately report any suspected security breach or unauthorized use of my identification number, username or password to CP-AOOperationsTeam@azahcccs.gov.

I will not use my CP-AO organization account to access or attempt to access records or eligibility information for myself, my family, my relatives, my roommate, the parent of my child, my significant other or my friends.

I will not use my CP-AO organization account to apply for benefits, report changes or renew eligibility for myself, my family, my relatives, my roommate, the parent of my child, my significant other or my friends.

I will not use my CP-AO organization account to apply for benefits, report changes or renew eligibility for another employee of my organization.

I will not use my CP-AO organization account to apply for benefits, report changes or renew eligibility for any person or household for which I am an Authorized Representative.

I will not use my CP-AO organization account to name myself as an Authorized Representative for any customer or household.

I will not charge or receive monetary payments from customers for helping them access information, apply for benefits, report changes, renew eligibility, or troubleshoot an application.

I will not contact or ask AHCCCS, Department of Economic Security (DES), or the CP-AO Call Center for information related to a customer unless I or someone from my organization has completed an allowable action in HEAplus for that customer using their HEAplus organization account.

I will not influence, coach, or recommend any AHCCCS health plan to a customer. I understand that the customer must make their own AHCCCS health plan choices.

I will not accept any premium payments from customers for AHCCCS KidsCare or Freedom to Work or for purchasing insurance through the Federal Insurance Marketplace.

I will not discriminate against any customers based on race, color, religion, gender, age, sexual orientation, or immigration status.

I will not release the name or any information about any HEAplus customer to any party, without the prior written consent of the customer or the customer's lawful representative.

I will provide information and services in a fair, accurate and impartial manner.

I will provide information that is appropriate to the needs of the individuals my organization serves, including individuals with limited English proficiency and will ensure accessibility to persons with disabilities.

I will protect the confidentiality of all information that may be obtained or used to perform customer assistance in accordance with applicable Federal, State, and local laws, regulations, ordinances, and directives relating to confidentiality.

I will obtain and upload a signed "Consent for an Assistor Form" before going beyond the "Information Belongs To" page in HEAplus when assisting a customer with an application.

I will not represent myself as an employee, agent, or officer of the State of Arizona, AHCCCS, DES or any affiliated agencies.

Denial or Revocation of HEAplus Access

I understand and agree that AHCCCS may deny my Individual User Application or revoke existing HEAplus access through a CP-AO organization account for failure to agree to or comply with any condition for access set forth in this form, the CP-AO's Agreement with AHCCCS, or for any reason which, in AHCCCS's sole discretion, presents concerns impacting the integrity of AHCCCS programs, the safety and privacy of AHCCCS members or presents a risk of potential fraud, waste or abuse. AHCCCS may consider a real or perceived conflict of interest in granting or continuing HEAplus system access. A violation of the conditions of access agreed to in this form or any other misuse of access to the HEAplus system may result in disciplinary or criminal action, based on the seriousness of the offense.

Individual User's Signature
By signing this form, I declare that I have read, understand and agree to the conditions for initial and continued access to the HEAplus system through a CP-AO organization account and the bases for denial or revocation of HEAplus access by AHCCCS. I understand, agree and authorize AHCCCS to consider any information available to it, including information obtained through a criminal background check, to determine whether to grant or continue my access to the HEAplus system through a CP-AO organization account. I understand and agree that AHCCCS may request additional information from me in order to consider my request for access, and that my failure to timely respond to the request will constitute a voluntary withdrawal of my Individual User Application. I declare that the information I have provided in this application is correct.

Signature of Individual User	**Date**
Name of Individual User (Please type or print)	**Title/Position of Individual User**

CP-AO Site Administrator's Signature
By signing this form, I confirm on behalf of the CP-AO identified herein that the individual user submitting this application is a volunteer or employee of the CP-AO and is authorized to request access to HEAplus pursuant to the terms of an active agreement between the CP-AO and AHCCCS. I acknowledge that the CP-AO assumes full responsibility and liability for the actions of the individual user in accessing HEAplus for the purpose of providing support services pursuant to the CP-AO's Agreement with AHCCCS. As the authorized CP-AO Site Administrator, I acknowledge that failure to supervise individual users, or report and address violations of the conditions of access by individual users, may result in the termination of the CP-AO's Agreement with AHCCCS.

Signature of CP-AO Site Administrator	**Date**
Name of CP-AO Site Administrator (Please type or print)	