CABINET FOR HEALTH AND FAMILY SERVICES
REQUEST FOR KPAP CLEARANCE

This form shall be completed for any person having a need and right to access *Kentucky Prescription Assistance Program (KPAP)* data through the Cabinet for Health and Family Services web-enabled system. All information must be accurate and complete.

Upon completion of the form, it **MUST BE SENT** for verification and approval to Department for Public Health, Health Care Access Branch (KPAP) by fax to 502-564-0655 or by email to 5025640655@cokfax.ky.gov

USER INFORMATION

OFFICE PHONE: ___ — ___ — _____ DATE: _____

NAME: _____ BIRTHDATE: ___ — ___ — _____

E-MAIL ADDRESS (required to create user account): _____

ORGANIZATION/ BUSINESS NAME: _____

ORGANIZATION/ BUSINESS ADDRESS: _____

CITY: _____ ZIP: _____ COUNTY: _____

ORGANIZATION/ BUSINESS TYPE: ☐ Free Clinic ☐ CHC ☐ LHD ☐ Human Services ☐ Hospital
☐ Other (Please Specify): _____

PREFERENCE(S): ☐ Accept referrals from KPAP Helpdesk ☐ Serve only your own patients/clients

SUPERVISOR AUTHORIZATION

I certify that the job duties of the User (listed above) require access to the KPAP system and that the access complies with appropriate use as specified in the Confidentiality / Security Agreement and the Non-Discrimination and Service agreement.

PRINT NAME of ORGANIZATION/ BUSINESS: _____

PRINT NAME of SUPERVISOR/ MANAGER: _____

SUPERVISOR SIGNATURE: _____ DATE: _____

E-MAIL ADDRESS: _____

FOR CABINET/ DPH INTERNAL OFFICE AUTHORIZATION ONLY

HCAB: _____ DATE: _____

PRINT NAME: _____

FOR SECURITY/ KPAP HELPDESK OFFICE ONLY - ACCOUNT

USER ID: _____ CREATED ON: _____

DISABLED DATE: _____

REASON (Select One): ☐ Non-Use ☐ Resigned ☐ Retirement ☐ Dismissed ☐ T/O Cabinet ☐ Other

CONFIDENTIALITY AGREEMENT

PRINT: _____ _____
(Last Name, First Name, M. I.) Organization/Business Name

KPAP SITE USER CONFIDENTIALITY/ SECURITY AGREEMENT

I understand that I will be allowed access to confidential information and /or records in order that I may perform my specific job or volunteer duties. I further understand and agree that I am not to disclose confidential information and/or records without the prior consent of the appropriate authority(s).

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), KPAP partners, purposes as described by the federal privacy regulation, 45 CFR Parts 160 and 164. HIPAA and the privacy rule information and medical records belong to that individual and, with certain exceptions, cannot be used, released or disclosed without the explicit permission of that individual or their legal guardian. Even casual or informal whether at work or not, may subject you to federal penalties and sanctions.

I understand that all USERID/Passwords issued by the Cabinet for Health and Family Services to access computer data are issued on an individual basis. I further understand that I am solely responsible for all information obtained, through system access, using my unique identification. At no time will I allow any other person use of my USERID/Password to logon to a network of the Cabinet or any other system. I understand my compliance is required and that intentional or inappropriate use can result in criminal penalties and fines.

I understand that accessing or releasing confidential information and/or records or causing confidential information and/or records to be accessed or released, on myself, other individuals, clients, relatives, etc., outside the scope of my assigned job duties would constitute a violation of this agreement and may be subject to disciplinary action up to and including involuntary termination. I understand all data, information, documents, etc. belong to the Cabinet for Health and Family Services, and/or their KPAP partners and I agree not to take any information in any form upon termination of my employment or volunteer work with the agency.

By affixing my signature to this document, I acknowledge that it is my responsibility to comply with the relevant laws, regulations and policies concerning access, use, maintenance and disclosure of confidential information and/or records which shall be made available to me through the Cabinet for Health and Family Services. I further agree that it is my responsibility to assure the confidentiality of all information, which has been issued to me in confidence even after my employment with the agency, has ended.

I further agree and understand that I am not allowed to charge patients to use KPAP services or use my access to KPAP software when not in the formal duties of my job/volunteer duties. I understand my compliance is required, and that intentional or inappropriate use may result in criminal penalties and fines.

I understand that failure to comply with these confidentiality requirements through disclosing information or sharing USERID/Passwords issued by the Cabinet for Health and Family Services to access computer data shall be cause by the Cabinet for Health and Family Services to revoke my access privileges and those of my agency.

_____ _____ _____ _____
Employee Signature Date Signed Supervisor/ Manager Signature Date Signed

KENTUCKY PRESCRIPTION ASSISTANCE PROGRAM NON-DISCRIMINATION AND SERVICE AGREEMENT

The Kentucky Prescription Assistance Program (KPAP) is free and available to ALL Kentuckians in need of assistance accessing free or reduced-cost prescription medications through existing pharmaceutical programs. Users of the KPAP Drug Assistant software are prohibited from charging patients and/or clients for drug assistance support through the KPAP Drug Assistant software. Users are prohibited from discriminating based on race, color, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from public assistance program, military service or affiliation, or political beliefs. By signing into the Drug Assistant system, you are agreeing to these terms.

User also agrees to assist patients/clients with KPAP Drug Assistant at no cost. User agrees to not misuse the Drug Assistant software for the purposes of obtaining payment or compensation from the patient/client.

Please sign and date below to acknowledge that you have read this document and agree to comply with KPAP's Non-Discrimination and Service Agreement.

_____
User's Printed Name

_____ _____
User's Signature Date