



HEALTHeLINK[™] Registration Application

Data Supplier (Mark appropriate boxes) Data Recipient

Organization legal Name (please print): _____

New Department/Group *within* Participant (if applicable): _____

Participant Alias (if applicable): _____

Organization NPI: _____ Organization TIN: _____

Participant Type (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Primary Care Practice | <input type="checkbox"/> Specialty Care Practice |
| <input type="checkbox"/> Multi Specialty Care Practice | <input type="checkbox"/> Other Clinical Practice | <input type="checkbox"/> Behavioral Health Entity |
| <input type="checkbox"/> Urgent Care | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> PPS/Health Home |
| <input type="checkbox"/> Public Health Agency/Clinic | <input type="checkbox"/> Licensed Laboratory | <input type="checkbox"/> Licensed Radiology Site |
| <input type="checkbox"/> Long Term Care Facility | <input type="checkbox"/> Home Care Agency | <input type="checkbox"/> EMS Agency |
| <input type="checkbox"/> Dental Practice | <input type="checkbox"/> Payer | <input type="checkbox"/> FQHC |
| <input type="checkbox"/> Community Based Organization | <input type="checkbox"/> Other (Describe) _____ | |

Specialty(Specialties): _____

Briefly describe your intended purpose of use: _____

1. Is Participant a Covered Entity? (as defined in the HIPAA rules) Yes No

2. Is Participant a 42 CFR Part 2 Entity or OASAS Facility Yes No

3. Is Participant a Hybrid* (45 CFR Sec 164.105)? Yes No

*If yes, please attach a copy of your election of Hybrid Designation document

4. Is Participant an OMH, OASAS, or OPWDD Licensed Facility Yes No If Yes, which: _____

Main Address: _____ Suite/Floor/Bldg: _____

City, State, Zip Code: _____

Primary Business Phone: _____ Fax: _____

Number of Providers (MD, DO, NP, PA): _____ No. of Sites: _____

EMR Vendor: _____ EMR Model: _____ EMR Version: _____

Address 2: _____

City/State/Zip Code: _____

Phone: _____ Fax: _____

Address 3: _____

City/State/Zip Code: _____

Phone: _____ Fax: _____

***Please list additional locations on Page 3**



Authorized Contact/s (See attached responsibilities):

1. Name: _____ 4-Digit PIN#: _____

Phone: _____

Email: _____

2. Name: _____ 4-Digit PIN#: _____

Phone: _____

Email: _____

Privacy Officer: (See attached responsibilities)

Name: _____ Phone: _____

Email: _____

Security Officer: (See attached responsibilities)

Name: _____ Phone: _____

Email: _____

Primary Business Contact:

Name: _____ Phone: _____

Email: _____

Secondary Business Contact:

Name: _____ Phone: _____

Email: _____

Providers

***Please list providers on page 3**

The undersigned represents and attests that all facts and information are accurate, current, complete, not misleading and that:

- (a) The Participant is what he / she represents it to be;
- (b) The Participant will notify HEALTHeLINK of any changes to the information contained on this form within ten (10) days of such change; and
- (c) The Participant and all agents and employees thereof will at all times accurately represent itself, himself and/or herself in all communications using HEALTHeLINK/HEALTHeNET Services.

Authorized Signer: _____ Title: _____

Printed Name: _____ Date: _____



Provider Name	Title (MD/DO/DPM, etc.)	NPI	Specialty	Location(s) worked at:

Additional Addresses:

Address 4: _____

City/State/Zip Code: _____

Phone: _____ Fax: _____

Address 5: _____

City/State/Zip Code: _____

Phone: _____ Fax: _____

HEALTHeLINK Use Only:

OCR Check Complete Participant Type permitted Approved Declined

Date Reviewed: _____ Date Approved/Denied: _____

Reason for Denial: _____



Responsibilities of the Authorized Contact (AC)

An “Authorized Contact” is the person(s) within your practice, facility or organization who will be responsible for the duties listed below. The AC may or may not also be the Privacy and/or Security Officer. If another individual serves in either of these roles, please identify them on the HEALTHeLINK Registration Application. Responsibilities of the AC include:

Communication

- Provide HEALTHeLINK with a valid business email address to ensure delivery of important notices regarding enhancements, maintenance or outages, or other critical communications
- Communicate all changes or additions in the practice address, email address, phone or fax numbers to your HEALTHeLINK account manager immediately.
- Communicate changes *prior to* major business transaction such as mergers, sale or incorporation of your practice. Notification could be *critical* to preserve your current Participation Agreement (PA) and patients’ consent status. Notifications after the fact may result in the termination of your current PA and loss of your current patients’ consents.

Administration

- Manage Authorized Users within the practice/organization by submitting requests through the AC Portal:
 - Deactivations must be reported within 24 hours of termination or role change that no longer requires use of HEALTHeLINK
 - New User Requests – be sure to select options carefully based upon the user’s role in the organization, i.e. need to view Clinical Results (Clinical) or Demographic Data/Consent Status only (Non-Clinical)
 - User Lists must be reviewed every 30 days. Failure to do so will block your ability to request any new users
- Ensure each User of HEALTHeLINK is trained in HIPAA and HEALTHeLINK Policies and Procedures prior to providing access, and annually thereafter
- Contact our Help Desk at 877-895-4724 with any User problems including difficulties accessing HEALTHeLINK

Other

- A practice may have more than one AC to handle off-hours password issues and manage multiple site practices. The AC will inform their HEALTHeLINK account manager of additional or new ACs.



Responsibilities of the Participant Privacy Officer (PO)

The “Privacy Officer” is the person(s) at your practice, facility or organization who is responsible for the duties listed below in their interactions with HEALTHeLINK as required by the HEALTHeLINK Participation Agreement, Privacy and Security Policies and as a HIPAA Covered Entity. The Privacy Officer reference in the HIPAA Privacy Rule is as follows:

§ 164.530 Administrative requirements.

(a)(1) Standard: Personnel designations. (i) A covered entity must designate a privacy official who is responsible for the development and implementation of the policies and procedures of the entity.

(ii) A covered entity must designate a contact person or office who is responsible for receiving complaints under this section and who is able to provide further information about matters covered by the notice required by § 164.520.

(2) Implementation specification: Personnel designations. A covered entity must document the personnel designations in paragraph (a)(1) of this section as required by paragraph (j) of this section.

Responsibilities related to the HEALTHeLINK Participation Agreement and the Policies and Procedures:

Communication

1. Provide HEALTHeLINK with a valid individual email address and phone number to ensure the delivery of important compliance related notices and other critical communications.

Investigations

2. HEALTHeLINK Compliance will contact you as needed for investigations, notifications and verifications. Please respond to any messages as soon as possible.

Reporting

3. Be aware of the phone number to contact HEALTHeLINK should there be a need to report a breach or discuss any patient or user related compliance issues, (716)206-0993, option 1.

Administration

4. In conjunction with your Authorized Contact (AC), ensure each HEALTHeLINK User is trained in HIPAA and HEALTHeLINK Policies and Procedures **prior to** providing access **and annually thereafter**. HEALTHeLINK Policy and Procedure training can be accomplished by having the User read the HEALTHeLINK Policies and Procedures documentation. Policies are also reviewed during a mandatory Computer Based Training Module launched on a new user’s first log in to HEALTHeLINK and annually thereafter.

Auditing

5. Privacy Officer will receive periodic usage audits requiring verification there is a treating relationship between the practice and the patient that was accessed by a User in your practice. The Privacy Officer or delegate must review the audit and reply to HEALTHeLINK. If HEALTHeLINK does not receive a response to an audit, sanctions will be levied.



Responsibilities of the Participant Security Officer (SO)

The “Security Officer” is the person(s) at your practice, facility or organization who is responsible for the duties listed below in their interactions with HEALTHeLINK as required by the HEALTHeLINK Participation Agreement, Privacy and Security Policies and as a HIPAA Covered Entity. The Security Officer reference in the HIPAA Privacy Rule is as follows:

§ 164.308 Administrative safeguards.

(a) (2) Standard: Assigned security responsibility. Identify the security official who is responsible for the development and implementation of the policies and procedures required by this subpart for the covered entity or business associate.

Responsibilities related to the HEALTHeLINK Participation Agreement and the Policies and Procedures:

Communication

1. Provide HEALTHeLINK with a valid individual email address and phone number to ensure the delivery of important compliance related notices and other critical communications.

Investigations

2. HEALTHeLINK Security will contact you as needed for investigations, notifications and verifications. Please respond to any messages as soon as possible.

Reporting

3. Be aware of the phone number to contact HEALTHeLINK should there be a need to report a breach or discuss any patient or user related compliance issues, (716)206-0993, option 1.

