

**State of Nebraska, Department of Health and Human Services (DHHS)  
External Access Confidentiality Statement**

I agree that any and all DHHS information gathered in the performance of my duties, either independently or through access to any DHHS system, shall be held in the strictest confidence.

I understand that DHHS, as a covered entity under HIPAA, must make reasonable efforts to limit my access to protected health information to the minimum necessary to accomplish the intended purpose<sup>1</sup>. In addition to HIPPA, I agree to follow the Medicaid level of privacy (see 42 CFR § 431.300 and Nebraska Revised Statute § 68-313) which makes it unlawful to solicit, disclose, receive, make use of, authorize, knowingly permit, participate in, or acquire information except in the course of the performance of official duties with DHHS. My access for any and all information related to Nebraska Casemix is limited to the minimum necessary for the purpose of care and treatment, payment, or required and necessary operation.

I agree that any and all information shall be released to no one other than DHHS or authorized individuals in strict compliance with any business agreements or contracts in force.

I agree to meet all applicable state and federal laws and regulations and to comply with all DHHS Security and Privacy Policies, Procedures and Standards.

I acknowledge that the Policies on Information Technology Security are available to me for review and that I have been informed and understand that it is my responsibility to become familiar with and abide by these policies.

I understand that if I wrongfully disclose the information described above, I may be subject to disciplinary action by my employer, and civil and criminal penalties.

I understand that due to security restrictions, Nebraska Casemix information may only be accessed through a secured internet connection. I agree not to access any Nebraska Casemix information through any unsecured internet connection.

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**Employee Information**

(Please clearly print all information except for signatures.)

**Employee Name:** \_\_\_\_\_

**Employee Title/Position** \_\_\_\_\_

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Work Phone** \_\_\_\_\_ **Work E-mail** \_\_\_\_\_

**Employer/Agency Name** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **NE** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Employee Work Site (if different than above address)** \_\_\_\_\_

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**Immediate Supervisor Information**

**Printed name:** \_\_\_\_\_

**Position Title:** \_\_\_\_\_

**Work Phone** \_\_\_\_\_ **Work E-mail** \_\_\_\_\_

**Signature:** \_\_\_\_\_

<sup>1</sup> Pursuant to HIPAA 45 CFR 160-164  
EACS v.1 approved 10-23-2003 (Revised 8/19/19)

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**Immediate Supervisor Information continued**

Does this supervisor have access to a DHHS Application? \_\_\_\_\_ Lotus Notes? \_\_\_\_\_  
Yes or No Yes or No

If not, who should be listed as supervisor on the requested Application? Give Name and Position

\_\_\_\_\_

Contact Person if different from immediate supervisor \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

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**Other Information**

Does your access request relate to:  NCS WEB

Other (Specify) \_\_\_\_\_

Have you had access to any DHHS applications such as N-FOCUS or CHARTS at another work place? \_\_\_\_\_  
Yes or No

If Yes, What application and Where? \_\_\_\_\_

Are you replacing existing staff? \_\_\_\_\_ If Yes, Name \_\_\_\_\_  
Yes or No

Date employee left \_\_\_\_\_ (OR)

Employee has new position in the same company and still needs existing access \_\_\_\_\_ Yes \_\_\_\_\_ No

Position and Location \_\_\_\_\_

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**Original signed copy to be sent to DHHS**

\*\*\*\*\* For DHHS Use Only \*\*\*\*\*

Employee Name \_\_\_\_\_

Information received \_\_\_\_\_ Sent to Help Desk \_\_\_\_\_  
Date Date

Comments:

NFOCUS Position # \_\_\_\_\_