

APS Healthcare, Inc. – West Virginia
**APS I/DD WAIVER PROVIDER ADMINISTRATOR USER ACCOUNT
REQUEST**

Please Type or Print Clearly

PROVIDER _____ **Agency ID** _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

Indicate the Provider Administrator's User account access role by checking only one box.

(Note: A **Service Coordinator Administrator** manages referrals and Service Coordinators employed by your agency.
A **Service Only Administrator** manages service referrals for an agency that does not provide Service Coordination.)

**REQUESTED
USER ACCESS:**

**Service
Coordinator
Administrator**

**Admin
Read Only**

**Service
Only
Administrator**

**** Administrators requiring access to multiple locations of their parent/corporate agency:
Please list the BHHF assigned Provider/Agency ID(s) below. Note that the Provider/Agency
ID listed above (top-right) is your Primary Location.**

Administrator's Name _____

Address _____

E-Mail _____

Direct Phone # & Extension: _____

**Provide a Security Question and Answer unique to you, which will be used to identify you when you request account reset.
This question should have nothing to do with your actual password; it is for identification purposes, and should be
something that you will remember. A good example is Mother's Maiden Name.**

**Security
Question** _____

Answer _____

User Agreement: I, individually and as an authorized web user of the aforementioned Provider, agree that I will access and use the information available through the APS Healthcare – WV Title XIX I/DD Waiver web site only for treatment and healthcare operations purposes (as those terms are defined in the HIPAA Privacy Rule.) I will use all reasonable precautions with respect to protecting the security of my unique login and the privacy and security of the data within this web site.

User Signature _____ **Date** _____

CEO Signature _____ **Date** _____

Submit to: APS-WV Information Services 100 Capitol Street Charleston WV 25301 or Fax 866-521-6882