Missouri Department of SOCIAL SERVICES
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APPLICATION TO CONDUCT RESEARCH/STUDY

PLEASE TYPE OR PRINT LEGIBLY - ATTACH ADDITIONAL PAGES AS NECESSARY

DATE OF REQUEST

TITLE OF STUDY	
RESEARCHER(S)	
ORGANIZATION	
PHONE NUMBER	FAX NUMBER
ADDRESS	
BEGIN DATE	END DATE
PUBLICATION INTENTIONS	
ENDORSEMENTS	

A. GENERAL INFORMATION REGARDING STUDY (ATTACH ADDITIONAL PAGES AS NECESSARY)

1. ARE YOU A TENURE-TRACK OR FULL-TIME RESEARCH FACULTY MEMBER AT AN ACCREDITED INSTITUTION OF HIGHER EDUCATION ENGAGED IN SCHOLARLY RESEARCH?

☐ Yes Institution/University: _____

☐ No

2. HAVE YOU PREVIOUSLY RECEIVED APPROVAL FOR THIS RESEARCH PROJECT FROM AN INSTITUTIONAL REVIEW BOARD (IRB)?

☐ Yes Institution/University: _____ (PLEASE ATTACH A COPY OF THIS APPROVAL)

☐ No

3. HAVE YOU RECEIVED A LETTER OF SUPPORT FROM A DIVISION DIRECTOR WITHIN THE MISSOURI DEPARTMENT OF SOCIAL SERVICES?

☐ Yes From: _____ (PLEASE ATTACH A COPY OF SUPPORT LETTERS)

☐ No

4. DESCRIBE THE PURPOSE/GOAL OF THIS STUDY.

5. DESCRIBE THE METHODOLOGY OF THE STUDY.

6. DESCRIBE THE SPECIFIC DATA/INFORMATION (INCLUDING TRANSACTION CODES, IF APPLICABLE) THAT IS REQUESTED.

7. IF YOU NEED INFORMATION WHICH IDENTIFIES SPECIFIC INDIVIDUALS, EXPLAIN IN DETAIL WHY THE IDENTIFYING INFORMATION YOU ARE REQUESTING IS ESSENTIAL TO YOUR RESEARCH.

8. DESCRIBE THE DETAILED PLAN OF MAINTAINING CONFIDENTIALITY OF THE IDENTIFYING INFORMATION USED IN YOUR RESEARCH OR EVALUATION. ALL ELEMENTS BELOW MUST BE EXPLAINED IN DETAIL.

A. WHO WILL HAVE ACCESS TO THE IDENTIFYING INFORMATION?

B. WHAT PROCEDURES ARE IN PLACE TO ENSURE ALL PERSONS WHO HAVE ACCESS TO THE IDENTIFYING INFORMATION UNDERSTAND THE REQUIREMENT TO KEEP THE IDENTIFYING INFORMATION CONFIDENTIAL AND THE LEGAL CONSEQUENCES OF ANY VIOLATION OF CONFIDENTIALITY?

C. DESCRIBE THE SECURITY MEASURES (PHYSICAL, ELECTRONIC, ETC.) THAT WILL BE USED TO PROTECT PARTICIPANTS' INFORMATION (E.G., LOCKED FILE CABINETS, COMPUTER PASSWORDS, ETC.)

D. IDENTIFYING DATA SHOULD BE DESTROYED WITHIN 60 DAYS UPON CONCLUSION OF THIS RESEARCH/STUDY. DO YOU AGREE TO COMPLY?

☐ Yes ☐ No IF YES, DESCRIBE THE DESTRUCTION METHOD TO BE USED.

E. IF THE RESEARCH DESIGN REQUIRES THE RELEASE OF ANY INFORMATION WHICH WOULD IDENTIFY PERSONS SERVED BY THE DEPARTMENT OF SOCIAL SERVICES, PLEASE DESCRIBE IN DETAIL THE PROCESS BY WHICH YOU WILL OBTAIN THE CONSENT OF THE PERSON SERVED OR, IF PERSON SERVED IS A CHILD, THE PARENT OR GUARDIAN OF THE PERSON SERVED IN ORDER TO RELEASE THE IDENTIFYING INFORMATION. PROVIDE A COPY OF THE PROTOCOL FOR OBTAINING CONSENT AND A COPY OF THE PROPOSED CONSENT FORM.

9. DO YOU AGREE THAT DATA RELEASED WILL BE USED ONLY FOR THE PURPOSE STATED IN THIS APPLICATION?

☐ Yes ☐ No

10. DESCRIBE HOW THE PARTICIPANTS WILL BE RECRUITED AND SELECTED.

11. DESCRIBE WHAT WILL BE REQUIRED OF THE DEPARTMENT OF SOCIAL SERVICES (PERSONNEL, RESOURCES, ETC.) TO COMPLY WITH YOUR REQUEST.

12. DESCRIBE THE EXPECTED BENEFITS OF THIS STUDY (TO CLIENTS, AGENCY, SOCIETY, ETC.)

13. DESCRIBE ANY POTENTIAL RISKS (PSYCHOLOGICAL, PHYSICAL, CONFIDENTIALITY, ETC.) THAT MAY BE EXPERIENCED BY THE PARTICIPANTS AND HOW THESE RISKS WILL BE MINIMIZED.

14. ADDITIONAL COMMENTS THAT MAY PROVE HELPFUL IN THE REVIEW OF THIS REQUEST.

B. HIPAA ASSURANCES AND PROTECTIONS (ATTACH ADDITIONAL PAGES AS NECESSARY)

1. IS IT POSSIBLE TO CONDUCT THE RESEARCH WITH DATA THAT DOES NOT IDENTIFY THE INDIVIDUALS?

☐ Yes If your research can be accomplished with all the individual identifiers, down to a three-digit zip code level deleted, then the data does not contain individually identifiable health information and HIPAA requirements do not apply. *Please briefly explain how this will be accomplished.*

☐ No Please continue

2. IS IT POSSIBLE TO OBTAIN THE INFORMED CONSENT OF THOSE PARTICIPATING?

☐ Yes ☐ No

3. IF DATA IS BEING REQUESTED, IS IT POSSIBLE TO OBTAIN INFORMED CONSENT OF THE PARTICIPANTS PRIOR TO DSS RELEASING DATA?

☐ Yes **Please include, with this request,** the HIPAA compliant authorization form to be used to get individual authorizations from the clients (or guardian, if minor) to release their information.

☐ No *Please provide a brief explanation* and continue.

4. HOW WILL YOU PROTECT THE IDENTIFIERS IN THE PROTECTED HEALTH INFORMATION (PHI) AGAINST IMPROPER USE AND DISCLOSURE?

5. WILL IT BE POSSIBLE TO ELIMINATE THE INDIVIDUAL IDENTIFIERS IN THE DATA AT **ANY** PHASE IN THE RESEARCH PRIOR TO THE COMPLETION OF THE RESEARCH? IF SO, PLEASE DESCRIBE HOW AND WHEN THIS WILL BE DONE.

6. IF THIS REQUEST IS APPROVED, I AGREE AND ASSURE THAT THE PROTECTED HEALTH INFORMATION WILL NOT BE REUSED OR DISCLOSED TO ANY OTHER PERSON OR ENTITY, EXCEPT AS REQUIRED BY LAW OR FOR AUTHORIZED OVERSIGHT OF THE RESEARCH STUDY.

☐ Yes I agree with this statement. ☐ No I do not agree with this statement.

By signing this document, you agree to carry out research precisely as stated in this application. You further agree that no changes in the research design or use of the data provided by the Department of Social Services may be made or implemented without the prior, written consent of the Department of Social Services. You acknowledge and understand that any information or data provided by the Department of Social Services is or may be confidential as a matter of law. You understand that unauthorized disclosure of confidential information provided by the Department of Social Services may be subject to significant civil liability and/or criminal prosecution. You agree that you and your institution shall be solely responsible for maintaining the confidentiality of the information and you shall be responsible for the actions of your agents, employees, students and other persons who may be working with this data. You agree that in the event the confidential information has been disclosed to unauthorized persons or entities you will immediately notify the Department of Social Services and all persons who may be impacted by the unauthorized disclosure and to take all reasonable measures to mitigate any harm caused by the unauthorized disclosure of confidential information. You further agree that you and your institution will be responsible for the payment of any damages, costs, penalties, fines, including attorneys' fees and litigation expenses, which may arise out of the disclosure of confidential information provided by the Department of Social Services. You also agree that you will defend, pay, indemnify and hold the State of Missouri and the Department of Social Services harmless from any and all claims, damages, fines, assessments and other liabilities including attorneys' fees and litigation costs, which may be charged against the State of Missouri or the Department of Social Services as a result of any improper release or disclosure of confidential data provided by the Department of Social Services. If approved, a Memorandum of Understanding (MOU) may also be required.

PRINTED NAME OF INDIVIDUAL SUBMITTING APPLICATION	TITLE

DATE	SIGNATURE

Instructions: Completed applications can be submitted via e-mail to the Children's Division at cd.researchcommittee@dss.mo.gov or at dss.privacyofficer@dss.mo.gov for the remaining divisions. Applications can also be mailed to the DSS Privacy Officer, Division of Legal Services, PO Box 1527, Jefferson City, MO 65102-1527.

C. DSS USE ONLY

DIVISION	☐ APPROVED ☐ REJECTED
DIVISION DIRECTOR OR DESIGNEE	DATE
DSS PRIVACY BOARD	☐ APPROVED ☐ REJECTED
DSS PRIVACY OFFICER OR DESIGNEE	DATE