

**MISSOURI WORK ASSISTANCE
DEPARTMENT OF SOCIAL SERVICES
ACCESS REQUEST FORM**

I. IDENTIFYING INFORMATION SECTION

SOCIAL SECURITY NUMBER

USER ID

NAME (LAST, FIRST, MI)			
CONTRACT WORKER <input type="checkbox"/> YES <input type="checkbox"/> NO		CONTRACTING AGENCY'S NAME	
REGION		SUPERVISOR ID	
LOCATION/COUNTY NAME		JOB TITLE	
WORK ADDRESS	CITY	STATE	ZIP CODE
WORK TELEPHONE NUMBER	WORK FAX NUMBER	MWA SYSTEM ROLE	

II. ACTION SECTION

ACTION REQUESTED		
<input type="checkbox"/> ADD USER ID	<input type="checkbox"/> ADD ADDITIONAL ACCESS	<input type="checkbox"/> DELETE ACCESS
<input type="checkbox"/> ADD ACCESS	<input type="checkbox"/> CHANGE ACCESS	<input type="checkbox"/> DELETE USER ID
EFFECTIVE DATE OF ACTION (MONTH/DAY/YEAR)		
CHANGE IDENTIFYING INFORMATION		
PREVIOUS	NEW	

III. ACCESS SECTION

E-MAIL	DO YOU ALSO NEED AN INTERNET MAIL ID?
	<input type="checkbox"/> YES <input type="checkbox"/> NO

COMMENTS:

IV. CONFIDENTIALITY/SIGNATURE SECTION

I, the undersigned, an employee or authorized contract representative of the State of Missouri, understand that approval and assignment of the requested ID or approval of the requested change enables me to access the resources, which by law, must be utilized only in the performance of my assigned duties. Therefore, I agree to make no inquiries or updates except in the performance of my official duties. I understand that state and federal statutes require confidentiality of information and provide penalties for unauthorized access, use, and/or disclosure of information. Violation or disclosures on my part may result in disciplinary action that may include one or all of the following: (1) suspension, (2) civil court action, and (3) dismissal. I agree to keep confidential all information made available to me in the performance of my official duties. In addition, I agree not to divulge or share my password with anyone.

REQUESTOR (SIGNATURE)	DATE
AGENCY'S SUPERVISOR/SECURITY COORDINATOR SIGNATURE	DATE
FSD/MWA AUTHORIZING SIGNATURE	DATE