Harmony Data System Access Coordinator Agreement

Name of Provider Agency: _____

An Access Coordinator will be responsible to oversee the following locations. If you are a worker for a Medicaid Provider, please list the Medicaid number(s) respective to each location (e.g. Anchorage – 1 234567).

Medicaid #: _____

As a Harmony Data System (Harmony) Access Coordinator, I understand that I am responsible for adhering to the rules listed below:

1. I understand that I am responsible for all the Provider Agency's workers who have access to Harmony and that they will comply with the rules listed in the Harmony Privacy and Security Agreement for Individual Provider User form;

2. I must notify immediately, no later than 24 hours of separation, to the Division of Senior and Disabilities Services (SDS) Harmony administrator at DSDSHarmonyHelp@alaska.gov when:
   a) a provider agency's worker who has access to Harmony is no longer affiliated to the provider agency.
   b) there is any suspected or actual breach of security, intrusion, or unauthorized access, use, or disclosure of client or related confidential information, as defined in the Harmony Privacy and Security Agreement for Individual Provider User form.
   c) changes occur with my legal name, affiliation with my current organization, or title. I understand that I am also responsible for notifying these changes, if they occur to any of the provider agency's workers who have access to Harmony.

3. I will comply with all federal and state laws, regulations, policies and rules, including, but not limited to:
   a) the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. LNo.104-191, 110 Stat.1936 (1996), (codified principally at 42 U.S.C. § 1320d-1320d-6);
   b) the HIPAA privacy and security regulations; and
   c) the HIPAA Title II Administrative Simplification and Compliance Act provisions governing electronic transactions and code sets, security, unique identifiers and privacy, Pub L. No. 107-105, 115 Stat. 1003 (2001), (codified principally at 45C.F.R. § 160, §162, and § 164).

4. I understand that I will only sign a Harmony Privacy and Security Agreement for Individual Provider User form after ensuring that the respective Provider Agency's:
   a) have a need for accessing Harmony to complete job function within the ProviderAgency; and
   b) b) have been approved through the Alaska Background Check Program prior to requesting Harmony access.

As a Harmony Access Coordinator for the provider agency, I hereby agree, by signing this form, that I have read the Harmony Access Coordinator Agreement and the Harmony Privacy and Security Agreement for Individual Provider User forms. I hereby agree to abide by the rules listed in both forms. I understand that failure to comply may result in losing the privilege of being a Harmony Access Coordinator and/or termination of access to Harmony at the sole discretion of SDS.

After completing and having this agreement signed by the Provider Agency's Owner, Administrator and/or Director, please scan it entirely and send it to DSDSHarmonyHelp@alaska.gov.

Harmony Access Coordinator Information

Printed Name: _____ Date: _____

Title: _____ E-mail: _____

Signature: _____ Phone: _____

Do you as the Access Coordinator need access to Harmony?

Yes ◯ No ◉

Note: If "Yes", you must complete a Privacy and Security Agreement for Individual Provider User (separate form) and send it to DSDSHarmonyHelp@alaska.gov.

Please select the type of the Provider Agency (check all that apply):

Care Coordination Agency ☐ Personal Care Services Agency ☐

Long Term Care Facility ☐ ADRC ☐

Note: If the Provider Agency is a covered entity under HIPAA, and SDS is acting as the Provider Agency's business associate, the Provider Agency and SDS will be bound by the Appendix A, the respective Business Associate Agreement signed.

As the Provider Agency's owner, administrator, and/or director, I understand that I am responsible for all the provider agency's access coordinators. I understand that this responsibility is not limited to the Harmony Access Coordinator Agreement forms which I have signed. I hereby agree, by signing this form, that I have read the Harmony Access Coordinator Agreement and the Harmony Privacy and Security Agreement for Individual Provider User forms. I hereby agree to abide by the rules listed in both forms and assure that the Provider Agency's policies and procedures support its intent. I understand that unauthorized use or disclosure of confidential information may subject the organization and/or individuals to administrative actions, prosecutions, and personal, civil, and/or criminal liabilities and legal penalties.

Provider Agency's Owner, Administrator and/or Director Information

Printed Name: _____ Signature: _____

E-mail: _____ Phone: _____ Date: _____