



FOCoSonline Account Authorization

Acknowledgement of Understanding and Responsibilities - Individuals

Who should complete this Form: This form must be completed by all individuals before they can be granted access to FOCoSonline.

First Name _____ Last Name _____

Company Name (Only if applicable): _____

Statement of Authorization and Acknowledgment of Responsibilities

FOCoS Innovation is a covered entity as defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Accordingly, FOCoS complies with the HIPAA Privacy Regulations promulgated in 45 CFR 160 and 164.

Therefore, I acknowledge that by having access to FOCoSonline, I have access to certain information contained in/or generated by FOCoSonline that is protected by HIPAA Security and Privacy Rules, in current form and as they are updated, and by other State and federal laws and regulations.

I further understand that a unique login and password have been assigned to me for use as a key to gain access to the system. I acknowledge that it my responsibility to change this password upon initial sign on to the system, at least every 90 days thereafter, and immediately in the event that I believe anyone other than myself may have gained access to my password information.

I agree that I will not leave my PC or any other electronic device unattended and logged on in a manner that would allow use of my PC or other electronic device by another operator. Passwords that have been disclosed under special circumstances and approval of your manager must be changed immediately.

I further acknowledge that my password is confidential to me, as an individual user, and may not be disclosed to any other person. I understand that my password may not be kept in written form or in a manner that would enable access to it by another person, and that logon scripts or macros that emulate a logon and password are prohibited and may not be used or created.

In the event I become aware, or otherwise suspect that any information contained in FOCoSonline has become compromised or otherwise accessed by an unauthorized individual, I agree to notify the appropriate State authority.

Additionally, you acknowledge that FOCoSonline is the intellectual property owned by FOCoS Innovations Corp and agree to only use FOCoSonline for its intended use.

By signing below, I attest that I have read and agree to the above Statement of Responsibilities.

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Please fax the completed form to 1-877-578-5561

User Account

Name (please print): _____

Contact Phone Number: (_____) _____ - _____ ext: _____

Email Address: _____

Last 4 of SSN _____

Date of Birth _____

Physical Address

Street and Number _____

City _____ State _____ Zip _____

Mailing Address

Street and Number _____

City _____ State _____ Zip _____

Please Check One (check both if access is needed in both programs):

☐ Mi Via ☐ Centennial Care

User Role - Please mark all that apply

☐ Participant/Member ☐ Employer of Record ☐ Employee
☐ Participant/Member Support Person

If you are the Employer of Record, please list the Participant/Member(s) you are the Employer of Record for: _____

If you are an Employee, please list the Participant/Member(s) you are an Employee for:

Signature: _____ Date: _____

For Employer of Record Only

If you are the Employer of Record for a Participant/Member please indicate whether you intend to (please check only one):

- ☐ Continue to fax signed time sheets to Xerox for entry and approval
- ☐ Approve time sheets using the FOCO*Sonline* system

If you select to approve time sheets using the FOCO*Sonline* system you agree that you will ensure that all employee time sheets are entered and approved in accordance with the approved payroll cycle (time sheets must be completed in the online system on Saturday immediately following the end of the payroll cycle). Additionally you agree to retain a signed paper copy of each employee's time sheet for the purposes of audit.

Signature: _____ Date: _____