CARES AUTOMATED SYSTEMS ACCESS REQUEST

Use this form to request access to CARES systems and reports managed by the Wisconsin Department of Health Services (DHS). Provide as much information as possible. For new users, **all** the fields in Sections 1 and 2 are required. Refer to the CARES Automated Systems Access Request Instructions, F-00476A, for information about completing this form. Authorized security officers must securely email the completed form to DHS CARES Access and Identity Management Services.

Note: Child Support Agency requests should be completed on DCF-F-2923-E and submitted using the instructions on the form.

REQUEST TYPE:

SECTION 1: USER INFORMATION

1. Name – Requester		2. Phone Number
3. Email Address	4. Four-Digit PIN	5. Secret Word

SECTION 2: USER'S EMPLOYMENT INFORMATION

6. Name – Agency		7. Agency Type	
8. Date Started at Agency	9. Name – Employer		10. Employer Type ☐ Private ☐ Public
11. Name – Supervisor	12. Phone Number	13. Email Address	

SECTION 3: SYSTEMS ACCESS

14. Indicate whether system access should be added or deleted.

System	Add	Delete	System	Add	Delete
CARES Mainframe	☐	☐	Extranet	☐	☐
CARES Worker Web (CWW)	☐	☐	KIDS	☐	☐
Local Consortia SharePoint **Access Level:**	☐	☐	SAVE	☐	☐
Consortia SharePoint Reports	☐	☐	Second-Party Review Tool **Access Level**:	☐	☐
Electronic Benefits Transfer (EBT) **Access Level:**	☐	☐	Wisconsin Integrated Security Application (WISA) – supervisors only	☐	☐
Electronic Case File (ECF)	☐	☐			
Other – specify:				☐	☐

SECTION 4: REPORTS ACCESS

15. Indicate whether report access should be added or deleted.

Income Maintenance Management (IMMR) Reports

Report	Add	Delete	Report	Add	Delete
Application	☐	☐	FoodShare Employment and Training (FSET) **Access Level:**	☐	☐
Benefit Allotment	☐	☐			
Benefit Issuance	☐	☐	Income Maintenance Quality Assurance (IMQA Tool Users Only)	☐	☐
Caseload Management	☐	☐	Potential Errors	☐	☐
Change	☐	☐	Renewal	☐	☐
Discrepancy	☐	☐	Six-Month Report Form (SMRF)	☐	☐
Documents	☐	☐	Supervisor	☐	☐
Enrollment	☐	☐	Verification Due	☐	☐
Fair Hearing	☐	☐	Other – Specify:	☐	☐

Control D Reports

Report	Add	Delete	Report	Add	Delete
Benefit Recovery	☐	☐	Human Services Reporting System (HSRS) **Reporting Unit:**	☐	☐
Economic Support	☐	☐			
			W-2 Reports	☐	☐

SECTION 5: ACCOUNT INFORMATION

16. CARES ID (leave blank if new user)	17. DWD WI Logon (WIEXT) ID
18. WAMS ID	19. WebI ID (leave blank if new user)

CARES Mainframe and CWW

20. Security Level	21. Worker Type	
22. Job Function Code	23. County/Tribal Number	24. Location Code

25. Primary CARES Access (position 4)

CARES Mainframe

26. Benefit Recovery (BV) Access (position 3)

Access level: ☐ Add ☐ Delete

SECTION 6: CONSORTIUM AND REGIONAL OFFICE ACCESS (Complete either 27 OR 28)

27. Indicate whether update access should be added or deleted for a consortium or region. The update access applies to **all** offices in the consortium or region.

IM Consortium	Add	Delete	FSET Region(s)	Add	Delete
	☐	☐	Region 1	☐	☐
W-2 Region(s)	**Add**	**Delete**	Region 2	☐	☐
Forward Services Corporation (FSC) – All	☐	☐	Region 3	☐	☐
Milwaukee East Central	☐	☐	Region 4	☐	☐
Milwaukee Northern	☐	☐	Region 5	☐	☐
Milwaukee Southern	☐	☐	Region 6	☐	☐
Milwaukee West Central	☐	☐	Region 7	☐	☐
North Central	☐	☐	Region 8	☐	☐
Northeast	☐	☐	Region 9	☐	☐
Northwest	☐	☐	Region 10	☐	☐
Southeast	☐	☐	Region 11	☐	☐
Southwest	☐	☐			
Western	☐	☐			

28. Indicate the office for which limited access is needed.

Name – Individual Office	Office Number	Add	Delete
		☐	☐

SECTION 7:   ADULT INCIDENT REPORTING SYSTEM ACCESS

FOR MCO AND MCQS USE ONLY

29. Indicate whether system access should be added or deleted.

Adult Incident Reporting System	Add	Delete	
	☐	☐	

30. MCO User – Enter MyWisconsin ID

31. MCQS (State staff only) – Enter preferred MCO

SECTION 8: USER AGREEMENT FOR ACCESS TO THE WISCONSIN DEPARTMENT OF HEALTH SERVICES SYSTEMS

I have a legal and ethical responsibility to protect the confidentiality and security of all protected data and information to which I have access through a DHS system(s). Confidential data includes, but is not limited to, financial information, personally identifiable information (PII), and protected health information (PHI). Confidential data is protected by state and federal laws. In order to be granted access to confidential data, I agree to the following:

I will not in any way access, use, divulge, copy, release, sell, loan, review, alter, or destroy any confidential data except as properly and clearly authorized within the scope of my job and all applicable policies and laws. I will not browse or use files that I am not authorized to and that exceed the minimum necessary to do my job. I will not redisclose any information I have accessed unless needed to complete my authorized task and as allowed by law.

I acknowledge the receipt of my IDs and passwords. I understand that passwords are the equivalent of my signature and that I am responsible for their use. I will not share my ID and passwords with other people. I understand that violation of this policy may result in immediate termination of my access to DHS systems.

If I know of an actual or attempted privacy or security violation or inappropriate use or disclosure of confidential data, I will notify my security officer and supervisor immediately.

I understand that my actions in a DHS system(s) may be intercepted, monitored, recorded, copied, audited, or inspected by and disclosed to authorized personnel. I understand that any improper use or unauthorized access of a DHS system(s) may result in immediate termination of my access and may subject me to administrative disciplinary action and civil and criminal penalties.

It is my responsibility to inform my supervisor and security officer, in writing, when I am leaving employment. When my employment ends, I will no longer access confidential data and will not take any confidential data with me.

By signing this form, I indicate that I consent to these terms and conditions.

SIGNATURE – User		Date Signed
Print User Name	Title	
SIGNATURE – Supervisor		Date Signed
SIGNATURE – Agency/County/Tribal Security Officer		Date Signed
Phone Number	Email Address	
SIGNATURE – State Security Officer		Date Signed