Health-e-Arizona Plus Community Partner Assistor Organization Application

This application collects the information for an organization to request access to the Health-e-Arizona plus (HEAplus) system as a HEAplus Community Partner Assistor Organization (CP-AO). The CP-AO's users have HEAplus accounts they use to help customers apply for benefits, renew benefits, and report changes for Medicaid, Nutrition Assistance, and Cash Assistance. CP-AOs have workload features in HEAplus to allow them to track the status of the applications they submit on behalf of their customers and create reports of their activities.

Complete this application and email it to CP-AOOperationsTeam@azahcccs.gov. All questions must be answered. Incomplete applications will be returned. Submitting this application does not guarantee approval as a HEAplus CP-AO. AHCCCS reserves the right to deny an application to be a HEAplus CP-AO.

A copy of this application must be retained by all parties for their records.

General Information
Name of the organization:
Is the organization an AHCCCS registered provider? If yes, what is the AHCCCS Provider ID?
URL for the organization's website:

Locations

Please enter the name, address, and phone number of each location you want to have included in the HEAplus account. *Note: Only specify the location(s) where staff will be directly using the HEAplus System.*

Name of Location	Address of Location (City, State, ZIP Code)	Phone Number

Type of Organization (Select one):
☐ AHCCCS Registered Medical Provider or Contractor (RBHA, health plan, FQHC, hospital, other clinic or medical provider)
☐ Tribal 638, IHS, Urban Indian Health Center or tribal social service office
☐ Non-Profit Community Organization (church, food bank, social services agency)
☐ State or Local Government
☐ Organization type is not listed, Please describe:

HEAplus Community Partner Agreement Contact Person	
The contact person is the person in the organization who has the authority to sign on behalf of the organization and will be the person AHCCCS communicates with for anything involving the contract. AHCCCS will send the agreement to this person for signature.	
Please provide the following information for the person who will be the organization's contact person:	
Name:	**Title/Position:**
Mailing Address (City, State, ZIP Code):	
Email Address:	**Phone Number:**

Site Administrator	
The HEAplus Site Administrator is the person in the organization who will be responsible for: • Creating HEAplus accounts for staff • Resetting HEAplus passwords for staff • Deactivating HEAplus user accounts and notifying AHCCCS when staff members leave employment or move to a new position that does not use HEAplus • Keeping the information for the organization's locations (sites) current in HEAplus.	
Please provide the following information for the person who will be the organization's Site Administrator:	
Name:	**Title/Position:**
Mailing Address (City, State, ZIP Code):	
Email Address:	**Phone Number:**

Briefly provide an explanation of how the organization plans to use the system:

The undersigned attests to being an authorized representative of the applying entity, has the authority to sign and submit this application, and attests to all the following by checking the boxes and signing below:
☐ **I affirm** that only approved and authorized users will be allowed to enter customer data in HEAplus.
☐ **I affirm** that all users must submit an individual user application to become an authorized user.
☐ **I affirm** that every person authorized to have a HEAplus account shall complete all required HEAplus training.
☐ **I affirm that confidentiality and privacy of customers' information disclosed in applying for benefits will be maintained as described in ARS 36-509 and in all applicable Federal and State laws and regulations.**
☐ **I affirm** that the security of any HEAplus user accounts within the organization will be maintained by the HEAplus Community Partner Assistor organization.
☐ **I affirm** that information and services will be provided to customers in a fair, accurate, and impartial manner.
☐ **I affirm** that our Community Partner Assistor Organization **will not** charge a fee for completing a HEAplus screening or application.
☐ **I affirm** that the organization will update all users and administrators within 48 hours of any changes.
☐ **I affirm** that inactivity of this account for a period of 12 months will result in termination of the agreement and deactivation of the HEAplus account.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this application.
☐ HEAplus CP-AO's users are acting as agents of our customers and not acting as agents or business associates of AHCCCS, Arizona Department of Economic Security (DES), or any affiliated agency or entity and will only use HEAplus at the request of and with written permission from our customers.

Signature of Organization Representative	**Date**
Name of Organization Representative (Please type or print)	**Title of Organization Representative**