Department of Health and Human Services (DHHS)
Division of Long Term Supports and Services (DLTSS)
Bureau of Adult and Aging Services (BAAS)

105 Pleasant St.
Concord, NH 03301

BAAS POLICY RELEASE (PR)	
PR NUMBER:	24-17
TO:	All BAAS Staff
FROM THE OFFICE OF:	Bureau Chief of Adult and Aging Services (BAAS), Wendi Aultman
SIGNATURE:	
SUBJECT:	Revisions To OPTIONS User Forms
EFFECTIVE DATE:	Revised 10.10.2024

SUMMARY

This Policy/Process Release (PR) releases revisions and obsoletion to OPTIONS User forms.

POLICY

No policy is being changed by the release of this PR.

DESCRIPTION OF REVISIONS MADE TO FORMS

- The following changes have been made to BEAS Form 3530, OPTIONS User Request:
  - *Name change from BEAS to BAAS*
  - *General formatting and language updates*
- OPTIONS Electronic Billing and Services Authorization (OEBSAM)
  - *Previously was not an official form, is now BAAS Form 3545,* OPTIONS Electronic Billing and Services Authorization (OEBSAM)

IMPLEMENTATION

This policy is effective upon release of this PR. All previous versions of the above mentioned forms must be destroyed immediately.

The New version of BAAS Form 3530 is available electronically ***only*** by requesting one via email from options.helpdesk@doit.nh.gov .

The New version of BAAS Form 3545 is also available electronically ***only*** on the DHHS website at www.dhhs.nh.gov/forms-documents-0.

FORMS INSTRUCTIONS

Remove and Destroy	Insert/Replace
BEAS Form 3530, OPTIONS User Request *All version*	BAAS Form, 3530, *OPTIONS User Request* *PR # 24-17*
N/A	BAAS Form 3545, *OPTIONS Electronic Billing and Services Authorization (OEBSAM)* PR # 24-17

BEAS 3510, OPTIONS *Change Request (CR) Workplan*	N/A
BEAS 3515, OPTIONS Release Notice	N/A
BEAS 3520, OPTIONS Systems Change Request	N/A
BEAS 3525. OPTIONS Application Requirements and Design	N/A
BEAS 3535, Options AD Hoc Request	N/A

DISTRIBUTION

This PR will be distributed according to the electronic distribution list for BAAS policy releases and will be available internally on the DHHS (N:) drive for staff to access and on the DHHS website at Bureau of Adult and Aging Services (BAAS) General Memos (GM) and Policy Releases (PR) | New Hampshire Department of Health and Human Services (nh.gov) for public access.

ACCESS TO OPTIONS – USER REQUEST

DATA USE AND CONFIDENTIALITY AGREEMENT

SECTION 1: User Information

☐ State Employee ☐ Contractor ☐ Other: ______________________________

Requestor's First Name:____________________MI:______ Last Name: ______________________________

Title: ____ Phone #: ______________________________

Email Address:____

Business/DO Office Name: ____

Address: ____

SECTION 2: Options Confidentiality Agreement – To be read and signed by the requestor

In the course of business, DHHS, of which Options is a part, receives, discloses, and utilizes personal information of individuals for a variety of reasons. All personal, financial, and health care information maintained by DHHS, including information in Options, is considered confidential. DHHS maintains privacy, confidentiality, and integrity with regard to confidential information, as required by state and federal laws, rules, regulations, and professional ethics.

DHHS may grant access to Options to authorized user(s) who have a justified business need to perform their assigned job duties remotely. This access may be temporary or ongoing.

I certify that I have read and understand the following:

- **I understand** that I may only access Options for authorized purposes
- **I understand** that I may have direct or indirect access to confidential information in the course of performing my work activities and I agree to protect the confidential nature of all information to which I have access
- **I understand** that I may not extract, print, print screen, scrape (hand copy information from screens), or photograph Social Security Administration (SSA) provided data from Options for any purpose.
- **I understand** that I am required to comply with DHHS policies and procedures related to the protection of individually identifiable information and Department assets
- **I understand** that I am required to take all necessary precautions to protect DHHS information and assets from unauthorized access, use, modification, destruction, theft, disclosure, loss, damage, or abuse (including, but not limited to, the Options system and its contents which include personally identifiable information (PII) and protected health information (PHI)
- **I understand** that if I fail to abide by Department of Information Technology (DoIT) and DHHS policies and procedures, my access to Options will be revoked immediately

Requestor's Name: ____

Requestor's Signature: ____ Date:____________________

Supervisor's Name: ____

Supervisor's Signature: ____ Date: ____________________

SECTION 3: DHHS Approvals

Approver's Name: ____ Agency: ____________________

Approver's Signature: ____ Date: ____________________

Approved: ☐ Yes ☐ No

Access Start Date: ____________________ Access End Date: ____________________

By Requesting and Receiving Approval To Access The DHHS Data:

- I understand that I will have direct and indirect access to confidential information in the course of performing my work activities.
- I agree to protect the confidential nature of all information to which I have access.
- I understand that there are state and federal laws and regulations that ensure the confidentiality of an individual's information.
- I understand that there are DHHS policies and agency procedures with which I am required to comply related to the protection of individually identifiable information.
- I understand that the information extracted from the site shall not be shared outside the DHHS Scope of Work or related signed Memorandum of Understanding and/or Information Exchange Agreement/Data Sharing Agreement agreed upon.
- I understand that my SFTP, information or any security credentials (user name and password) should not be shared with anyone. This applies to credentials used to access the site directly or indirectly through a third party application.
- I will not disclose or make use of the identity, financial or health information of any person or establishment discovered inadvertently. I will report such discoveries *immediately* to **DHHSInformationSecurityOffice@dhhs.nh.gov** as soon as feasible, but no more than 24 hours after the aforementioned has occurred and that Confidential Data may have been exposed or compromised. If a suspected or known information security event, Computer Security Incident, Incident or Breach involves Social Security Administration (SSA) provided data or Internal Revenue Services (IRS) provided Federal Tax Information (FTI).
- I will not imply or state, either in written or oral form, that interpretations based on the data are those of the original data sources or the State of NH unless the data user and DHHS are formally collaborating.
- I will acknowledge, in all reports or presentations based on these data, the original source of the data.
- I understand how I am expected to ensure the protection of individually identifiable information. Should questions arise in the future about how to protect information to which I have access, I will immediately notify my supervisor.
- I understand that I am legally and ethically obligated to maintain the confidentiality of DHHS applicants, recipients, patient, and other sensitive information that is protected by information security, privacy or confidentiality rules and state and federal laws even after contract termination or leaving DHHS employment.
- I have been informed that this signed agreement will be retained on file for future reference.

__________________________________ ____________________________
Requestor Printed Name Date

__________________________________ ____________________________
Requestor Signature Title

____
Business Name or DO/Office Name

INSTRUCTIONS

Fill out page 1 and 2 completely. When the form is filled out and signed, email it to the Options Help Desk at OPTIONS@dhhs.nh.gov

Section 1: User Information

State Employee: Any full-time or part-time employee of a New Hampshire state agency or entity

Contractor: Any employee contracted by a New Hampshire state agency or entity to provide a service.

Other: Any individual authorized by a New Hampshire state agency or entity to provide a service who is neither a State Employee nor a contractor.

First Name, MI, Last Name: Name of the individual requesting access

Phone: The requestor's phone number

Email: The requestor's email address

Business Name: The entity the requestor is employed by

Section 2: Data Use and Confidentiality Agreement

Page 1 – Options Confidentiality Agreement

Requestor's Name: Printed name of the requestor

Requestor's Signature: Signature of the requestor

Date: The date the form was signed by the requestor

Page 2 – DHHS DATA USE AND CONFIDENTIALITY AGREEMENT

Signature: Signature of the requestor

Printed Name: Printed name of the requestor

Business Name: The entity the requestor is employed by

Date: The date the form was signed by the requestor

Title: Business title of the requestor

Section 3: Approvals

Approver's Name: Printed name of a full-time State Employee operating in an administrative or supervisory capacity and who is authorized to provide access to the Options application. Adult Protective Services District Office supervisors are able to approve requests for their staff.

Agency: The state agency or entity the approver is employed by.

Approver's Signature: Signature of a full-time State Employee operating in an administrative or supervisory capacity and who is authorized to provide access to the Options application.

Date: The date the form was signed by the approver.

Access Start Date: The effective date when the requestor may begin accessing the Options application.

Access End Date: The expiration date when the requestor may no longer access the Options application. Access for non-DHHS/DoIT users cannot exceed one year.

OPTIONS Electronic Billing and Service Authorization (OEBSAM) – USER REQUEST

DATA USE AND CONFIDENTIALITY AGREEMENT

SECTION 1: User Information

☐ State Employee ☐ Contractor ☐ Other: ______________________________

Type of Access:

☐ Electronic Billing ☐ Service Authorization Maintenance

Requestor's First Name:____________________MI:______ Last Name: ____________________

Title: ______________________________ Phone #: ____________________

Email Address:____

Business Name: ____

Address: ____

SECTION 2: Options Confidentiality Agreement – To be read and signed by the requestor

In the course of business, DHHS, of which Options EBSAM is a part, receives, discloses, and utilizes personal information of individuals for a variety of reasons. All personal, financial, and health care information maintained by DHHS, including information in Options, is considered confidential. DHHS maintains privacy, confidentiality, and integrity with regard to confidential information, as required by state and federal laws, rules, regulations, and professional ethics.

DHHS may grant access to Options EBSAM to authorized user(s) who have a justified business need to perform their assigned job duties remotely. This access may be temporary or ongoing.

I certify that I have read and understand the following:

- **I understand** that I may only access Options EBSAM for authorized purposes
- **I understand** that I may have direct or indirect access to confidential information in the course of performing my work activities and I agree to protect the confidential nature of all information to which I have access
- **I understand** that I may not extract, print, print screen, scrape (hand copy information from screens), or photograph Social Security Administration (SSA) provided data from Options EBSAM for any purpose.
- **I understand** that I am required to comply with DHHS policies and procedures related to the protection of individually identifiable information and Department assets
- **I understand** that I am required to take all necessary precautions to protect DHHS information and assets from unauthorized access, use, modification, destruction, theft, disclosure, loss, damage, or abuse (including, but not limited to, the Options EBSAM system and its contents which include personally identifiable information (PII) and protected health information (PHI)
- **I understand** that if I fail to abide by Department of Information Technology (DoIT) and DHHS policies and procedures, my access to Options EBSAM will be revoked immediately

Requestor's Name: ______________________________

Requestor's Signature: ______________________________ Date:____________________

SECTION 3: DHHS Approvals

Approver's Name: ______________________________ Agency:____________________

Approver's Signature: ______________________________ Date:____________________

Approved: ☐ Yes ☐ No

Access Start Date: ____________________ Access End Date: ____________________

By Requesting and Receiving Approval To Access The DHHS Data:

- I understand that I will have direct and indirect access to confidential information in the course of performing my work activities.
- I agree to protect the confidential nature of all information to which I have access.
- I understand that there are state and federal laws and regulations that ensure the confidentiality of an individual's information.
- I understand that there are DHHS policies and agency procedures with which I am required to comply related to the protection of individually identifiable information.
- I understand that the information extracted from the site shall not be shared outside the DHHS Scope of Work or related signed Memorandum of Understanding and/or Information Exchange Agreement/Data Sharing Agreement agreed upon.
- I understand that my SFTP, any information or security credentials (user name and password) should not be shared with anyone. This applies to credentials used to access the site directly or indirectly through a third party application.
- I will not disclose or make use of the identity, financial or health information of any person or establishment discovered inadvertently. I will report such discoveries *immediately* to **DHHSInformationSecurityOffice@dhhs.nh.gov** as soon as feasible, but no more than 24 hours after the aforementioned has occurred and that Confidential Data may have been exposed or compromised. If a suspected or known information security event, Computer Security Incident, Incident or Breach involves Social Security Administration (SSA) provided data or Internal Revenue Services (IRS) provided Federal Tax Information (FTI).
- I will not imply or state, either in written or oral form, that interpretations based on the data are those of the original data sources or the State of NH unless the data user and DHHS are formally collaborating.
- I will acknowledge, in all reports or presentations based on these data, the original source of the data.
- I understand how I am expected to ensure the protection of individually identifiable information. Should questions arise in the future about how to protect information to which I have access, I will immediately notify my supervisor.
- I understand that I am legally and ethically obligated to maintain the confidentiality of DHHS client, patient, and other sensitive information that is protected by information security, privacy or confidentiality rules and state and federal laws even after contract termination or leaving DHHS employment.
- I have been informed that this signed agreement will be retained on file for future reference.

______________________________	______________________________
Requestor Printed Name	Date
______________________________	______________________________
Requestor Signature	Title
______________________________	
Business Name	

INSTRUCTIONS

Fill out page 1 and 2 completely. When the form is filled out and signed, email it to Options Help Desk at OPTIONS@dhhs.nh.gov

Section 1: User Information

State Employee: Any full-time or part-time employee of a New Hampshire state agency or entity

Contractor: Any employee contracted by a New Hampshire state agency or entity to provide a service.

Other: Any individual authorized by a New Hampshire state agency or entity to provide a service who is neither a State Employee nor a contractor.

First Name, MI, Last Name: Name of the individual requesting access

Phone: The requestor's phone number

Email: The requestor's email address

Business Name: The entity the requestor is employed by

Section 2: Data Use and Confidentiality Agreement

Page 1 – Options EBSAM **Confidentiality Agreement**

Requestor's Name: Printed name of the requestor

Requestor's Signature: Signature of the requestor

Date: The date the form was signed by the requestor

Page 2 – DHHS DATA USE AND CONFIDENTIALITY AGREEMENT

Signature: Signature of the requestor

Printed Name: Printed name of the requestor

Business Name: The entity the requestor is employed by

Date: The date the form was signed by the requestor

Title: Business title of the requestor

Section 3: Approvals

Approver's Name: Printed name of a full-time State Employee operating in an administrative or supervisory capacity and who is authorized to provide access to the Options EBSAM application.

Agency: The state agency or entity the approver is employed by.

Approver's Signature: Signature of a full-time State Employee operating in an administrative or supervisory capacity and who is authorized to provide access to the Options EBSAM application.

Date: The date the form was signed by the approver.

Access Start Date: The effective date when the requestor may begin accessing the Options EBSAM application.

Access End Date: The expiration date when the requestor may no longer access the Options EBSAM application. Access for non-DHHS/DoIT users cannot exceed one year.