COLORADO
Department of Health Care
Policy & Financing

SOLICITATION #:
2017000265

Appendix KK
Regional Accountable Entity for the Accountable Care Collaborative – Data Access Request

COLORADO
Department of Health Care Policy & Financing

Regional Accountable Entity for the Accountable Care Collaborative – Data Access Request

This request and agreement will be used to grant access to a subset of data the Department of Health Care Policy and Finance (Department) administers or maintains. The request must be completed in full or it cannot be processed. Incomplete applications will be returned for additional information which may delay access.

This request must be filled out and returned to the Department's Purchasing and Contracting Services Section. Requests will be processed on a first-come, first-served basis, with data access approximately one week after the form is processed.

No Usernames will be provided until the User has executed all the forms described in Appendix A, Section 2.3. Any questions should be directed to the Department's Purchasing and Contracting Services Section.

All information provided shall be used solely for purposes of supporting the bidding process for the Regional Accountable Entity for the Accountable Care Collaborative.

User Access Start Date: Seven (7) to ten (10) days after receipt of signed executed Agreements.

Access Termination Date: 6/30/2017

Section 1 – Offeror Information

Organization Name: ______________________________

Organization Phone Number: _________________

Organization Physical Address / City / Zip: ____

Primary Contact Name: ____
(This is the person responsible for the Offeror's proposal)

Primary Contact Phone Number: ____

Primary Contact Email: ____

Section 2 – Offeror's Security Administrator Information

Security Administrator Name: ____

Security Administrator Phone Number: _________________

Security Administrator Email: ____
Access information will be sent to this email address.

If the organization that employs the Offeror's Security Administrator is different from the Offeror listed in Section 1, please include the Security Administrator's organization name and physical address.

Section 3 – Offeror's Responsible Party Information

The Responsible Party is the individual who will bear primary responsibility for the security of this data during the procurement process.

Responsible Party Name: ____

Responsible Party Phone Number: _________________

Responsible Party Email: ____

If the organization that employs the Offeror's Responsible Party is different from the Offeror listed in Section 1, please include the Responsible Party's organization name and physical address.

Section 4 – System User Agreement

☐ **HTTPS – Secure Web Interface to MoveIT web application service for Regional Accountable Entity for the Accountable Care Collaborative Data Access.**

Responsible Parties and Security Administrators will have the following responsibilities:

- Ensure System users are aware of any/all applicable HIPAA Privacy/Security Policies and Procedures.
- Shall establish appropriate administrative, technical, procedural, and physical safeguards to ensure the confidentiality and integrity of the data provided.
- Shall ensure all computers used to access and process this data contain appropriate, updated anti-virus software.
- Shall serve as the contact for any privacy/security issue that requires escalation of investigation.
- Shall immediately report alleged or actual privacy/security incident to the Department. These would include any/all incidents that could affect the system such as virus incidents, unauthorized access, improper use/disclosure of records and/or information, and any other activity that may be considered a violation or suspected violation, of this Agreement or the Limited Data Use Agreement.
- Shall update Appendix A of this Agreement and forward it to the Department if/when the information changes.

Responsible Party Signature: ____
(By signing, the signee attests that information provided is accurate and agrees to the responsibilities outlined above.)

Security Administrator Signature: ____
(By signing, the signee attests that information provided is accurate and agrees to the responsibilities outlined above.)

Please return completed form to:

RFPquestions@state.co.us

Appendix A

Please list the name and job class of each person who will be viewing / manipulating the raw data. If this list changes, a revised Appendix A must be sent to RFPquestions@state.co.us

Offeror's Name: ____

Contact information: ____

NAME	JOB CLASS	ENTITY NAME