DETD-OM-300B
(Rev. 10/29/2025)

STATE OF MONTANA
Department of Public Health and Human Services
Disability Employment and Transitions Division

NON-DPHHS EMPLOYEE SYSTEM/FILE ACCESS REQUEST

*** Denotes Required Fields**

*** LEGAL Name of Individual Requiring Access:** ______________________________
(Please Print) *First* *MI* *Last*

*** Employer:** ______________________ *** Work Phone:** ______________________

*** Work Address:** ______________________ **County:** ______________________

______________________ **Job Title:** ______________________

*** E-mail Address:** ______________________________

*** Please list access requested here:**

Madison / Wellsky

*** Justification** ***(Give a brief description as to why access is needed):***

DETD Providers for purposes of Community Rehabilitation Provider and/or Extended Employment (EE) program billing and client management.

CONFIDENTIALITY/CONSENT STATEMENT: ***(To be read and signed by the individual requiring access.)***

I hereby certify that I am entitled to the confidential client information to which I am requesting access. I will not release the confidential information to others unless it is for purposes directly connected to the administration of the program for whose purposes it was originally provided. Further release of this information may only be done upon authorization by the client whose privacy interest is involved or it may be released to others if specifically permitted by law. I understand that a violation of this policy may subject me to disciplinary action by my employer and may result in termination of my employer's contract with DPHHS.

I agree that all network activity conducted while doing State business and being conducted with State resources is the property of the State of Montana. I understand that the State and Department reserve the right to monitor and log ***all*** network activity including E-mail and Internet use, with or without notice, and therefore, I should have no expectations of privacy in the use of these resources.

*** Signature of Employee:** ______________________ **Date:** ______________

*****Provider Supervisor:*** *I understand that it is my responsibility to inform the Provider Liaison immediately when this employee terminates or no longer needs access.***

*** Printed Name of Supervisor:** ______________________ **Phone:** ______________

*** Signature of Supervisor:** ______________________ **Date:** ______________

This space to be completed by Data Owner(s) *(if applicable)*

Printed Name of Data Owner: Steve McCann

Data Owner Signature: ______________________ **Date:** ______________

Printed Name of Data Owner: Lacey Conzelman

Data Owner Signature: ______________________ **Date:** ______________