



Department of Health & Social Services  
 Division of Senior & Disabilities Services

**Harmony Data System Access Coordinator Agreement**

Provider Agency Name:

Coordinator is responsible to oversee the following locations. If you are a Medicaid provider, list MMIS billing number with each location.

As the Harmony Data System Access Coordinator, I understand that I must:

1. Report immediately and no later than 24 hours of separation to my supervisor and to the Division of Senior and Disabilities Services system administrator at [DSDSHarmonyHelp@alaska.gov](mailto:DSDSHarmonyHelp@alaska.gov) that a person with Harmony access is no longer affiliated with this agency.
2. Report immediately and no later than 24 hours to my supervisor and to the Division of Senior and Disabilities Services system administrator at [DSDSHarmonyHelp@alaska.gov](mailto:DSDSHarmonyHelp@alaska.gov) any suspected or actual breach of security, intrusion or unauthorized access, use or disclosure of client or related confidential information as defined in the Harmony Data System user agreement.
3. Ensure applicants from this agency have a need for access to the DSDS Harmony Data System
4. Ensure applicants have been approved through the Alaska Background Check Program prior to application for access.
5. Ensure the persons approved and provided access comply with all aspects of their Harmony Data System User Agreement.
6. Report to the DSDS system administrator at [DSDSHarmonyHelp@alaska.gov](mailto:DSDSHarmonyHelp@alaska.gov) when changes occur with my legal name, affiliation with this organization, or title and for this agency's Harmony users.

If the provider is a covered entity under the Health Insurance Portability and Accountability Act (HIPAA), and the Division of Senior and Disabilities Services is acting as the provider's business associate, the provider and the Division are bound by Appendix A to this agreement, the Business Associate Agreement.

As the Harmony System Access Coordinator within the organization, my signature shows that I have read this entire Agreement and the Harmony Data System User Agreement and consent to abide by both agreements and assure our organization's policies and procedures support its intent. I understand that unauthorized use or disclosure of confidential information may subject the organization and/or individuals to administrative actions, prosecutions, and personal, civil, and/or criminal liabilities and legal penalties.

**After completion, scan and send this agreement to [DSDSHarmonyHelp@alaska.gov](mailto:DSDSHarmonyHelp@alaska.gov)**

### Agency Information

Print Name of the Agency's Access Coordinator	Title
Signature of the Access Coordinator	Phone Number
Date	Contact Email address:

Do you as the Access Coordinator need access to the Harmony Data System? Yes    No
If Yes, you must complete the Harmony Data System Individual User Agreement (separate form)

What type of agency? Check all that apply.	
Care Coordination Agency	ADRC Grantee
Personal Care Services Agency	STAR Grantee
Hospital (Discharge Planners)	Long Term Care Facility
Other, describe:	

Printed Name of Agency Owner/Administrator/Director	
Agency Owner, Administrator or Director Signature	Date
Contact Email Address	Contact Phone