WV FACTS PLUS Application

To request access to the FACTS PLUS System, please fill in the following form. All mandatory fields (*) must be completed. Once the Application form is complete use your Internet Browser button to print (LM=0.5", RM=0.25") the form. The Application must be signed by the person for whom access to FACTS PLUS is being requested and by the Agency Director authorizing the request. Please fax the completed FACTS PLUS Application to the FACTS Help Desk at (304)558-5868 or mail it to the FACTS Project, WV -DHHR, 1 Davis Square Suite 200, Charleson WV 25301. A Confidentiality Statement signed by the person for whom access to FACTS PLUS system is being requested should be submitted with the application. Application requests will not be processed until both the completed application and the signed Confidentiality Statement have been received. A Confidentiality Statement signed by the person for whom acces to the FACTS PLUS System is being requested should be submitted with the application. For Agency/Facility requests, an additional authorization letter from the Agency Director on agency letterhead is also required

A. USER INFORMATION - Please identify the person to whom access to the FACTS PLUS System is being requested.

* **First Name:** **Middle Name:** * **Last Name:**

* **Email:**

SSN: - - (Optional)

* **Phone:** - - **Extn:**

* **Address:**

* **City:**

County: * **State:** ***Zip:**

B. AGENCY INFORMATION - Please indicate the agency that user should be given permission to access.

* **Agency/Person Name:** **Agency ID:**

Email:

* **Phone:** - - **Extn:**

* **Address:**

* **City:**

County: * **State:** ***Zip:**

C. AGENCY DIRECTOR AUTHORIZATION - Please identify the Director authorizing the user's access to FACTS PLUS system.

* **First Name:** **Middle Name:** * **Last Name:**

* **Email:**

* **Phone:** - - **Extn:**

* **Address:**

* **City:**

County: * **State:** * **Zip:**

D. ASSOCIATED PROVIDER - Please indicate any additional providers that the user should be given permission to access.

1. Provider Name:
Provider Address:
Provider Phone Number:

2. Provider Name:
Provider Address:
Provider Phone Number:

3. Provider Name:
Provider Address:
Provider Phone Number:

USER SIGNATURE **DATE** **AGENCY DIRECTOR SIGNATURE** **DATE**

NOTE: A signed copy of the Confidentiality Statement for each user must be on the file before permission to access the FACTS PLUS system will be granted.

FACTS OFFICE USE ONLY		
Assigned or Modified By	**Date**	**Date Confidentiality Form Received**