CHILDREN'S ADMNISTRATION (CA)\

FamLink Data Access Request / Change

For Non-Children's Administration employees

NOTE: This form to be completed **two weeks prior** to date access is needed.

☐ New Access ☐ Change Access ☐ Revoke Access

CA Use Only
DATE OF REQUEST
AGENCY, TRIBE OR OTHER ENTITY WITH ACCESS TO FAMLINK
FAMLINK ON-LINE DATA ACCESS AGREEMENT NUMBER

Access: In accordance with the FamLink On-line Data Access Agreement between the DSHS Children's Administration and the Agency, Tribe or other Entity with On-line Data Access to FamLink listed above, hereafter referred to as Agency; the Agency is requesting that the individual named below be granted on-line access to FamLink, consistent with the FamLink On-line Data Access Agreement identified above.

NAME	LAST	FIRST	MIDDLE
Current			
Previous. List all including maiden and other aliases.			

Date of Birth:	Gender: ☐ Male ☐ Female

RESIDENTIAL ADDRESS. LAST FIVE YEARS.

YEAR	CITY, STATE	YEAR	CITY, STATE
	,		,
	,		,

EMPLOYMENT HISTORY. LAST FIVE YEARS.

YEAR	CITY, STATE	AGENCY, TITLE, ROLE
	,	
	,	
	,	

CURRENT TITLE	EMPLOYMENT: START DATE END DATE	PHONE NUMBER (WITH AREA CODE)

Check all that apply:

☐ I am a licensed foster parent in the State of Washington, licensed with (agency name): _____

☐ I am an unlicensed relative / suitable other caregiver.

☐ I am a contracted provider in the State of Washington.

☐ I believe there is information about me, my business, or my family in FamLink. Please list below:

NAME	RELATIONSHIP	WHAT TYPE OF RECORDS EXIST?

By my signature below, I certify the following:

1. The identifying information listed above is accurate and complete.
2. I understand that this information will be used to conduct a search of FamLink records.
3. I understand CA may deny or revoke access for any reason. I understand that I will be informed of the denial or revocation.
4. I will not access FamLink data for any personal purpose.
5. I understand my use of FamLink will be monitored by Children's Administration.
6. I understand that in accordance to DSHS Information and Technology Security Policy 15.10, I shall not disclose my confidential passwords and access codes used to gain access to these systems. I also understand that if any of these codes or passwords is compromised, they will be changed immediately.
1. The policies and procedures for information confidentiality have been explained to me and agree to follow all requirements. I agree to keep all information contained in these systems confidential.
7. I will immediately report a breach or suspected breach of FamLink data to HELP300@dshs.wa.gov and any applicable CA program manager.

EMPLOYEE / USER'S SIGNATURE	DATE	SUPERVISOR'S SIGNATURE	DATE
PRINTED NAME		PRINTED NAME	

Children's Administration Use ONLY

	COMPLETION DATE	BY WHOM	RESULTS
☐ Verify Data Access Agreement			
☐ Individual / Provider FamLink Record Check Completion			
☐ Family Record Check Completed			
☐ All required records restrictions completed and documented in FamLink			

FamLink Person ID: _____

FamLink Provider ID: _____

I certify that all terms of the FamLink On-line Data Access Agreement have been and will continue to be met in regard to the above named individual's access to FamLink data.

Please check the following action to be taken regarding the individual named below:

☐ Grant On-line FamLink Data Access

☐ Deny Access. Reason for denial:

☐ Revoke Security and Eliminate FamLink Data Access

CA ADMINISTRATOR / SPONSOR'S SIGNATURE	DATE	PRINTED NAME