

CACFP Agreement #: _____

SECTION 1 CHAIR OF THE BOARD OF DIRECTORS OR OWNER AUTHORIZATION

I hereby authorize the person listed in Section 2 to be responsible for assigning security access to other staff members, monitoring staff capability to accurately enter information, assuring that access to the HCS account is used only for authorized purposes and protecting the information from alteration or corruption.

Original Signature (Chair of the Board of Directors or Owner): _____

Print Name: _____ Chair of the Board of Directors Owner

Date: _____

SECTION 2 HCS DIRECTOR INFORMATION

The HCS Director establishes a binding agreement with NYS Department of Health to access HCS and must abide by the policies and procedures for using information within the HCS network. The HCS Director has the highest security level for the organization and can also function as an HCS Coordinator OR can designate one or more staff members for that position. **Only one staff member may be designated as the HCS Director.** The HCS Director must have or create an HCS account prior to completing this form.

First Name	Middle Name	Last Name
Title		E-mail Address
Work Address		
Office Phone/Ext		Office Fax
NYSDOH Health Commerce System ID:		

Original Signature (HCS Director): _____ **Date:** _____

Copy of the front and back of the HCS Director's photo identification attached.

FOR STATE USE ONLY		
<input type="checkbox"/> Identity Verified <input type="checkbox"/> Identity Not Verified	ID Type	Date of Video Verification
Signature (STATE REVIEWER)		Date

This institution is an equal opportunity provider.