Developmental Disabilities Division

Provider Portal

Request User Account or Change Form

This form is used to request a user account or to change information for an existing user account for the Provider Portal. The DDD will create the following types of accounts for Providers:

1) **Administrators**: Each provider agency will be limited to two (2) **Administrator** level accounts. Administrators should be provider staff who are authorized and responsible for overseeing operations of the agency. Responsibilities in the Provider Portal will include, but is not limited to, ensuring agency contact information is updated, ensuring rendering provider (employee or independent contractor) information is current, submitting requests to the DDD to add or change Provider Portal user accounts, and deactivating user accounts once a rendering provider leaves the agency.
2) **Users:** Users should be limited to provider staff who are responsible for tasks such as creating or managing Individual Plans (IP), creating and submitting Quarterly Reports, and reviewing, completing and submitting Adverse Event Reports (AER).

Please type responses and submit completed form by email to:
doh.dddproviderhelpdesk@doh.hawaii.gov

Providers will be notified by email once DDD has completed the request or change.

Date Request Form Completed:			
Type of Account Check One:	Administrator Level ☐	User Level ☐	
Request Type Check One:	Add User: ☐	Change Information: ☐	Remove User: ☐
INFORMATION FOR RENDERING PROVIDER USER ACCOUNT			
Effective Date:			
Name of Provider Agency:			
Rendering Provider Name (first and last name):			
Rendering Provider Position Title:			
Rendering Provider Email Address:			
Rendering Provider Telephone Number*: *List a telephone number that employee or independent contractor can access when they are using the Provider Portal (mobile number preferred).			
Rendering Provider Date of Hire:	Date Rendering Provider Removed:		
Rendering Provider completed annual training requirements for HIPAA? Check one: Y ☐ N ☐	Date of most recent HIPAA training:		
Rendering Provider has access to a computer and/or mobile device that meets DDD minimum requirements? Check one: Y ☐ N ☐			
Reason for Request or Change:			
Print Name of Provider Portal Administrator:			
Portal Administrator Email Address:			
Signature of Provider Portal Administrator:			

For DDD Use Only:	
Authorized by:	Date: