STEP 1

Complete the Authorization for Online Health Commerce System (HCS) Account Creation (DOH-5158) form. Remember to have the Board Chair or Owner sign Section 1 of the form.

STEP 2

Mail the original completed DOH-5158 to:

NYSDOH DON Child & Adult Care Food Program – CIPS
150 Broadway Suite 600
Albany, NY 12204

STEP 3

HCS will email the HCS application form to the HCS Director listed on the DOH-5158. HCS will also send materials which include important information about the organization's rights and responsibilities.

Complete the application and verify that the signature is notarized.

Mail the completed and signed HCS application form to HCS.

STEP 4

HCS will send the account holder a PIN # and instructions to activate the account. Call HCS at 1-866-529-1890, option 1, if you need assistance.

STEP 5

CACFP will email the HCS Director confirming the CIPS account is active and will attach a CIPS training manual.

Congratulations!

You are ready to start using CIPS.

NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

Authorization for Online Health Commerce System (HCS) Account Creation

CACFP Agreement #_____

Please complete this form to begin the process of obtaining an HCS account to access CACFP web-based applications.

SECTION 1

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

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.

Original Signature _____

Print Name _____

Title _____ Date _____

First Name:	Middle Name:	Last Name:	
E-Mail Address:		Month of Birth:	Day of Birth:
Work Address:			
Office Phone/Ext:	Office Fax:		
NYSDOH Health Commerce System ID (if one exists):			

This institution is an equal opportunity provider.