**Health Commerce System Account Creation**

1. **Director Account Health Commerce System Application**

|  |  |
| --- | --- |
| 1. Organization type
 |  CMA, HH, or MCP? Indicate if serving children or adults. |
| 1. Legal Organization name
 |  |
| 1. Full first name (DO NOT use nicknames), full middle name (not just the initial), and full last name. (For example: Elizabeth Ann Doe)
 |  |
| 1. Month and day of birth
 |  |
| 1. NYSDOH Health Commerce System (HCS) ID (if one exists)
 |  |
| 1. Job title (needed for Director requests)
 |  |
| 1. Work address
 |  |
| 1. Office telephone number
 |  |
| 1. Office fax number
 |  |
| 1. E-mail address
 |  |
| 1. Existing Director being replaced (if applicable)
 |  |
| * 1. If the Coordinator is replacing someone, does the Coordinator being replaced need to retain an account as a user for the organization?
 |  |

|  |  |
| --- | --- |
| Director’s Name  |  |
| Director’s Title |  |
| Date |  |
| Director’s Signature |  |

1. **Health Commerce System Coordinator Account Application**

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|  |  |
| --- | --- |
| 1. Organization type
 |  |
| 1. Legal Organization name
 |  |
| 1. Full first name (DO NOT use nicknames), full middle name (not just the initial), and full last name. (For example: Elizabeth Ann Doe)
 |  |
| 1. Month and day of birth
 |  |
| 1. NYSDOH Health Commerce System (HCS) ID (if one exists)
 |  |
| 1. Work address
 |  |
| 1. Director's name (needed for Coordinator requests)
 |  |
| 1. Office telephone number
 |  |
| 1. Office fax number
 |  |
| 1. E-mail address
 |  |
| 1. Existing Coordinator being replaced (if applicable)
 |  |
| * 1. If the Coordinator is replacing someone, does the Coordinator being replaced need to retain an account as a user for the organization?
 |  |

1. **Health Commerce System Coordinator Account Application**

|  |  |
| --- | --- |
| 1. Organization type
 | Care Management Agency |
| 1. Legal Organization name
 |  |
| 1. Full first name (DO NOT use Ito expeditnicknames), full middle name (not just the initial), and full last name. (For example: Elizabeth Ann Doe)
 |  |
| 1. Month and day of birth
 |  |
| 1. NYSDOH Health Commerce System (HCS) ID (if one exists)
 |  |
| 1. Work address
 |  |
| 1. Director's name (needed for Coordinator requests)
 |  |
| 1. Office telephone number
 |  |
| 1. Office fax number
 |  |
| 1. E-mail address
 |  |
| 1. Existing Coordinator being replaced (if applicable)
 |  |
| * 1. If the Coordinator is replacing someone, does the Coordinator being replaced need to retain an account as a user for the organization?
 |  |