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

Health Commerce System (HCS) Account Request

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. **Only one staff member may be designated as the HCS Director.**

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

Original Signature _____
HCS DIRECTOR

Date _____

This institution is an equal opportunity provider.