NEW YORK STATE | Department of Health | Office of Health Insurance Programs

HEALTH COMMERCE SYSTEM (HCS)

HOSPITAL APPLICATION ACCESS FORM

DIVISION OF FINANCE AND RATE SETTING

One Commerce Plaza – Room 1405, 99 Washington Avenue, Albany, NY 12210

****Please scan and e-mail completed form to: hospFFSunit@health.ny.gov****

SECTION I (HCS User & Facility Information):

Name (Please Print): _____

Title: _____

HCS User ID: _____

Hospital Name: _____

Operating Certificate Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( ) _____

E-Mail Address: _____

Signature: _____ Date: _____

) ss.: On the ___ day of _____ in the year _____ before me, the undersigned, personally appeared to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, that by his/her signature on the instrument, the individual executed the instrument, and that such individual made such appearance before the undersigned in the _____ (insert the city or other political subdivision and the state or country or other place the acknowledgement was taken.)

Notary Signature and Stamp on this line: _____

SECTION II (AUTHORIZATION TO ACCESS HOSPITAL DATA):

HCS Coordinator Name (Please Print):_____

Signature: _____ Date: _____

) ss.: On the ___ day of _____ in the year _____ before me, the undersigned, personally appeared to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, that by his/her signature on the instrument, the individual executed the instrument, and that such individual made such appearance before the undersigned in the _____ (insert the city or other political subdivision and the state or country or other place the acknowledgement was taken.)

Notary Signature and Stamp on this line: _____

DIVISION OF FINANCE AND RATE SETTING

HOSPITAL APPLICATION ACCESS FORM (continued)

SECTION II (continued):

Name (Please Print): _____

HCS User ID: _____

Hospital Name: _____

Operating Certificate Number: _____

SECTION III (REQUESTED ACCESS TO APPLICATIONS):

Note: ***If application is not marked with an "X" for YES, it will be considered NO for Access.***

	YES	NO
HOSPITAL APPLICATIONS:		
Note: if "Yes" is marked, access will automatically be granted to all of the following applications (or none if "No" is marked): 1) Healthcare Financial Data Gateway, which includes: ❖ Budgeted Capital Report Software ❖ Disproportionate Share (DSH) Audits ❖ Indigent Care Calculation ❖ Inpatient Reform Rates ❖ Institutional Cost Report (ICR) Base Year Information ❖ Institutional Cost Report (ICR) Audit Files ❖ Outpatient Rate Reports ❖ Outpatient Reform Rates		
2) Institutional Cost Report (ICR) – Instructions/Submissions		
HOSPITAL-BASED NURSING HOME APPLICATIONS:		
3) RHCF-2 (only for facilities with hospital-based nursing homes)		

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HOSPITAL APPLICATION ACCESS FORM (continued)

Note: User must already have an HCS account established before access may be granted.

INSTRUCTIONS:

SECTION I (HCS User & Facility Information):

Name: Name of the individual who has an HCS account and is requesting access to the Division's HCS hospital applications.

Title: Official title of the individual within the organization which he/she is employed.

HCS User ID: The personal HCS User Id of the individual requesting access to the hospital applications. The user MUST ALREADY have an HCS Account before completing this form to request access to the applications. Contact your HCS Coordinator or the Commerce Accounts Management Unit (1-866-529-1890) if you need assistance with getting an account established.

Hospital Name: Name of the facility or legal entity responsible for the submission and/or retrieval of public health data using the HCS that the user is requesting access for.

Operating Certificate Number: Operating Certificate Number of the hospital (Ex.1112222H).

Street Address: Number and street location (or box number) of HCS user's place of employment.

City, State, Zip Code: City, State and Zip Code of HCS user's place of employment.

Telephone Number: Office telephone number, including area code, where the HCS user can be reached.

E-mail Address: Complete e-mail address of HCS user requesting access. It is importation that the user has this same email address established within the HCS so that they may receive notifications regarding publications and other notifications regarding the rates, cost reports, etc.

Signature & Date: A notarized official signature of the HCS user requesting access and the date of signing.

SECTION II (Authorization to Access Hospital Data):

HCS Coordinator Name: Name of the HCS Coordinator for the hospital stated in Section I (please print name).

Signature & Date: A notarized official signature of the HCS Coordinator from the hospital the HCS user is requesting access for and the date of signing.

Name, HCS User ID, Hospital Name and Operating Certificate Number: same as Section I.

SECTION III (Requested Access to Applications):

Hospital Applications: Place an "X" in either **"YES"** or **"NO"** for the applications that the User in Section I is requesting access. **If nothing is marked for an application, access will not be granted for that application.**

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