Commonwealth of Kentucky
Cabinet for Health and Family Services (CHFS)
Division of Child Care (DCC)
Division of Regulated Child Care (DRCC)

Kentucky Integrated Child Care System (KICCS) Provider Portal Account Agreement

SECTION 1: USER INFORMATION

REQUEST DATE: 10/5/16 KY DL/PHOTO ID NO. _____

FIRST NAME: Kim M.I. A LAST NAME: Bell

EMAIL USED ON KOG: Kim.bell@boone.kyschools.us

PRIMARY PHONE: (859) 334-4410 SECONDARY PHONE: (859) 393-4899

ENTER NAME OF THE HEAD OF ORGANIZATION/OWNER: Randy Poe, / Boone Co Board of Education

BUSINESS NAME: Conner Middle Child Dev. Ctr. FAX NUMBER: (859) 334-4435

CERTIFIED, LICENSED OR REGISTRATION NO. L356895

(If you have multiple centers, and need additional space to enter information, attach a separate piece of paper listing information for each. The business name for each C,L,R is required)

BUSINESS MAILING ADDRESS: 3300 Cougar Path

CITY: Hebron STATE Ky ZIP: 41048 COUNTY: Boone

SECTION 2: KICCS PROVIDER PORTAL ACCOUNT USER AGREEMENT

By accepting this user agreement, I acknowledge that I have been made aware of my responsibilities to protect the confidentiality of the information in the KICCS Provider Portal Account. I am only permitted to use KICCS Provider Portal Account for the purpose of reporting child care activity for payment and/or filing Renewal and Provider Change Request applications online through CHFS in Kentucky. I acknowledge that I have been made aware that misuse of the information may potentially lead to penalties and/or system revocation.

As an authorized user, I agree to the following terms of use:

1. I agree to make only authorized use of any information in the KICCS Provider Portal Account. I agree to not divulge the contents of any record except as permitted by state or federal law.
2. I agree to not share any user name or password information. I acknowledge that I am responsible for any actions taken on the KICCS Provider Portal Account under my login name.
3. I agree not to access the information contained in the KICCS Provider Portal Account other than for authorized business actions.
4. I agree to terminate my access to the KICCS Provider Portal Account when my employment with the reporting entity ends or when my job responsibilities no longer require me to access KICCS Provider Portal Account information.
5. I agree to immediately report any misuse of the KICCS Provider Portal Account or violations of this agreement to the CHFS IT Security Officer.

Any misuse of the KICCS Provider Portal Account or its information may lead to temporary revocation of access privileges, permanent loss of access privileges or penalties under state and/or federal law.

SECTION 3: AUTHORIZATION SIGNATURE FOR ALL ACCOUNT REQUESTORS

I attest to the best of my knowledge that the information provided above is true, accurate, and complete and that I have read and agree to the KICCS Provider Portal Account user agreement terms within this document.

▶ Kim Bell ▶ 10/5/16

YOUR SIGNATURE HERE — DATE

Your Printed Name *(must be legible)*: Kim Bell

▶ _____ ▶ _____

YOUR ADMINISTRATOR SIGNATURE HERE (IF YOU ARE THE OWNER, HEAD OF ORGANIZATION, OR ADMIN, SIGN HERE AGAIN) — DATE

Your Administrator Printed Name *(must be legible)*: _____

Section 4 is for the Division of Child Care/Division of Regulated Child Care staff only. Do not write below this line.

SECTION 4: AUTHORIZATION SIGNATURE(S) FOR CCAP ADMINISTRATORS ONLY

I certify that the job duties of the User requires access to the program(s) requested and that the access complies with appropriate use as specified in the KICCS Provider Portal Account User Agreement.

CCAP ADMINISTRATOR: _____ DATE: _____