DARMHA Provider Registration Agreement Form

Indiana Family and Social Services Administration, Division of Mental Health and Addiction

DARMHA (Data Assessment Registry Mental Health and Addiction) is a web-based database application. Patient information is confidential and is only available to authorized users of the system. This form must be completed and on record with the DARMHA Support Center before Individual User and Confidentiality Agreement Forms can be processed.

As a condition of participating in DARMHA, the Provider enters into this agreement with the Indiana Family and Social Services Administration, Division of Mental Health and Addiction, and agrees to the following:

- The Provider will abide by the requirements in this document and the DARMHA New User Form. Staff members that need access to DARMHA must sign the DARMHA Individual User and Confidentiality Agreement, which must be kept with the employee's personnel file.
- The Provider acknowledges that unauthorized disclosure of confidential information may result in civil penalties. The Provider will take all reasonable steps to assure employee compliance with confidentiality requirements.
- If an authorized user leaves the provider employment, the provider CEO or designee must immediately notify the DARMHA Support Center to request user removal from the DARMHA system. This must occur prior to the employee's last day of employment.
- If this agreement is violated by any unauthorized misuse of the system, Indiana DMHA reserves the right to terminate access to the system.

Signing this form signifies agreement to be a DARMHA authorized organization. Please retain a copy for your records. Please email the signed form to the Indiana Division of Mental Health and Addiction.

Name of Provider:	
Provider D.B.A. (Doing Business As):	
If a DMHA Contracted Provider - DMHA Provider Number:	
If not a DMHA Contracted Provider - Type of Organization (Child Residential Facility, Recovery Works, School System, etc):	
What State Program is requiring DARMHA usage?:	
Provider Headquarter Address:	
Provider City:	
Provider State:	
Provider Zip Code:	
Provider CEO Printed Name:	
Date:	
Provider CEO Signature:	
Designees control Provider DARMHA access. Designees will be the primary contact for the DARMHA Support Center.	
Designee #1 First/Last Name:	
Designee #1 Telephone Number:	Designee #1 Signature:
Designee #1 Email Address:	
Designee #2 First/Last Name:	
Designee #2 Telephone Number:	Designee #2 Signature:
Designee #2 Email Address:	

Do you need access to DARMHA	☐	Crisis Survey	☐	QA Environment	☐	Webservices	☐

E-mail the **signed** form to DARMHA.fssa.fssa.in.gov