

DSCYF is excited to have providers utilizing FOCUS/ FOCUS Portal.

In order to provide access to FOCUS or FOCUS Portal the following forms must be completed and signed.

- ◆ **DSCYF FOCUS User information/Access form**
- ◆ **DSCYF Contractor Non-Disclosure/Confidentiality**
- ◆ **DTI Acceptable Policy form.**

Forms are located on the DSCYF Contracting webpage:

<https://kids.delaware.gov/management-support-services/contracting-information/>

Under the **DSCYF System Access and Confidentiality** section.

DSCYF System Access and Confidentiality

- [DSCYF System Access Form](#)
- [DTI-0042.02 Acceptable Use Policy](#)
- [DTI Acceptable Use form](#) - submit only page 9 of 13 of Acceptable Use Policy above
- [DSCYF Policy #205 - under Direct Client Service Policies](#)
- [DSCYF Contractor Confidentiality Form](#)

Completed forms should be submitted to :

DSCYF_Contracts_Forms@delaware.gov

Note: Incomplete forms will result in system credentials/profiles not being issued.

Providers/Contractors are also required to have a Criminal History Background Check completed through DSCYF and determined to be eligible.

Completing the DSCYF FOCUS Contractor Information/Access Form

Request Type section

- ◆ Enter the **Effective Date**.
- ◆ Select a check box -**New User, Inactive User** or **Information Change**. Note: **Information Change**– please enter where the change is needed in the **Identify the change needed** field.

Request Type	
Effective Date:	12/01/2022
<input checked="" type="checkbox"/> New User	<input type="checkbox"/> Inactivate User
<input type="checkbox"/> Information Change	Identify the change needed:

Provider Person Information section

- ◆ Complete **Name** fields.
- ◆ Enter the **Date of Birth, SSN last 4 digits**.
- ◆ Select **Gender, Race** and **Ethnicity**.
- ◆ Enter the **Provider Name** and **Job Title**.
- ◆ Indicate if you are a **Supervisor** –Y/N.
- ◆ Enter **Work Phone** number and **Email**

Provider Person Information				
First Name Sally	Last Name Seashells	Middle Name Sells	Former Name (if changing name) enter if a Name Change is required	
DOB 01/01/1970	SSN last 4 digits 7890	Gender Female	Race Asian	Ethnicity Not Hispanic or Latino
Provider Name BY the Sea Shore		Job Title Caseworker	Supervisor <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Email Sallysells.seashells@provider.org	Work Phone 302-555-5555	Ext	County New Castle	

Account Requested section

- ◆ **System Access Requested** -Indicate which system needed - *FOCUS* or *Provider Portal*.
- ◆ **Account Type**– *Contractor* is prepopulated
- ◆ Select a the **Division** access is needed for– *DMSS, DPBHS, DYRS, DFS* Note:: If multiple Divisions are needed, please indicate that in the “Describe” text box section.
- ◆ **FOCUS Role Type**– *Worker/Supervisor*.
- ◆ **FOCUS Supervisor**–enter the *name of the person* that will be your supervisor in FOCUS.

Account Requested		
System Access Requested <input type="checkbox"/> FOCUS <input checked="" type="checkbox"/> Provider Portal	Account Type Contractor	Division DFS
FOCUS Role Type <input checked="" type="checkbox"/> Worker <input type="checkbox"/> Supervisor	FOCUS Supervisor Sandy Dune	

Description section:

- ◆ Review and answer the questions. The information is important to help determine the access needed and timely assignment of FOCUS/Portal User Profile.
- ◆ Additional Information– add any additional information that maybe helpful.

Describe the function the person needs to perform in FOCUS or Portal and any additional information.
<ul style="list-style-type: none">• Contract number or description of service. Example: 12345 or Provide Outpatient Mental Health Services and Therapeutic Support for Families.• What will the person be utilizing FOCUS for? Example: Providing DBPHS and will be completing the Admission Summaries and Progress reviews in the Portal.• Does the person currently have access to FOCUS or Portal for another Division? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If so, please indicate the Division DMSS Explain. Example: Currently, I utilize the Portal for Interstate Compact Home Study and Progress Reviews and need to complete Pre and Post Adoption.• If the person is responsible for supervising others in FOCUS/Portal, please provide staff names. Example: I will be supervising Ocean Breeze & Sandy Feet in FOCUS.• Additional Information. Example: I am also a DSCYF Employee.

Provider Authorization Certification section

- ◆ Review the Certification section
- ◆ Indicate if the person has completed a **DSCYF Background Check**.
Note: A DSCYF Background check is required
- ◆ **Approver's Name**– the provider person designated to approve access.
- ◆ Enter **Title, Phone Number** and **Date**.
- ◆ **Submit completed form to DSCYF_Contracts_Forms@delaware.gov**
Please include the 5 digit contract number in the subject line.



Reminder: For new users , please submit Acceptable Use form (page 9) and Confidentiality form.

Provider Authorized Certification			
I certify that:			
<ul style="list-style-type: none">• I am authorized by the above-named provider to approve this form.• I/my employer is currently contracted by DSCYF, and the above information is true and correct to the best of my knowledge.• The person requires access to the systems I have indicated to complete normally assigned job tasks.• Typing my name in the "Approver's Name" field constitutes approval and my signature.			
<input checked="" type="checkbox"/> The person has completed a Criminal Background Check for DSCYF using the DSCYF form.			
Approver's Name	Title	Phone	Date Approved
Supervisor/Approvers Name	Director	302-555-5555	01/01/2023
Submit to the DSCYF Contracts Unit at DSCYF_Contracts_Forms@delaware.gov Include 5-digit contract number in email Subject line.			

Separation of Employment/Inactivate User

Notify the Contracts Unit immediately.

Request Type section

- ◆ Enter the **Effective Date**.
- ◆ Select a check box -**Inactive User**

Request Type	
Effective Date:	12/01/2022
<input type="checkbox"/> New User	<input checked="" type="checkbox"/> Inactivate User
<input type="checkbox"/> Information Change	Identify the change needed:

Provider Person Information section

- ◆ Complete **Name** fields.
- ◆ Enter the **Date of Birth**
- ◆ Select **Gender**
- ◆ Enter the **Provider Name** and **Job Title**.

Provider Person Information				
First Name Sally	Last Name Seashells	Middle Name Sells	Former Name (if changing name)	
DOB 01/01/1970	SSN last 4 digits	Gender Female	Race	Ethnicity
Provider Name BY the Sea Shore	Job Title Caseworker	Supervisor <input type="checkbox"/> Yes <input type="checkbox"/> No		
Email	Work Phone	Ext	Countv	

Provider Authorization Certification section

- ◆ **Approver’s Name**– the provider person designated to approve access.
- ◆ Enter **Title, Phone Number** and **Date**.
- ◆ **Submit completed form to DSCYF_Contracts_Forms@delaware.gov**
Please include the 5 digit contract number in the subject line.

Provider Authorized Certification			
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<input type="checkbox"/> The person has completed a Criminal Background Check for DSCYF using the DSCYF form.			
Approver’s Name Supervisor/Approvers Name	Title Director	Phone 302-555-5555	Date Approved 01/01/2023
Submit to the DSCYF Contracts Unit at DSCYF_Contracts_Forms@delaware.gov Include 5-digit contract number in the email Subject line .			