



Form 0-10
7/1/2022

Contract Provider Email Setup/Change Form

Provider Company Name: _____

Telephone: _____ () _____

Provider E-mails

Primary E-mail: _____
(For the use of correspondence about general business information, announcements, etc., from DSPD)

Financial E-mail: _____
(For the use of correspondence about client specific financial information from DSPD)

Incident E-mail: _____
(For the use of correspondence about client specific incident reporting information from DSPD.)

STATEMENT OF UNDERSTANDING

I understand each email address type (as specified above) is intended to received information about people in services and/or general business information disseminated from DSPD. I understand employee access to the email address(es) and the information they contain must be controlled by internal provider company policy and procedures. I understand the information may contain confidential information and must be maintained and protected in a safe, secure and confidential manner. I understand the provider company can designate a unique email address for each type specified above or use the same address for all three.

Initial:

Optional Information

The provider company email address and telephone number specified below will be published on DSPD's website as public information. I understand that by providing the information, I grant permission for DSPD to publish it on their website and make it available to the public. If the provider company chooses to omit the email address and telephone number, then DSPD will only publish the provider company name on their website. The provider company public email address can be the same as one of the email addresses specified above. If the provider company wants DSPD to publish their public email address, then it must be written completely. "Same as above" will not be accepted.

Public Facing E-mail: _____
(The contact e-mail of the provider to be used on the DSPD website.)

Public Facing Telephone: _____ () _____
(The contact telephone number of the provider to be used on the DSPD website.)

Provider Authorization

I certify the information provided is true and accurate in compliance with existing provider company policy and procedures.

Provider Representative Signature: _____ **Date:** _____

Provider Representative Name: (please print) _____

-For Office Use Only-

USTEPS Team: _____
Activation _____ Date _____

Validation (Initial & Date)

USTEPS Team: _____
Inactivation _____ Date _____

Validation (Initial & Date)