

## eWiSACWIS USER AGREEMENT

All employees, subcontractors, or other individuals under the control of a Custodial Agency<sup>1</sup> or an Accessing Agency<sup>2</sup> with a eWiSACWIS Agency Agreement who will have access to eWiSACWIS shall sign the following Agreement:

I hereby certify that I have read and understand the eWiSACWIS Agency Agreement and the Department of Health and Family Services' "Access to eWiSACWIS and Information Contained in eWiSACWIS" Policy. I also certify that I am aware of the laws and regulations affecting my access to information and my ability to re-disclose any information maintained in eWiSACWIS.

I acknowledge my responsibilities under the above-noted Agreement, Policy, and laws and regulations and agree to abide by them. I understand that programs within eWiSACWIS may maintain a record of any files or other information I may access.

**I acknowledge that I must have a valid, work-related reason to access or review any record or part of a record within eWiSACWIS.**

---

Name – eWiSACWIS User (Type or Print)

---

Title

---

**SIGNATURE** – eWiSACWIS User

---

Date Signed (mm/dd/yyyy)

---

<sup>1</sup> "Custodial Agency" means an agency which enters information into eWiSACWIS on behalf of clients it is serving. In virtually all cases, this will be the Department of Health and Family Services or a County Department of Human / Social Services.

<sup>2</sup> "Accessing Agency" means an agency, other than the Department of Health and Family Services or a County Department of Human / Social Services, which, through an "Agency Agreement on Access to eWiSACWIS," has direct access to eWiSACWIS for the purpose of viewing, adding, deleting, or modifying information on that system.

Distribution: For County / Department staff, the original shall be maintained by the supervisor and a copy provided to the employee.  
For Accessing Agencies, the original shall be maintained by the supervisor and copies provided to the employee and the Custodial Agency.