Pennsylvania
Department of Health

Password Agreement

For Office Use Only
*Date Sent _____

Facility Name: _____ License/Reg.#: _____

Address: _____ Phone: _____

Reason for Completing this Form:

☐ Updating Email Address of Current Password Agreement Holder (PWAH) and/or Emergency Contact

NAME	NEW EMAIL ADDRESS

☐ Changing Point of Contact / (PWAH)

NEW CONTACT NAME	EMAIL ADDRESS
PHONE NUMBER	TITLE

☐ Changing Emergency Contact

NEW CONTACT NAME	EMAIL ADDRESS
PHONE NUMBER	TITLE

☐ Changing the CEO or Administrator Date Notice Sent _____

The Department must be notified in writing within 30 days of a change in CEO/Administrator of a health care facility (28 Pa. Code Chapter 51.4(c)). Notification should include the name, title and effective date of the change, and should be sent to RA-DAAC@pa.gov. Submission of this form alone, without including notification of the change in management is not sufficient.

NEW CEO / ADMINISTRATOR NAME	EMAIL ADDRESS
PHONE NUMBER	TITLE

☐ First Time Completing for a New Facility

☐ CEO / ☐ ADMINISTRATOR NAME	EMAIL ADDRESS	PHONE

POINT OF CONTACT (PWAH)	TITLE	EMAIL	PHONE

EMERGENCY CONTACT	TITLE	EMAIL	PHONE

I, _____, hereby certify that: I am the ☐ Chief Executive Officer / ☐ Administrator appointed by the governing body; the person designated above as the PWAH will be the main point of communication with the Department; I am responsible for ensuring that the facility license/registration is renewed timely; and I am responsible for ensuring that a Plan of Correction is submitted in a timely fashion in response to deficiencies cited by the Pennsylvania Department of Health (Department) on any Statement of Deficiencies.

1. I acknowledge that the email address given for the PWAH on this "Password Agreement" will be used as the Department's primary method of communication with the facility.
2. I acknowledge that the PWAH named above will receive the facility login identification number and the individual password provided by the Pennsylvania Department of Health.
3. I agree to ensure the confidentiality of both the facility login identification number and the password.
4. I recognize and acknowledge that the use of the password to electronically submit a Plan of Correction in response to deficiencies cited in the Statement of Deficiencies identifies me as the signer of the Plan of Correction.
5. I recognize and acknowledge that the use of the password to electronically submit the license/registration renewal application obligates me to ensure the complete and timely submittal of the application.
6. I further recognize and acknowledge that the use of the password, in conjunction with the submission of a Plan of Correction and license/registration renewal application, authorizes the Pennsylvania Department of Health to conclusively accept an electronic license/registration renewal application or Plan of Correction as my authorized submission.

I have had the opportunity to review this "Password Agreement" and hereby agree to the above statements.

CEO/Administrator Signature _____ **Date Signed** _____

Witness Signature _____

CEO/Administrator Email Address _____ **Change Effective Date** _____

Please email the completed form to: RA-DAAC@pa.gov

* **PLEASE NOTE**: This form must be returned within 30 days from the "Date Sent" listed above. Failure to return this form timely will result in the facility being cited.

Revised 11-04-25