



Provider/CCN Number: _____
Initial Applicants: This section is for Dept. use Only

Password Agreement

I, _____ (Name) hereby certify that effective _____ (date became administrator), I am the Administrator/Director/Chief Executive Officer for _____ (Facility Name) and that I am responsible for submitting a Plan of Correction in response to deficiencies cited by the Pennsylvania Department of Health on CMS Form 2567.

1. I acknowledge receipt of the facility identification number and my individual password (which will be provided after receipt of this agreement) from the Pennsylvania Department of Health.
2. I agree to main the confidentiality of both the facility identification number and my password.
3. I recognize and acknowledge that the use of my password to electronically submit a Plan of Correction, in response to deficiencies cited on the CMS Form 2567, identifies me as the signer of the Plan of Correction.
4. I further recognize and acknowledge that the use of my password, in conjunction with the submission of a Plan of Correction, authorizes the Pennsylvania Department of Health to conclusively accept that electronic Plan of Correction as my authorized submission.

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

Email Address

Signature of Administrator/Director/CEO

Signature of Witness

Date

Already Certified Facilities -- Return to: ra-dhhmedicarechnge@pa.gov
With the required supporting documentation - resume and copy of professional license(s) - if applicable