



New Jersey Department of
Human Services
Division of Aging Services

Salesforce Government Cloud

INFORMATION SECURITY REPRESENTATIVE (ISR) REQUEST FORM

***Required**

***Date:** _____

A. REQUEST TYPE

***Salesforce Portal (Check One):**

☐ EARC Portal (*Hospital*) ☐ NF Portal (*NF/SCNF*) ☐ NJ Choice Portal (*ADRC/PACE*)

***ISR Submission Type (Check One):**

☐ Initial ☐ Change in ISR

B. PROVIDER INFORMATION

***Name of Provider Organization:** _____

(*Check One*) ☐ ADRC ☐ Hospital ☐ NF ☐ PACE ☐ SCNF (*specify type*) _____

***Medicaid Provider Number:** _____

***Street Address:** _____

***City, State, Zip and County:** _____

***Telephone:** _____

***Organizational Email (*not the portal user email, required for NF/SCNF*):**

C. INFORMATION SECURITY REPRESENTATIVE (ISR) RESPONSIBILITIES

Each provider shall have a minimum of one designated ISR on file with the Division of Aging Services (DoAS). The provider shall submit the ISR Request Form and list the individual(s) who will fulfill the duties of an ISR.

The ISR shall be an employee of the provider. The ISR shall not be a portal user or a supervisor of a portal user. The ISR is not permitted access to the Salesforce Portal system. Examples of staff who may serve as the ISR include: administration, IT staff, or HR staff.

The ISR is a designated individual within the provider's organization who shall verify the requested portal user:

1. Is employed by or contracted with the provider listed on this application; **AND**
2. Requires the access being requested.

The Primary or Secondary ISR shall sign all Portal User Access Request Forms prior to DoAS submission.

The ISR shall notify DoAS when any of the following occurs:

- A portal user is no longer employed with the provider organization;
- A portal user no longer requires access to the portal due to a change in job duties; or



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- A portal user is assigned to a different supervisor.
- A suspected or actual breach of consumer/applicant protected health information or other personal information. **In such case, notify DoAS immediately at 609-588-6675.**

D. PRIMARY ISR

*Primary ISR Name: _____

*Title: _____

*Work Address (if different from provider address noted above):

*Telephone: _____

*Primary ISR Email: _____

My signature certifies that I have read the ISR responsibilities and understand my role as the primary ISR.

*Date: _____

*Primary ISR Signature: _____

E. SECONDARY ISR

*Secondary ISR Name: _____

*Title: _____

*Work Address (if different from provider address noted above):

*Telephone: _____

*Secondary ISR Email: _____

My signature certifies that I have read the ISR responsibilities and understand my role as the secondary ISR.

*Date: _____

*Secondary ISR Signature: _____

F. VALIDATION OF ISR APPOINTMENT

As the Administrator/Director/Manager of the organization and employee(s) identified above, I appoint the aforementioned staff as our ISR(s).

*Date: _____

*Name: _____

*Title: _____

*Signature: _____



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F. EMAIL INSTRUCTIONS

Submit this fully completed SF-1, Information Security Representative Request Form to DOAS via email as listed below; handwritten and/or faxed submissions will not be accepted.

- EARC Portal – Email: EARCRegistration@dhs.nj.gov
- NF Portal – Email: Doas-NFPortal.Registration@dhs.nj.gov
- NJ Choice Portal – Email: DoAS-NJChoice.Support@dhs.nj.gov

NOTE: Forms with any required information (*) missing, shall be returned for completion. Please submit any comments or questions to the appropriate email above.
