

Commonwealth of Kentucky
Cabinet for Health and Family Services (CHFS)
Division of Child Care (DCC)
Division of Regulated Child Care (DRCC)

Kentucky Integrated Child Care System (KICCS) Provider Portal Access Agreement

Form and Online Request Instructions

General Procedure

To obtain access to the KICCS Provider Portal and its online features, an applicant must have a citizen account accessible through the Kentucky Online Gateway (KOG), submit a legible copy of their driver's license or state photo ID, and complete and submit this form. Please type or complete this form in ink. All information must be accurate and complete, and the form must contain the appropriate authorized signature(s) from an owner or authorized agent registered with the Kentucky Secretary of State's Office. Once the form is completed, it must be submitted to CHFS for approval.

- **Step 1:** Print this form. Submit one form for each user requesting an account and for each license number to which the user needs access.
- **Step 2:** Follow the instructions available on the KICCS Provider Portal Launch Site <https://chfs.ky.gov/agencies/dcbs/dcc/Pages/kiccsportal.aspx> to create a citizen account or request KICCS portal roles through the KOG. If you need help completing the online request, contact the KICCS Help Desk (502) 564-0104, Option 6, or toll free at 866-231-0003, Option 6.
- **Step 3:** Complete ALL fields of the form. Handwritten information must be legible. Access will not be granted if the user information is incomplete or illegible.
- **Step 4:** Please ensure the administrator signature line is signed by the owner or registered agent documented with the Kentucky Secretary of State.
- **Step 5:** Submit the completed form, a copy of your driver's license or valid photo ID issued by the state electronically to fax number 502-564-3464 or by email: Portal.Access@ky.gov.

If you prefer, you may mail these documents to:

Division of Child Care
ATTN: CCAP Portal Administrator
275 E. Main St, 3C-F
Frankfort, KY 40621

NOTE: Please enlarge and lighten your driver's license before faxing. It will make the image easier to read.

For questions or assistance, please call the help desk at (502) 564-0104, Option 6, or toll free at 866-231-0003, Option 6.

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SECTION 1: USER INFORMATION

REQUEST DATE: _____ KY DL/PHOTO ID NO. _____
FIRST NAME: _____ M.I. _____ LAST NAME: _____
EMAIL USED ON KOG: _____
PRIMARY PHONE: () _____ SECONDARY PHONE: () _____
ENTER NAME OF THE HEAD OF ORGANIZATION/OWNER: _____
BUSINESS NAME: _____ FAX NUMBER: _____

CERTIFIED, LICENSED OR REGISTRATION (CLR) NO. _____
(If you have multiple centers and need additional space, attach a separate piece of paper listing the information for each center including the business name for each C.L.R).

BUSINESS MAILING ADDRESS: _____
CITY: _____ STATE _____ ZIP: _____ COUNTY: _____

SECTION 2: KICCS PROVIDER PORTAL ACCOUNT USER AGREEMENT

By accepting this user agreement, I acknowledge I have been made aware of my responsibilities to protect the confidentiality of the information in the KICCS Provider Portal Account. I am only permitted to use KICCS Provider Portal Account for the purpose of reporting child care activity for payment, submitting for Renewal, and/or submitting Provider Change Request applications online. I acknowledge I have been made aware that misuse of the information may potentially lead to penalties and/or system revocation.

As an authorized user, I agree to the following terms of use:

1. I agree to make only authorized use of any information in the KICCS Provider Portal Account. I agree to not divulge the contents of any record except as permitted by state or federal law.
2. I agree not to share any user name or password information. I acknowledge I am responsible for any actions taken on the KICCS Provider Portal Account under my login name.
3. I agree not to access the information contained in the KICCS Provider Portal Account other than for authorized business actions.
4. I agree to terminate my access to the KICCS Provider Portal Account when my employment with the reporting entity ends or when my job responsibilities no longer require me to access KICCS Provider Portal Account information.
5. I agree to report any misuse of the KICCS Provider Portal Account or violations of this agreement immediately to the CHFS IT Security Officer.

Any misuse of the KICCS Provider Portal Account or its information may lead to temporary revocation of access privileges, permanent loss of access privileges or penalties under state and/or federal law.

SECTION 3: AUTHORIZATION SIGNATURE FOR ALL ACCOUNT REQUESTORS

I attest to the best of my knowledge the information provided above is true, accurate, and complete and that I have read and agree to the KICCS Provider Portal Account user agreement terms within this document.



YOUR SIGNATURE HERE



DATE

Your Printed Name (must be legible): _____



YOUR ADMINISTRATOR'S SIGNATURE HERE



DATE

(IF YOU ARE THE OWNER, HEAD OF ORGANIZATION, OR ADMINISTRATOR, SIGN HERE AGAIN)

Your Administrator's Printed Name (must be legible): _____

Section 4 is for the Division of Child Care/Division of Regulated Child Care staff only. Do NOT write below this line.

SECTION 4: AUTHORIZATION SIGNATURE(S) FOR CCAP ADMINISTRATORS ONLY

I certify the job duties of the User require access to the program(s) requested and the access complies with appropriate use as specified in the KICCS Provider Portal Account User Agreement.

CCAP ADMINISTRATOR: _____ DATE: _____
