U.S. COMMITTEE FOR REFUGEES AND IMMIGRANTS

EVERYONE. EVERYWHERE. EQUAL VALUE.

OFMA MICHIGAN USER ACCESS REQUEST FORM

Staff members who assist clients with their ORR-Funded Medical Assistance (OFMA), must complete this form to request user access to the OFMA portal and/or the RMA & OFMA Resource portal. Please send this completed request form to the Regional Refugee Health Officer.

APPLICANT INFORMATION	
First Name	
Last Name	
Title	
Email	
Phone Number	
Agency Name	Select
State	Michigan
Public IP Address	

I would like to request access to: ☐ **OFMA Portal** (www.ofmauscri.org) ☐ **RMA & OFMA Resource Portal** (https://rma.pointcomfort.com/) ☐ **Both**

I completed the following required training:

- ☐ Immigration documentation training and I understand the eligibility criteria for ORR services and benefits.
- ☐ OFMA training provided by the agency's internal OFMA expert and at least one the following USCRI trainings (check the method of training):
  - ☐ Watched the recorded comprehensive OFMA training.
  - ☐ Participated in USCRI comprehensive OFMA Training via Zoom/in person.
- ☐ Reviewed the Michigan OFMA Policy Manual.

By signing this form, I attest that I am using the OFMA portal and/or the RMA & OFMA Resource portal on behalf of the agency named above for the limited purpose of determining the eligibility under the ORR-Funded Medical Assistance (OFMA) program, preparing related and official program reports, printing OFMA ID Cards, and assisting OFMA enrollees with their health benefits.

I agree to act in accordance with all applicable state and federal laws concerning the privacy and confidentiality of Private Health Information (PHI) and other personally identifying information. I also understand that even though USCRI is not a HIPAA Covered Entity, it chooses to follow the Health Insurance Portability and Accountability (HIPAA) Regulations as a best practice and requires me to comply with the terms of this form.

I understand that I am also responsible for the confidentiality of the OFMA portal system's configuration and network architecture. I further understand that my breach of this agreement could result in violation of state and federal laws, under which civil and criminal penalties could be assessed for each violation. I will not disclose nor release my username and password to anyone at any time. In the event my username and password have been compromised, I will immediately notify USCRI by sending an email to medical.assistance@uscrimail.org so that my account can be inactivated immediately. A new account may be issued to me with a new username and password. I also agree to notify USCRI immediately if my job changes, I leave the URM agency, etc. so that my user access can be terminated appropriately.

Registered User's Signature _____ Date _____

USCRI Representative's Signature _____ Date _____