

Please submit form to:
EDL@health.mo.gov



Missouri Department of Social Services
Family Support Division
Automated Security Access Processing Pre-ASAP Request



Complete this form to request computer security access or make changes to existing access. Directions for submission and additional information can be found on [Security Homepage](#). * Indicates a required field.

* SSN (i.e: 999999999)

* Last Name

* Contract Worker or Non-DSS Employee?

Yes No

* Department

* Section/Unit

* Job Title

* Office Phone (i.e. 5739991111)

Phone Extension

* Work Address

* City

* UserID (Required for all actions except Add ID)

* First Name Middle Initial

* Agency's Name

* Division

* County Name/FIPS - Office Location

* State

* Zip Code (i.e. 65101 or 651019999)

Enter the Action Requested (such as Add ID/Access, Add Access, Name Change, Location Change, Delete ID, etc.), then use the Comments Regarding Requested Access field to list all security accesses being requested for that user.

* Action Requested

* Effective Date of Action

* User's Supervisor

* Reason for Request

Previous

New

Comments Regarding Requested Access:

Please include return email address here. Thank you.