HAP Data Product Request Form

This form collects the information needed to review your Health Analytics Program (HAP) data product request. Before submitting, review the Available Data section and the Request Process page on the HAP Portal. Email the completed form and supporting documents, including any applicable Institutional Review Board (IRB) documentation to hihap_dg@dhs.hawaii.gov. HAP staff will review your request for completeness and appropriateness, contact your supervisor or authorized official to confirm the request, and arrange an interview to discuss your needs, timelines, and delivery or access method. HAP will assess whether the request can be supported and confirm any required documentation, agreements, and approvals. For questions, contact hihap_dg@dhs.hawaii.gov. Fields marked with an asterisk (*) are required.

Section 1: Requester Details

Please provide information about the person submitting this request.

First Name * | **Middle Initial** | **Last Name** *

Email Address * | **Phone Number** *

Job Title * | **Organization Name** *

Department/Office Name * | **If you are a State contractor, please indicate which Department/Office**

Section 2: Supervisor or Authorized Official Information

Provide information for your immediate supervisor or authorized official. If you are the appropriate authority, list yourself.

First Name * | **Middle Initial** | **Last Name** *

Email Address * | **Phone Number** *

Job Title * | **Organization Name** *

Section 3: Request Overview and Intended Purpose

Request or Project Title

Is this a new request or a modification/re-run of an existing request? *

If modifying or re-running, provide the existing report name or ID below.

☐ New ☐ Modification to Existing ☐ Re-run of Existing

Existing Report Name and ID (if applicable)

Business Purpose and Expected Benefit
Briefly describe the question or task, how the results will be used, and the benefit to Hawai'i or the relevant program.

Section 4: Data and product requirements

Which data source(s) does your request include? *
Select all that apply.

☐ Medicaid ☐ Medicare FFS[1] ☐ EUTF

[1] Access to record-level or identifiable Medicare data through HAP requires State direction, at least partial State funding, IRB approval and completion of Section 6 of this form.

Why are these sources needed?
Explain the role of each source. You may refer to the Business Purpose and Expected Benefit section without repeating it.

State Agency Involvement
If applicable, identify the State agency or official directing or overseeing the work and describe any State funding or other support.

Population and Geographic Scope *
Describe the population, subgroups, and any exclusions, such as age, eligibility, health condition, provider type, or claim type. Specify the geographic area and level of detail needed, such as statewide, island, county, or community. If known, indicate whether geography refers to member residence, provider location, or service location. Note any details that need further discussion.

Reporting Period *
Provide the actual start and end dates (MM/DD/YYYY) for the requested reporting period. Indicate whether the period is based on a calendar year, State fiscal year, federal fiscal year, program year (identify the program), or another timeframe. Specify which date field should determine whether a record falls within that period, such as claim start date, claim paid date, or enrollment date. Enter "Not sure" for any details that need further discussion.

Information to include *
Describe what the data product should show and list any specific columns or fields you need. For example, "Number of members using a service, grouped by program, year and age group." Attach a sample table or existing report if helpful. HAP staff will work with you to confirm the detailed requirements.

What type of data product are you requesting? *
Select all that apply.

☐ Data Extract: a pull of specific data elements based on request information

☐ Report: a written summary or analysis of the data

☐ Other (Please specify):

Data Sensitivity Level Required *
Select the option that best describes your request. HAP staff will confirm the appropriate privacy classification.

☐ Aggregate Results: Summary information for groups, such as counts, totals, averages, or rates

☐ De-identified Data: Fully anonymized, no PHI or PII

☐ Limited Data: Contains health info but excludes direct identifiers

☐ Identified Data: Includes direct identifiers (names, full addresses, dates of birth)

Section 5: Data Sharing, Delivery, and Review

Intended Audience or Recipients *
Identify the people, teams, or organizations that will receive the product and whether each needs only summary findings or individual records.

Publication or public presentation plans *
If you plan to publish or publicly present the findings, describe where and how they will be shared (for example, through a public report, website, article, conference, or legislative presentation). If not planned, state "Not planned." If undecided, briefly explain what is still being considered.

Preferred Delivery or Access Method *
Indicate how you would like to receive or access the data. The final delivery or access method is subject to HAP review and approval.

☐ Secure File Transfer Protocol (SFTP)

☐ Snowflake sandbox access [2]

☐ Not sure; assistance needed

[2] *Snowflake sandboxes require HAP system access. Interactive dashboards may also require it if they are not publicly available. HAP staff will confirm the requirements and coordinate the applicable System Access Request steps.*

Do you intend to link HAP data to any external data sources? * ☐ Yes ☐ No

If yes, specify the external data you plan to use.
List any other dataset and owner, purpose, proposed matching fields if known, and who would perform the linkage. Linkage is subject to HAP review and approval.

Delivery Timing * ☐ Specific date needed ☐ Flexible

Is this request recurring? * ☐ One-time ☐ Recurring

Timing and recurring details
Provide the requested delivery date (MM/DD/YYYY), if known. For recurring requests, use the first delivery date and include the frequency and expected duration or end date, if known. If a specific date is needed, explain the deadline and impact of delay. HAP determines the feasibility of the scheduling request and the priority of the request in the queue.

Section 6: Research Study Questions

Does this request involve an academic project or a research study? *

☐ Yes — IRB approval required ☐ No — internal program or operational use ☐ Not sure

If "Yes," complete the research and IRB questions below. If "Not sure," complete them as best you can and indicate any unknowns. HAP staff will help identify the appropriate review pathway. If "No," skip the research and IRB questions.

Study and Principal Investigator (PI) Information
Provide the study title and the PI's name, organizational affiliation, and email address. Use the study title and PI name shown on associated documents. If any information is not yet assigned or is unknown, state that.

Other Investigators and Individuals with Data Access
List each person other than the PI who will have access to the requested data. List the name, organizational affiliation, and email address for each person listed. Enter "None" if there are no additional individuals. Add rows or attach a continuation sheet if needed.

Name of Reviewing Body

Determination or Current Review Status

☐ Approved ☐ Exempt ☐ Pending ☐ Not Submitted ☐ Other (Please specify):

Reviewing Body Contact Information
If a determination has been issued, provide the reviewing body's name, email address or phone number, reference ID, review or decision date, and expiration date, if applicable. If the determination is pending, provide the information currently available.

Supporting documents and explanations
Select the documents you are attaching. One letter may address multiple items.

☐ IRB approval, exemption, or other determination ☐ Informed consent waiver or alteration ☐ HIPAA authorization waiver or alteration ☐ Other (Please specify):

Section 7: Attestations

Please review and confirm the statements below to certify that your request complies with State of Hawai‘i data use requirements. *

- ☐ I confirm that my request will benefit the State of Hawai‘i (e.g., improving public services, supporting policy decisions, or enhancing research).
- ☐ I confirm that this data will not be used for commercialization or marketing (e.g., selling products, promoting services, or advertising).
- ☐ I confirm that this data will not be used for any anti-competitive behavior (e.g., using data to limit competition, gain an unfair business advantage, or exclude others from the market).

Requester Signature *	**Date ***

Additional Request Details

Use this page to provide additional information that does not fit in the previous sections of the form. Begin each entry with the section title and section number, if applicable. If you are providing details for multiple sections, use a separate heading for each section to clearly identify which response you are expanding on.