Electronic Visit Verification (EVV) Proprietary System Request Form

An EVV proprietary system is an HHSC-approved EVV system that complies with all requirements listed in the HHSC EVV Proprietary Systems Policy that a program provider or FMSA may opt to use instead of an EVV vendor system from the state vendor pool.
The purpose of this form is only to request to use a proprietary system and not to select an EVV vendor system.

Instructions for Completing and Submitting This Form
You must complete each section of this form. Please note "N/A" if an item is not applicable. You may provide additional explanation for an item that does not apply by attaching it to this form in a separate document.
Submit the completed form by emailing it to Texas Medicaid & Healthcare Partnership (TMHP) at EVV_PSO@tmhp.com or by faxing it to 512-506-6619.
Submit questions to EVV_PSO@hhs.texas.gov.

A. Program Provider or Financial Management Services Agency (FMSA) Information

Legal Entity Name:		
Entity Type: ☐ Program Provider ☐ FMSA		
List all National Provider Identifiers (NPI) or Atypical Provider Identifiers (API):		Doing Business As (DBA) Name:
Taxpayer Identification Number (TIN) (One TIN per form):		Texas Provider Identifier (TPI):
HHSC Provider Contract Number:		
Street Address or PO Box:		Suite or Apt. No.:
City:	State:	ZIP Code:
Telephone:	Fax:	Email:
Do you currently deliver Medicaid services that require the use of EVV? ☐ Yes ☐ No		
If Yes, which EVV system do you currently use? ☐ First Data/AuthentiCare ☐ DataLogic/Vesta ☐ HHSC Approved proprietary system (insert name)		

B. EVV Proprietary System Information

System name and version:
Will the requested system be (select one of the following):
☐ Developed within your organization?
☐ Purchased/leased from a software vendor? If selected, enter the software company name:
Indicate your preferred Readiness Review session (see Go-Live dates for each session on the HHSC EVV Proprietary System webpage): (Choose only one) ☐ Session 1 ☐ Session 2

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C. Designated EVV Contact Information

Name of Designated EVV Contact (print name):		
Telephone:	Fax:	Email:

The Designated EVV Contact will:

- Act as the Program Provider's or FMSA's single point of contact for the EVV proprietary system implementation.
- Report progress and escalate issues that may arise to TMHP and HHSC during the EVV proprietary system implementation.

Name of Designated EVV Training Contact (print name):		
Telephone:	Fax:	Email:

The Designated EVV Training Contact will:

- Act as the Program Provider's or FMSA's single point of contact for the EVV proprietary system training and documentation during implementation.
- Act as a contact for HHSC, MCOs (if applicable), and TMHP related to any training or system access required post deployment.

D. Program Provider or FMSA Signature Authority

The Signature Authority must be duly authorized to act on behalf of the program provider or FMSA listed in Section A and is responsible for certifying the organization's compliance with HHSC rules and policies by signing the Proprietary System Certification Form during the Readiness Review Phase.

Name of Signature Authority (print name):		
Title of Signature Authority for Legal Entity:		
Street Address or PO Box:		Suite or Apt. No.:
City:	State:	ZIP Code:
Telephone:	Fax:	Email:

By signing below, I confirm:

- I have an owner or an authority relationship with the Program Provider or FMSA identified in Section A.
- I am authorized to view the Program Provider's or FMSA's historical health-related data.
- I understand that unauthorized access of health-related data violates federal and state laws protecting the privacy of protected health information.
- I have read all HHSC EVV Business Rules for Proprietary Systems and will adhere to those rules as well as all HHSC EVV policy.
- I understand that I must demonstrate electronic data exchange and secure connectivity capabilities with TMHP two weeks prior to the start of my EVV proprietary system Readiness Review.
- I understand that I cannot use my EVV proprietary system to comply with Texas EVV requirements prior to completing all required Readiness Review criteria and receiving HHSC approval.
- I designate the individual listed in Section C of this document to be the Designated EVV Contact with whom TMHP and HHSC will coordinate all aspects of my EVV proprietary system implementation.

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Signature *(stamped signatures not accepted)* Date