**New Hampshire EVV System Declaration Form**

This form is to be completed and signed by agencies. This will enable us to identify whether you will be using the State-sponsored EVV solution, AuthentiCare, or using a Third-Party EVV solution. If you use a Third-Party EVV solution it must be approved by the New Hampshire Department of Health and Human Services (DHHS), and must comply with the list of requirements that can be found here:

[Electronic Visit Verification | New Hampshire Department of Health and Human Services (nh.gov)](https://www.dhhs.nh.gov/programs-services/adult-aging-care/electronic-visit-verification)

Please submit the completed form, along with any questions you may have, to: [evv@dhhs.nh.gov](mailto:evv@dhhs.nh.gov)

Please fill in your agency/provider information:

|  |  |
| --- | --- |
| Name |  |
| Medicaid Provider ID |  |
| Contact Person Name |  |
| Contact Person Phone |  |
| Contact Person Email |  |
| Mailing Address 1 |  |
| Mailing Address 2 |  |
| City |  |
| State & Zip Code |  |
| Will you be using a centralized Billing Location for all sites? |  |

Please fill in your EVV solution vendor selection and information:

I will be using the State Sponsored EVV Solution, NH AuthentiCare.

I will be using a Third Party EVV solution and will complete the box below:

|  |  |
| --- | --- |
| Name of Vendor/Company |  |
| Name of EVV solution |  |
| Vendor Contact Person Name |  |
| Vendor Contact Person Phone |  |
| Vendor Contact Person Email |  |

I agree that the information I have provided is accurate and that I will comply with the State of New Hampshire EVV requirements.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: |  | | Email: |  | | |
| Signature: | |  | | | Date: |  |