

Request to Schedule Demonstration

Electronic Visit Verification (EVV)

Alternate System Certification

Each alternate EVV system vendor must successfully complete a demonstration of core system functionality as defined by the Demonstration Checklist found on the ODM EVV webpage. If the alternate system (with the same functionality) has not successfully been demonstrated previously, the demonstration is required before the alternate system will be certified. If the alternate system (with the same functionality) has been successfully demonstrated previously, the provider and vendor should complete the certification in Part 2 of this document in lieu of requesting a demonstration.

Note: Part 2 of the Request to Schedule Demonstration should be completed by the provider and vendor for any alternate system that has successfully completed a demonstration previously. Failure to either successfully complete a demonstration or submit this form with Part 2 completed, will result in a failure to complete the alternate EVV system certification process.

Provider Name: _____

Medicaid Provider Number _____

Vendor/System _____

Date: _____

Part 1: To be completed by the provider requesting the demonstration.

1. Please indicate whether the alternate system has been developed solely for services provided through waivers administered by the Ohio Department of Developmental Disabilities (DODD).

All Services DODD Only

2. Do you have multiple versions/approaches (e.g., hosted on your server vs. hosted on a provider server)?

Yes No

If yes, please list the versions/approaches the vendor offers and indicate the approach that will be shown in the demonstration.

3. Demonstrations are typically scheduled on Tuesdays and Thursdays and will be scheduled in the order requested. Vendors are required to participate in person. Providers must participate in

person or remotely. **Please indicate the first date when both the vendor and provider are available for a demonstration.**_____

Part 2: To be completed by the provider and vendor when the vendor has previously completed a successful demonstration of the system that will be used by the provider.

_____(*vendor*) and _____
(*provider*) hereby attest that the _____(*alternate system*) was
successfully demonstrated to the Ohio Department of Medicaid on _____(*date*).

Vendor:

Provider:

(*Signature*)

(*Signature*)

(*Name – Please Print*)

(*Name – Please Print*)

(*Title*)

(*Title*)

(*Date*)

(*Date*)