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| **General Program Eligibility Questions\***  You will need to refer to your completed Medicaid EHR Incentive Program attestation in order to answer the questions below. You can access the attestation in MAPIR by going to: [https://www.or-medicaid.gov](https://www.or-medicaid.gov/ProdPortal/Home/tabId/36/Default.aspx). Please note, some of the questions may require additional supporting documentation.  We prefer the questionnaire and supporting documentation are uploaded directly to MAPIR. If you need to submit via secure email, you may send the information to: [Medicaid.EHRIPAudits@state.or.us](mailto:Medicaid.EHRIPAudits@state.or.us). |
| **Name of Eligible Hospital:**  **NPI:**  **CCN:** |
| 1. Person responsible for completing this questionnaire:   Name:  Title:  Phone:  Email: |
| 1. Patient Volume:    1. For the 90-day patient volume period you selected for your attestation [Enter Dates]; please provide a report (in Excel format) listing all patient encounters. Fields required are patient ID, date of service, type of service (inpatient or emergency department), Medicaid ID for active Medicaid recipients, and cost of service.    2. Please describe how you determined the numerator and denominator for the patient volume timeframe.      * 1. Please demonstrate how you calculated the patient volume |
| 1. Technical assistance:   While not required, many providers were assisted by third parties in adopting, implementing, or upgrading their EHR. Did you receive assistance from any of the following sources (check all that apply)?  Regional Extension Center  Consultant  Internal Information Technology Department  EHR Vendor  Received No Assistance |
| 1. Eligible Hospital Certification:   I certify that the responses documented in this questionnaire and the supporting documentation provided are accurate to the best of my knowledge.    EH Signature/Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  EH Facility Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |