APPENDIX F

Pennsylvania eHealth Partnership Program

EHR Incentive Program Grant

Meaningful Use Attestation

To be completed by the Home Health Agency (HHA):

Home Health Agency Name: _____

Date of Achieving Meaningful Use of 2016 CEHRT as per RFA 12-22: _____

HHA's Electronic Health Record System Vendor/Product:

_____

HHA's P3N HIO Connection:

_____

1. Please identify which of the following functions your P3N HIO has enabled for your organization (check all that apply):

   ☐ Send Discharge Summaries

   ☐ Query for Discharge Summaries

   ☐ Query for Historical Lists (Medications, Allergies, etc.)

   ☐ Query for Longitudinal Medical Record

   ☐ Exchange in Support of Referrals or Consultations

   ☐ Exchange of Patient Care Plans

   ☐ Query for Diagnostic Results

   Other (please describe):

   _____

   _____

2. Approximate number of individuals within your organization who have access to the functions described above: _____

Name of Individual Completing This Form: _____

Title of Individual Completing This Form: _____

Phone Number: _____ Email Address: _____

By my signature below, I attest to the following:

A. I certify that the information on the enclosed attestation is accurate and complete as submitted.
B. I understand that the payment for these services will be from federal and state funds and that I may be prosecuted for false claims, statements or documents, or concealment of material facts.

Signature: _____ Date: _____

Please note that the Department of Human Services may contact you to validate that you completed this form.