



# EVV TIME CORRECTION/ADJUSTMENT FORM

Please fill out all fields completely and legibly. Incomplete forms will not be processed. All reasons for adjustment are subject to State of Nevada verification.

**Submit one form per shift worked** by Email: [infocdnv@consumerdirectcare.com](mailto:infocdnv@consumerdirectcare.com) or Fax: 1-877-786-4998

**Submit by Wednesday at midnight** following the two-week pay period. Refer to the payroll calendar.

Consumer Name: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_

Worker ID #: \_\_\_\_\_

Shift to be Adjusted: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Service Code: \_\_\_\_\_

Check In: \_\_\_\_:\_\_\_\_ am / pm Check Out: \_\_\_\_:\_\_\_\_ am / pm Hours Worked: \_\_\_\_\_

**ADL's Performed:** (tasks completed per Service Plan - check all that apply)

- 10 - Bathing
- 11 - Dressing
- 12 - Grooming
- 13 - Toileting
- 14 - Transferring
- 15 - Mobility/Ambulation
- 16 - Eating
- 17 - Light Housekeeping
- 18 - Laundry
- 19 - Essential Shopping
- 20 - Meal Preparation
- 21 - Skilled Service\*
- 22 - Skilled Service (SD)\*
- 30 - Chore
- 31 - Homemaker
- 32 - Companion Care
- 33 - Respite

\*Skilled services only – specify services performed:

**Describe in detail your request for the EVV time adjustment.**

What caused you to not use the EVV system: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What action was taken to remedy the cause: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Caregiver verification of Check In/Out:** I acknowledge by signing below that I understand I am required to check in and out of my scheduled shift using the AuthentiCare EVV system. I understand and agree that all missed check in/check out times are subject to audit by the State of Nevada and that submitting this form with fraudulent information can be considered Medicaid Fraud.

Caregiver Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Consumer verification of Check In/Out:** By signing this form, I hereby certify that I received these documented services on the date and time listed above. I understand it can be considered Medicaid fraud if I sign this form without having received the services listed.

Consumer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Office Use Only**

Issue:  Pending Check-Out     Pending Check-In     Time Exceeds Authorized Hours  
 Time Overlap     Missing Time (EVV not used)

Date Prepared: \_\_\_\_/\_\_\_\_/\_\_\_\_    Date Adjusted in EVV: \_\_\_\_/\_\_\_\_/\_\_\_\_

Prepared by: \_\_\_\_\_    Adjusted by: \_\_\_\_\_

Comments: \_\_\_\_\_