CONSUMER DIRECT CARE NETWORK

EVV TIME CORRECTION/ADJUSTMENT FORM

Please fill out all sections of the form clearly. Incomplete forms may 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 or **Fax:** 1-877-786-4998

Submit by Monday at midnight following the two-week pay period to ensure timely payment. Refer to the payroll calendar. **Forms submitted more than 45 days after the date of service may not be accepted.**

Consumer Name: _____

Caregiver Name: _____ **Worker ID #:** _____

Shift to be Adjusted: Date: _____/_____/____ Service Code: _____

Check In: _____:_____ am / pm Check Out: _____:_____ am / pm Hours Worked: _____

Tasks Performed: (per Service Plan - check all that apply)

☐ Bathing	☐ Dressing	☐ Grooming	☐ Toileting
☐ Transferring	☐ Mobility/Ambulation	☐ Eating	☐ Light Housekeeping
☐ Laundry	☐ Essential Shopping	☐ Meal Preparation	☐ Skilled Service
☐ Respite	☐ Chore	☐ Homemaker	☐ Companion Care

To approve this shift, you must submit a matching shift to DirectMyCare.com.
Is this shift submitted in DirectMyCare.com? _____

Describe in detail your request for the EVV time adjustment.

Reason for not using the EVV system or adjusting the shift: _____

_____

If you are having issues with the EVV system, you must tell Consumer Direct Care Network within 24 hours or the next business day. If you do not report the issue, time submitted on this EVV Time Correction/ Adjustment Form may not be processed.

Caregiver verification of Check In/Out: By signing, I agree to check in and out for my shift with the approved EVV system. I understand that all information on this form may be audited by the State of Nevada. I understand submitting false information can be considered Medicaid Fraud.

Caregiver Signature: _____ Date: _____

Consumer verification of Check In/Out: By signing, I confirm I received the services on the stated date and time. I understand submitting false information can be considered Medicaid Fraud.

Consumer Signature: _____ Date: _____

Office Use Only **Issue:** ☐ CA Data Mismatch ☐ IVR Correction ☐ Client declined DMC

Auth to begin date: _____/_____/_____ **CareAttend Eff Date:** _____/_____/_____

Prepared by: _____ **Approved by:** _____