



# 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 Arizona verification.

**Submit one form per shift worked** by Email: infocdaz@consumerdirectcare.com or Fax: 1-877-398-8413

**Submit by Monday at midnight. Forms submitted more than 45 days after the date of service may not be accepted.**

Member Name: \_\_\_\_\_

Member ID: \_\_\_\_\_

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

SL Employee ID: \_\_\_\_\_

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

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

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

- |                                       |  |   |   |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> Bathing      | <input type="checkbox"/> Dressing            | <input type="checkbox"/> Grooming         | <input type="checkbox"/> Toileting          |
| <input type="checkbox"/> Transferring | <input type="checkbox"/> Mobility/Ambulation | <input type="checkbox"/> Eating           | <input type="checkbox"/> Light Housekeeping |
| <input type="checkbox"/> Laundry      | <input type="checkbox"/> Essential Shopping  | <input type="checkbox"/> Meal Preparation | <input type="checkbox"/> Skilled Service    |
| <input type="checkbox"/> Respite      | <input type="checkbox"/> Chore               | <input type="checkbox"/> Homemaker        | <input type="checkbox"/> Companion Care     |

**This form is not intended to replace the use of an EVV system. Caregivers are required to use an approved EVV system for all shifts. This form should only be used to correct errors that occurred during a shift, and it must not be used as a substitute timesheet or in place of an EVV system.**

Describe in detail your request for the EVV time adjustment. Reason for not using the EVV system:

**Caregiver verification of Clock In/Out:** By signing, I confirm that I provided the services on the stated date and time. I understand submitting false information can be considered Medicaid Fraud.

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

**Consumer verification of Clock 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:  EVV CG Error

Client unavailable to sign

Approved by: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_