SKYE CANYON HOME CARE

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:** myinfo@skyecanyoncare.com

Submit by Monday at midnight following the two-week pay period to ensure timely payment. Refer to the payroll calendar. **Forms submitted more than 30 days after the date of service will not be accepted!**

Client 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	□ 30 - Chore
□ 31 - Homemaker	□ 32 - Companion Care	□ 33 - Respite	

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 difficulty with the Mobile app or IVR system, you must notify Skye Canyon Home Care within 24 hours or the next business day to get assistance. If you do not report the issue, time submitted on this EVV Time Correction/Adjustment Form will not be processed. This form was created to correct a shift that was submitted through the AuthentiCare EVV System.

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: _____

Client 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.

Client 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: _____