TEXAS Health and Human Services Commission

Form H0500
July 2016-E

Medicaid Electronic Visit Verification (EVV) Small Alternative Device Agreement

Escoja su idioma
English | **Español**

Name of Medicaid Individual/Member

First Name _____ MI _____ Last Name _____

Provider Agency Use Only
Receipt Date (Enter the date form was received for processing.)
Medicaid ID (Enter number above)
Date of Birth (Enter as mm/dd/yyyy)
SAD Serial No. (Optional)

Texas Medicaid uses an electronic system for certain Medicaid services to record the time your attendant or assigned staff begins and ends providing services to you. The electronic system is called Electronic Visit Verification or EVV.

This means you must allow your attendant or assigned staff to (1) use your home landline telephone to call a toll-free number or (2) agree to have a small alternative device installed in your home to record the time your attendant or assigned staff begins and ends providing service to you.

You have requested the small alternative device (SAD) to be installed in your home because:

☐ You do not have a home landline telephone.

☐ You do not want your attendant or assigned staff to use your home landline telephone for EVV.

By signing this form, you agree to allow the small alternative device to be installed in your home. You understand the device must be in your home at all times. If the device is removed or damaged for any reason, you agree to tell your provider agency immediately. When you are no longer getting services, you must return the device to the provider agency.

The "Requestor" and a "Witness" are required to sign this form, and both signatures must be in ink. The “Witness” may be the attendant, assigned staff, or other provider agency employee. A guardian or legally authorized representative (LAR) may sign as the “Requestor” but not as the “Witness.” By signing this form you understand failure to report unauthorized removal of a small alternative device (SAD) from the home could result in a Medicaid fraud referral.

Requestor Signature

☐ Medicaid individual/member ☐ LAR ☐ Person requesting use of devise

Date of Signature _____

Printed Name _____
(If other than the Medicaid individual/member identified at the top of this form)

Witness Signature

Date of Signature _____

Printed Name _____

The Section Below Is for Provider Agency / Financial Management Services Agency (FMSA) Use Only

Select the EVV Program/Services Provided:

Program	Services	Program	Services
☐ STAR+PLUS Dual Eligible Integrated Care Demonstration	• Personal assistance services (PAS) • Personal care services (PCS) • In-home respite services • Community First Choice (CFC) (PAS/ Habilitation (HAB)	☐ STAR Kids	• PCS • In-home respite services • Flexible family support services • CFC (PAS/HAB)
☐ Fee-for Service	• Comprehensive Care Program CCP-PCS • CFC (PAS/HAB)	☐ Community Living Assistance and Support Services (CLASS)	• In-home respite services • CFC (PAS/HAB)
☐ STAR Health	• PCS • CFC (PAS/HAB)	☐ Community Attendant Services (CAS)	• PAS
☐ Medically Dependent Children Program (MDCP)	• In-home respite services • Flexible family support services	☐ Primary Home Care (PHC)	• PAS
☐ Family Care (FC)	• PAS		

Service claims for this Medicaid member are submitted to: (check all that apply)

☐ Aetna Better Health of Texas Inc.
☐ Amerigroup Corporation
☐ Children's Medical Center
☐ Cigna-HealthSpring
☐ Community First Health Plans, Inc.
☐ Cook Children's Health Plan
☐ Driscoll Children's Health Plan
☐ Molina Healthcare
☐ Health Care Service Corporation DBA Blue Cross and Blue Shield of Texas (BCBSTX)
☐ Superior Healthcare
☐ Texas Children's Health Plan, Inc.
☐ TMPH (includes DADS contracted providers)
☐ UnitedHealthcare

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Medicaid Electronic Visit Verification (EVV) Small Alternative Device Order

Order History (Sequential history and reason for ordering a new device for the Medicaid individual/member)

A Medicaid EVV Small Alternative Device Agreement form must be signed before ordering an initial device for a Medicaid individual/member. Before placing a reorder, the provider agency must reaffirm with the individual/member his or her need for requesting a small alternate device by having the individual/member sign a new Medicaid EVV Small Alternative Device Agreement form.

Order Number

Reason for Order (Check only one box)

☐ Initial Order ☐ Lost Device - Reorder ☐ Nonfunctioning Device - Reorder ☐ Change of Address

☐ Vendor Transfer From: Vendor Transfer To:

Location where the device will be installed:

Street Address | Unit or Apartment No.

City | State | ZIP Code

Provider Agency / FMSA Information Associated with Service Delivery to the Medicaid Individual/Member Named on Page 1

(Check one) ☐ Provider Agency Legal Entity Name or ☐ FMSA Legal Entity Name | Provider NPI or API | Provider TPI

DBA | DADS Region/MCO-SDA | Provider TIN | DADS 9-Digit Contract Number

Certification

My signature below certifies that I have the authority to sign Medicaid EVV Small Alternative Device Order forms on behalf of the provider agency or FMSA identified above. I attest the information provided on this form is correct and complete. The provider agency, or individual receiving the device on behalf of the FMSA, agrees to

(1) install the device in the Medicaid individual's/member's home,
(2) return all nonfunctioning devices and devices that are no longer used to the appropriate vendor, and
(3) return all devices timely to the issuing EVV vendor upon termination of its affiliation with the issuing EVV vendor. (Consult your EVV vendor for more information.)

Signature of Representative | Date

Title | Telephone No. with Area Code | Email Address

Shipping Information

Shipping Information for Provider Agency (Non-Consumer Directed Services)

Provider Agency Contact for Shipment

Provider Agency Legal Entity Name | Name

Street Address or P.O. Box | Building / Suite No. | Telephone No. with Area Code

City | State | ZIP Code | Email Address

Shipping Information for FMSA – Consumer Directed Services (CDS) Only

A device ordered for a person enrolled in CDS qualifies for direct delivery to an individual other than the provider agency or FMSA identified at the top of this order form. You are required to provide shipping information for a device ordered under the CDS model.

Ship to:

First Name | MI | Last Name

Street Address or P.O. Box | Unit or Apartment No.

City | State | ZIP Code

Home Phone with Area Code | Alternate Phone with Area Code