The Ohio Department of Medicaid

ELECTRONIC VISIT VERIFICATION EXEMPTION REQUEST

Instructions for Exemption Requests

Ohio Administrative Code rule 5160-32-01, Electronic Visit Verification (EVV) program, permits an exemption to visit capture requirements when the direct care worker (DCW) is a resident of the same household as the individual receiving services. DCW's must continue to log all services subject to EVV until ODM approves the submitted EVV exemption request. Prior to submission of this form, the provider must ensure the DCW/employee record and recipient record are in the Sandata EVV system. For those providers using an Alternate EVV vendor, a Fiscal Management Service (FMS) entity, or both, the DCW or employee record and recipient record must be documented in the state's Aggregator system.

- Submit documents via encrypted email to evv@medicaid.ohio.gov or fax to 614-318-4956. No other methods will be accepted. ODM will respond via email.
- The approval date from ODM is the effective date of the exemption.
- If an exemption request is unable to be processed, a resubmission of a new form and documentation of shared address will be required.
- Any change in residential status, payor or service requires submission of the **EVV Exemption Request: Notification of Change** form ODM 10377.
- ODM can request proof of shared address at any time and may require annual attestation.
- ODM may reconsider and revoke a previously granted exemption. Notice will be provided before revocation.

Section I: To be Completed by the Provider *(Check only one box.)*

1. Initial Request: This is the first submission for the recipient.

2. Resubmission: Resubmitting due to an "Unable to Process" email from ODM-EVV, which requested that the form and proof of address be resubmitted with corrections.

Section II: To be Completed by the Provider *(All fields must be completed.)*

3. Provider Type: Indicate if you are an agency or an Independent/Self-Directed Provider.

4. Provider Agency or FMS Name: Enter your Provider Agency name. If you are an Independent or Self-Directed provider associated with an FMS, enter your FMS name as either PPL or GT Independence.

5. Provider 7-digit Medicaid ID or FMS 7-digit ID: Enter your Provider Medicaid ID as found in the PNM system. If you are associated with an FMS and do not know your FMS ID, contact your FMS *(PPL or GT Independence)* representative for assistance.

6. Provider or Sandata FMS – EVV Account Number: Provide your EVV Account Number or Sandata STX number, which can be found in your Welcome Kit letter from Sandata.

7. Medicaid Recipient Name: Enter the recipient's first name and last name.

8. Recipient Medicaid ID: Enter the recipient's 12-digit Medicaid ID.

9. Shared Street Address or Service Site: Enter the street address, city, state, and zip code shared by the recipient and the DCW. This must match the recipient's address in ODM's record system, Ohio Benefits.

10. Service Procedure Code: Check the applicable service procedure codes.

10a. Medicaid Payor for selected service: Select the payor from the drop-down list for the selected service(s).

11. Documentation provided for address verification: Indicate the type of proof of shared address provided for the DCW. Examples include utility bills, driver's licenses, state IDs, tax returns, and W-2 forms. This must be provided to be considered for an exemption.

Section III: Provider Signatures *(Please read the attestations carefully before signing the document.)*

12. DCW, Independent or Self-Directed Provider: Enter first name, last name, last four digits of Social Security Number (SSN), and email address.

13. DCW, Independent, or Self-Directed Provider Signature: Sign after reading the attestation.

14. Date: Enter the date of signature.

15. Agency Provider Representative Name: Enter the representative's name for the agency provider.

16. Agency Provider Representative Signature: Sign after reading the attestation.

17. Date: Enter the date of signature.

18. Agency Provider Representative Email Address

Section I: For completion by PROVIDER *(choose one)*

1. ☐ Initial request	2. ☐ Resubmission due to unable to process initial request

Section II: For completion by PROVIDER

3. Provider Type *(Check One)* ☐ Agency ☐ Independent or Self Directed	4. Provider Agency or FMS Name	
5. Provider 7-digit Medicaid ID or FMS 7-digit ID	6. Provider or Sandata FMS - EVV Account Number	
7. Medicaid Recipient First Name and Last Name		8. Recipient Medicaid ID
9. Shared Street Address/Service Site *(Must match recipient address in ODM's recipient system of record, Ohio Benefits)*		
City	State	Zip Code

10. Service Procedure Codes *(choose all that apply)*	10a. Medicaid Payor for selected service
☐ Choices Home Care Attendant *(T2025)*	Choose One
☐ Enhanced Community Living *(T2025 with UA and U1 modifiers)*	Choose One
☐ Home Care Attendant *(S5125)*	Choose One
☐ Homemaker/Personal Care *(HPC)*	Choose One
☐ Nursing Delegation Consultation – RN *(G0493)*	Choose One
☐ Personal Care Service *(T1019)*	Choose One
☐ Private Duty Nursing *(T1000)*	Choose One
☐ Residential Respite	Choose One
☐ RN Assessment *(T1001)*	Choose One
☐ RN Consultation *(T1001 with U9 modifier)*	Choose One
☐ State Plan Home Health Aide *(G0156)*	Choose One
☐ State Plan Home Health Nursing - LPN *(G0300)*	Choose One
☐ State Plan Home Health Nursing – RN *(G0299)*	Choose One
☐ State Plan Home Health Occupational Therapy *(G0152)*	Choose One
☐ State Plan Home Health Physical Therapy *(G0151)*	Choose One
☐ State Plan Home Health Speech Therapy *(G0153)*	Choose One
☐ Waiver Nursing Delegation Assessment – *RN (G0493 with U9 modifier)*	Choose One
☐ Waiver Nursing Service – LPN *(T1003)*	Choose One

☐ Waiver Nursing Service – RN *(T1002)*	Choose One
11. Documentation provided for address verification (e.g. utility bill, driver's license, State ID, tax return, W-2)	

Section III: Provider Signatures

By signing this document, I attest that, to the best of my knowledge, the information on this form is true and accurate. Any changes to my live-in status will be reported to my agency and evv@medicaid.ohio.gov within five (5) business days. I understand that falsifying information may result in termination of my provider agreement with Ohio Medicaid, the applicable program, and/or recoupment of caregiver payments. I understand ODM may request verification of my live-in status at any time and verification of my live-in status is subject to review to ensure that program requirements are being met.

12. DCW, Independent, or Self-Directed Provider		
First Name	Last Name	Last Four Digits of SSN
Email address		
13. DCW, Independent, or Self-Directed Provider Signature		14. Date

By signing this document, I attest that, to the best of my knowledge, the information on this form is true and accurate. Any changes to the DCW's live-in status will be reported to evv@medicaid.ohio.gov within 5 business days. I understand that falsifying information may result in termination of my provider agreement with Ohio Medicaid and the applicable program, recoupment of caregiver payments, or both.

15. Agency Provider Representative Name *(if applicable)*	16. Agency Provider Representative Signature *(if applicable)*	17. Date
18. Agency Provider Representative Email Address *(if applicable)*		