ELECTRONIC VISIT VERIFICATION EXEMPTION NOTIFICATION OF CHANGE REQUEST

Ohio Administrative Code rule 5160-32-01, Electronic Visit Verification (EVV) program, permits an EVV exemption when the direct care worker (DCW) lives with the person receiving services. DCWs must continue to log all services subject to EVV until the Ohio Department of Medicaid (ODM) approves the 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 Services (FMS) entity, or both, the DCW or employee record and recipient record must be documented in the state's Aggregator system.

Instructions for Notification of Change Requests

1. **Change in Residential Address:** You **do not** need to complete a change request form when the DCW and the person they are providing services for (recipient) move to a new shared residential address. Please have the recipient or their authorized representative call the Ohio Medicaid Consumer Hotline at 800-324-8680 to update the address in ODM's Eligibility System. If the recipient and DCW no longer live together, please terminate the exemption request by following the instructions in number 3 below.
2. **Change in Payor or Services:** To request a change in payor or services, complete **Sections 1, 2, 3a, 3b and 5** of the form. The end date for the previous payor and service will be recorded as the date ODM receives your change request form. When entering the effective date for the new payor and service, the date cannot be more than **120 days prior** to the date the form is submitted. *For example, if the form is submitted on January 1, 2026, the effective date must be no earlier than September 3, 2025.*
3. **Termination Request to End an Existing Approved Exemption:** To request the termination of an already approved exemption, complete **Sections 1, 2, 3a, 4 and 5** of the form.

Electronic Visit Verification Exemption Notification of Change Request

Section 1: Change Request Type

Change Request Type: *(choose one)* ☐ Add or Remove Payor or Services ☐ Termination Request

Section 2: Provider/DCW and Recipient Information

Provider Type: ☐ Agency ☐ Independent ☐ Self-Directed			
EVV Account Number: *(5-6 digits; or provide FMS EVV Account Number if applicable)*			
Provider Medicaid ID: *(7 digits; or provide FMS 7-digit ID)*			
Medicaid Recipient First Name:	Medicaid Recipient Last Name:		
Provider or Agency Name: *(include FMS Name if applicable)*		Recipient Medicaid ID: *(12 digits)*	
Shared Street Address/Service Site *(Must match recipient address in ODM's recipient system of record, Ohio Benefits)*			
Street Address:	City:	State:	Zip Code:
DCW Santrax ID: *(In the EVV system, this is shown as "DCW/Employee ID" which is the 6-digit number that needs to be entered as the DCW Santrax ID.)*			
Recipient Santrax ID: *(In the EVV system, this is shown as "Recipient ID" which is the 6-digit number that needs entered as the Recipient Santrax ID.)*			
DCW First Name:	DCW Last Name:	DCW Last Four Digits of Social Security Number (SSN):	

Section 3: Change in Payor or Services *(3a, 3b, and 3c must be completed)*

3a. Confirm the Previous Payor and Service.

Previous Medicaid Payor:
Previous Service Procedure Name or Code:

3b. Select the New Payor and Service and enter an Effective Date no more than 120 days before the form submission date.

Service Procedure Codes: (*choose all that apply)*	**Medicaid Payor:** *(choose one for each selected service)*				**Effective Date:** *(mm/dd/yyyy)*
☐ Choices Home Care Attendant (T2025)	☐ Aetna ☐ CareSource	☐ Anthem ☐ Molina	☐ Buckeye ☐ ODA ☐ UHC		
☐ Enhanced Community Living (T2025 with UA and U1 modifiers)	☐ Aetna ☐ CareSource	☐ Anthem ☐ Molina	☐ Buckeye ☐ ODA ☐ UHC		
☐ Home Care Attendant (S5125)	☐ Aetna ☐ Molina	☐ Anthem ☐ ODA	☐ Buckeye ☐ ODM	☐ CareSource ☐ UHC	
☐ Homemaker/Personal Care (HPC)	☐ DODD				
☐ Nursing Delegation Consultation - LPN (G0494)	☐ DODD				
☐ Nursing Delegation Assessment - RN (G0493 with U9 modifier)	☐ DODD				
☐ Nursing Delegation Consultation - RN (G0493)	☐ DODD				
☐ Participant-Directed Homemaker Personal Care (PDHPC)	☐ DODD				
☐ Personal Care Service (T1019)	☐ Aetna ☐ Molina	☐ Anthem ☐ ODA	☐ Buckeye ☐ ODM	☐ CareSource ☐ UHC	
☐ Private Duty Nursing (T1000)	☐ Aetna ☐ Buckeye ☐ Molina	☐ AmeriHealth Caritas ☐ CareSource ☐ ODM	☐ Anthem ☐ Humana ☐ UHC		
☐ Residential Respite	☐ DODD				
☐ RN Assessment (T1001)	☐ Aetna ☐ Buckeye ☐ Molina	☐ AmeriHealth Caritas ☐ CareSource ☐ ODM	☐ Anthem ☐ Humana ☐ UHC		
☐ RN Consultation (T1001 with U9 modifier)	☐ Aetna ☐ Buckeye ☐ Molina	☐ AmeriHealth Caritas ☐ CareSource ☐ ODM	☐ Anthem ☐ Humana ☐ UHC		
☐ Self-Directed Personal Care Service (T1019)	☐ Aetna ☐ Molina	☐ Anthem ☐ ODA	☐ Buckeye ☐ ODM	☐ CareSource ☐ UHC	

☐ State Plan Home Health Aide (G0156)	☐ Aetna ☐ Buckeye ☐ Molina	☐ AmeriHealth Caritas ☐ CareSource ☐ ODM	☐ Anthem ☐ Humana ☐ UHC	
☐ State Plan Home Health Nursing - LPN (G0300)	☐ Aetna ☐ Buckeye ☐ Molina	☐ AmeriHealth Caritas ☐ CareSource ☐ ODM	☐ Anthem ☐ Humana ☐ UHC	
☐ State Plan Home Health Nursing - RN (G0299)	☐ Aetna ☐ Buckeye ☐ Molina	☐ AmeriHealth Caritas ☐ CareSource ☐ ODM	☐ Anthem ☐ Humana ☐ UHC	
☐ State Plan Home Health Occupational Therapy (G0152)	☐ Aetna ☐ Buckeye ☐ Molina	☐ AmeriHealth Caritas ☐ CareSource ☐ ODM	☐ Anthem ☐ Humana ☐ UHC	
☐ State Plan Home Health Physical Therapy (G0151)	☐ Aetna ☐ Buckeye ☐ Molina	☐ AmeriHealth Caritas ☐ CareSource ☐ ODM	☐ Anthem ☐ Humana ☐ UHC	
☐ State Plan Home Health Speech Therapy (G0153)	☐ Aetna ☐ Buckeye ☐ Molina	☐ AmeriHealth Caritas ☐ CareSource ☐ ODM	☐ Anthem ☐ Humana ☐ UHC	
☐ Waiver Nursing Service - LPN (T1003)	☐ Aetna ☐ CareSource ☐ ODA	☐ Anthem ☐ DODD ☐ ODM	☐ Buckeye ☐ Molina ☐ UHC	
☐ Waiver Nursing Service - RN (T1002)	☐ Aetna ☐ CareSource ☐ ODA	☐ Anthem ☐ DODD ☐ ODM	☐ Buckeye ☐ Molina ☐ UHC	

Section 4: Termination Request

Effective Date of Termination:

Section 5: Agency Representative, DCW, Independent, or Self-Directed Provider Signature

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 provider 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.

First Name:	Last Name:
Agency Representative, DCW, Independent, or Self-Directed Provider Signature:	Signature Date:
Email Address for Correspondence:	