Medicaid Electronic Visit Verification (EVV)
Small Alternative Device Agreement

Name of Medicaid Individual/Member

<table>
<thead>
<tr>
<th>First Name</th>
<th>MI</th>
<th>Last Name</th>
</tr>
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</table>

Texas Medicaid uses a system to record the time your attendant or nurse provides services you get today. The system is called Electronic Visit Verification or EVV.

This means you must allow your attendant or private duty nurse to 1) use your home landline phone to call a toll-free number or 2) agree to have a small alternative device installed in your home to mark the time he or she starts and stops providing service to you.

You have said that you need the small alternative device installed in your home because:

☐ You do not have a home landline phone.
☐ You do not want your attendant or private duty nurse to use your home landline phone 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 persons signing below must sign this form in ink. Electronic or stamped signatures are not allowed. The “Witness” may be the attendant, private duty nurse, or other provider agency employee who gave the form to you. A guardian or legally authorized representative (LAR) may sign as the “Requestor” but not as the “Witness.”

Requestor Signature
(Medicaid Individual/Member, LAR, or Person Requesting Use of Device)

Witness Signature

Date of Signature

Date of Signature

Printed Name
(If other than the Medicaid Individual/Member identified at the top of this form)

Printed Name

The Section Below is for PROVIDER AGENCY / FINANCIAL MANAGEMENT SERVICES AGENCY (FMSA) Use Only

Indicate the program(s) services Provider Agency or FMSA delivers to the Medicaid Individual/Member named above: (check all that apply)

<table>
<thead>
<tr>
<th>CFC</th>
<th>DADS</th>
<th>HHSC CCP</th>
<th>MCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ CFC</td>
<td>☐ CLASS</td>
<td>☐ PHC / CAS / FC</td>
<td>☐ PAS waiver</td>
</tr>
<tr>
<td>☐ MDCP</td>
<td>☐ MD</td>
<td>☐ PCS</td>
<td>☐ PCS</td>
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<tr>
<td>☐ MD</td>
<td>☐ MDCP</td>
<td>☐ PDN</td>
<td>☐ PAS non-waiver</td>
</tr>
<tr>
<td>☐ MD</td>
<td>☐ MDCP</td>
<td>☐ PC</td>
<td>☐ PDN</td>
</tr>
</tbody>
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Service claims for this Medicaid Member are submitted to: (check all that apply)

☐ Amerigroup Corp.  ☐ Cigna-HealthSpring  ☐ Molina Healthcare  ☐ Superior HealthPlan  ☐ UnitedHealthcare  ☐ TMHP / Accenture

Order History  (Sequential history and reason for ordering a new device for the Medicaid Individual/Member)
A 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 his or her need for requesting an alternate device by having the individual sign a new Small Alternative Device Agreement Form.

Order Number
Reason for Order  (Check only one box)
☐ First Order  ☐ Lost Device - Reorder  ☐ Nonfunctioning Device - Reorder

Location where the device will be installed:

Street Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Version 1.1
Effective 03/16/2015
Provider Agency / FMSA Information Associated with Service Delivery to the Medicaid Individual/Member Named on Page 1

Provider Agency / FMSA Legal Entity Name

MCO-SDA

Provider NPI or API

Provider TPI

DBA

Provider TIN

DADS 9 Digit Contract Number

Certification

My signature below certifies that I have the authority to sign 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 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 Provider Agency Representative

Date

Title

AC Phone

Email Address

SHIPPING INFORMATION

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

Provider Agency Name

Street Address or PO Box

Bldg / Ste #

City

State

Zip Code

Provider Agency Contact for Shipment

Name

( )

AC Phone

Email Address

Shipping Information for FMSA – Consumer Directed Services

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 PO Box

Unit or Apartment #

City

State

Zip Code

( )

AC Home Phone

( )

AC Alternate Phone