SeniorCare
Home Health Agency, Inc.

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

PERSONAL INFORMATION:

Last _____ First _____ SS# _____

Street Address _____ City/Town _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____

EDUCATION:

High School Name _____ City/Town _____

College _____

HOURS AVAILABLE

- ☐ DAYS
- ☐ NIGHTS
- ☐ LIVE-IN

MON _____
TUE _____
WED _____
THU _____
FRI _____
SAT _____
SUN _____

PROFESSIONAL TRAINING:

Name of School, City & State	Date of Entrance	Graduate Yes/No	Cert/Degree

SKILLS CHECKLIST (please check any that apply):

☐ Home Care	☐ Denture Care	☐ Non-Sterile Dressing	☐ Patient Teaching
☐ Special Diets	☐ Range of Motion	☐ Vital Sign	☐ Child Care
☐ Kosher Cooking	☐ Transfer Techniques	☐ Urine Testing	☐ Newborn
☐ Household Maintenance	☐ Hoyer Lift	☐ Geriatrics	☐ Other _____
☐ Laundry	☐ Foyer Lift	☐ Orthopedics	_____
☐ Bed Bath	☐ Ostomy Care	☐ Diabetes	_____

TRANSPORTATION (Convenient Transportation to Assignment):

Bus/Train/Car? ☐ Yes ☐ No Routes _____

Valid Licenses? ☐ Yes ☐ No

Do you give permission for a criminal screen to be conducted by the consumer? ☐ Yes ☐ No

I have received the Personal Assistant guide to the Consumer Directed Personal Assistance Program: ☐ Yes ☐ No

_____ _____

Signature **Date**

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

► **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
► **Give Form W-4 to your employer.**
► **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2021

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		► **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ► $ _____

Multiply the number of other dependents by $500 . . . . ► $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

► _____ **Employee's signature** (This form is not valid unless you sign it.)

► _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

NEW YORK STATE OF OPPORTUNITY.

Notice and Acknowledgement of Pay Rate and Payday Under Section 195.1 of the New York State Labor Law

Notice for Hourly Rate Employees

1. Employer Information

Name:

Doing Business As (DBA) Name(s):

FEIN (optional):

Physical Address:

Mailing Address:

Phone:

2. Notice given:

☐ At hiring

☐ Before a change in pay rate(s), allowances claimed or payday

3. Employee's rate of pay:

$ _____ per hour

4. Allowances taken:

☐ None

☐ Tips _____ per hour

☐ Meals _____ per meal

☐ Lodging _____

☐ Other _____

5. Regular payday: _____

6. Pay is:

☐ Weekly

☐ Bi-weekly

☐ Other

7. Overtime Pay Rate:

$ _____ per hour (This must be at least 1½ times the worker's regular rate with few exceptions.)

8. Employee Acknowledgement:

On this day I have been notified of my pay rate, overtime rate (if eligible), allowances, and designated pay day on the date given below. I told my employer what my primary language is.

Check one:

☐ I have been given this pay notice in English because it is my primary language.

☐ My primary language is _____. I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

_____

Print Employee Name

_____

Employee Signature

_____

Date

_____

Preparer's Name and Title

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

Please note: It is unlawful for an employee to be paid less than an employee of the opposite sex for equal work. Employers also may not prohibit employees from discussing wages with their co-workers.

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

SeniorCare
Home Health Agency, Inc.

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

PERSONAL ASSISTANT ATTESTATION TO COMPLY WITH CDPAP REGULATIONS

Personal Assistant Name: _____ **SS#** _____-_____

Name of Consumer: _____

1. I understand that it is against the New York State CDPAP regulations to work as a Personal Assistant if I am a spouse, or the consumer or the parent of a consumer 21 years of age or older who is legally responsible for the care and support of the consumer.

2. I am at least 18 years old.

3. I agree to complete a pre-employment physical before I begin work, then annually.

4. I am not the Designated Representative of the Consumer enrolled in the Family Home Health Care.

5. I am not an employee of SeniorCare HHA, Inc. or affiliated individual.

6. I understand that the consumer, or if applicable, the designated representative is responsible to notify SeniorCare HHA, Inc. if my relationship with the Consumer changes and if I reside with the Consumer.

a. Do you reside in the home of the Consumer? Yes ☐ No ☐

b. Are you related to the Consumer by blood, marriage, or adoption? Yes ☐ No ☐

If yes, identify what your relationship is: _____

7. I understand that I may only work while the consumer is home. Services may not be provided while the consumer is in the hospital, in nursing homes, or rehab facilities.

I have read all the above statements, and will comply with these requirements. I also understand that failure to abide by the rules stated above could be considered Medicaid Fraud and could subject me to investigation and possible criminal prosecution by the Office of the Attorney General Medicaid Fraud Control unit, and the Medicaid Inspector General.

Name of Consumer	**Signature of Consumer**	**Date**
Designated Representative *(if applicable)*	**Signature of Designated Representative**	**Date**
Personal Assistant Name	**Signature of Personal Assistant**	**Date**

SeniorCare
Home Health Agency, Inc.

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

THE PERSONAL ASSISTANTS GUIDE TO THE CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

Personal Assistant Name: _____ **SS#** _____-_____

Name of Consumer: _____

I have received, read, and understand my role and responsibilities as Personal Assistant working for a Consumer or his/her Designated Representative participating in the Consumer Directed Personal Assistance Program. I have had an opportunity to ask questions concerning my wage and bene fit package. I understand that SeniorCare HHA, Inc. is the chosen Fiscal Intermediary and is responsible for processing on behalf of the Consumer the payroll and benefit administration.

I understand that I am hired, trained, supervised and receive my schedule by the Consumer and/or their Designated Representative. I also understand it is the Consumer or Designated Representative who can terminate my services or dismiss me from working for them if they choose to do so.

Name of Consumer	**Signature of Consumer**	**Date**
Designated Representative *(if applicable)*	**Signature of Designated Representative**	**Date**
Personal Assistant Name	**Signature of Personal Assistant**	**Date**

SeniorCare
Home Health Agency, Inc.

CORPORATE COMPLIANCE EDUCATION ACKNOWLEDGEMENT FORM

This is to certify that I, _____
(print employee name)

have received Corporate Compliance Training and Educational Materials from my Consumer enrolled in the SeniorCare HHA, Inc. CDPAP pertaining to the Federal False Claims Act, New York False Claims Act, Whistle-blower Protection and Identifying Fraud and Abuse Law, as well as where to report these issues should they be suspected or uncovered.

_____
Print Name

_____ _____
Signature **Date**

SeniorCare
Home Health Agency, Inc.

HIPPA ACKNOWLEDGEMENT

I have been informed regarding HIPAA Privacy Rules by as provided to me by SeniorCare HHA, Inc. CDPAP and I acknowledge compliance with these rules as per N.Y.S. mandate.

I understand that the major goal of the privacy rule is to assure that all of our consumers health information is properly protected, while allowing the flow of vital healthcare/clinical information to all employees participating in providing patient care/services. As such, we can provide and promote high quality, safe and effective home health care.

SeniorCare HHA, Inc. CDPAP also protects the public's health and their well-being by implementing disciplinary action upon notifications on any HIPAA violations by our employees.

_____

Print Name

_____ _____

Signature **Date**

SeniorCare
Home Health Agency, Inc.

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

HEPATITIS B VACCINE DECLARATION
&
ACKNOWLEDGEMENT OF UNIVERSAL PRECATION

I certify that I have received training from the Consumer, of if applicable, the Designated Representative regarding Hepatitis-B virus and the Hepatitis-B Vaccine, and the use of Universal Precautions.

I have also been informed about the procedure to follow should a work-related accident occur that may have exposed me to the Hepatitis-B virus. I have also been informed that the Hepatitis-B vaccine is available to meat no cost if I choose to receive it.

Decline Hepatitis-B Vaccination ☐

I decline Hepatitis-B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis-B, a serious disease. If in the future, if I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis-B vaccine, I can receive the vaccination series at no charge to me.

I am aware of the risks of not being given the Hepatitis-B vaccine, but choose not to be given the vaccination at this time.

Accept Hepatitis-B Vaccination ☐

I wish to receive the Hepatitis-B Vaccine at no cost to me. I understand the information and training provided to me by the Consumer regarding Hepatitis-B virus and the benefits for receiving the Hepatitis-B vaccine. I will contact the Family Home Health Care enrollment representative to complete the necessary arrangement s to receive the vaccination which will consist of a series of 3 shots. I understand failure to complete the series of shots will may require me to receive the series of shots again or receive an additional shot.

Name of Consumer	**Signature of Consumer**	**Date**
Designated Representative *(if applicable)*	**Signature of Designated Representative**	**Date**
Personal Assistant Name	**Signature of Personal Assistant**	**Date**

SeniorCare
Home Health Agency, Inc.

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

CONSUMER DECLARATION REGARDING HEPATITIS-B VACCINATION

I understand that as a participant enrolled in the Consumer Directed Personal Assistance Program, I am responsible for the training of my Personal Assistant. Included in my training is a discussion regarding the Hepatitis-B virus, the Hepatitis-B vaccine, and the use of Universal Precautions.

Use of Personal Protective Equipment

1. I understand the use of Personal Protective Equipment such as gloves, gowns, or face masks may be necessary while providing care. I understand that these items must be provided by me to maintain Universal Precautions for my Personal Assistant, and provided at NO cost to the Personal Assistant. These items may be provided by me with or without the assistance of the Medicaid funded program.

2. I have informed my Personal Assistant and he/she understands that due to his/her occupational exposure to blood or other potentially infectious materials, they may be at risk of acquiring Hepatitis-B virus (HBV) infection. The Personal Assistant has been given the opportunity to be vaccinated with the Hepatitis-B vaccine at no charge to them, if they choose to receive the vaccine.

3. If a work-related accident occurs, which may have ca used my Persona l Assistant an exposure to Hepatitis-B virus, I agree to instruct the Personal Assistant to contact their Physician or visit the local hospital Emergency Room immediately for treatment. I will also immediately notify Senior care HHA, Inc., who then may report this occurrence to the authorizing. Managed Long-Term Care Plan.

Name of Consumer	**Signature of Consumer**	**Date**
Designated Representative *(if applicable)*	**Signature of Designated Representative**	**Date**
Personal Assistant Name	**Signature of Personal Assistant**	**Date**

SeniorCare
Home Health Agency, Inc.

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

DECLINATION OF INFLUENZA VACCINATION FOR THE CONSUMER DIRECTED PERSONAL ASSISTANCE

Personal Assistant Name: _____ **SS#** _____-_____

Name of Consumer: _____

I have been advised by the consumer, or if applicable, the designated representative that I should receive the influenza vaccine to protect myself and the client I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a health-care provider. I am aware of the following facts:

♦ Influenza is a serious respiratory disease that kills thousands in the United States each year.

♦ Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications, and death.

♦ If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.

♦ If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.

♦ I understand that I cannot get influenza from the influenza vaccine.

♦ I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.

♦ The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.

♦ Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in areas where patients or residents may be present during the influenza season. I acknowledge that I have read this document in its entirety and fully understand it.

Despite these facts, I have decided to decline the influenza vaccine by my signature below. I realize that I may readdress this issue at any time and accept vaccination in the future.

Name of Consumer	**Signature of Consumer**	**Date**
Designated Representative *(if applicable)*	**Signature of Designated Representative**	**Date**
Personal Assistant Name	**Signature of Personal Assistant**	**Date**

SeniorCare
Home Health Agency, Inc.

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

ELECTRONIC VISIT VERIFICATION TRAINING

Personal Assistant Name ________________________________ **SS#**__________________

Name of Consumer: _

I have received, read, and understand that effective 01/01/2021 the Department of Health requires electronic proof of hours worked for payment. Timesheets will not be accepted anymore. Personal Assistants / Aides have an opportunity to clock in and out from the patient's or caregiver's phone (instructions are included).

I have also been instructed that Senior Care cannot issue payment without an electronic verification. The agency must receive the proof of hours worked for payment. Timesheets may only be used only if the Personal Assistant was unable to call in/out AND reported the issue to the agency immediately. If the Personal Assistant performs the call in / call out but it does not go through, Senior Care will contact the Personal Assistant to notify them of the issue and seek a resolution.

I received training on how to use the Electronic Verification System and was given the opportunity to ask all my questions to the Human Resources Clerk.

____________________	____________________	________
Name of Consumer	**Signature of Consumer**	**Date**
____________________	____________________	________
Designated Representative ***(if applicable)***	**Signature of Designated Representative**	**Date**
____________________	____________________	________
Personal Assistant Name	**Signature of Personal Assistant**	**Date**

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

What Caregivers Should Know About:

Electronic Visit Verification (EVV)

The main things you should know:

EVV data is required for all personal care or consumer directed personal assistance services that you provide in a Medicaid beneficiary's home.

EVV does not change the care you provide.

- The **services** you provide do not change.
- The **amount of care** you provide does not change.
- The **location** where you provide services does not change.

What is EVV?

VV is a way to use technology to ensure Medicaid beneficiaries et the services they are approved to receive in their home. As a aregiver providing services in a Medicaid beneficiary's home, ou will use EVV during each visit to report the following:

- the date of the visit
- the times when the visit starts and ends
- the type of service given during the visit
- your name, as the caregiver providing the services
- the name of the Medicaid beneficiary receiving the services
- the location of the visit

nly you can complete EVV. Medicaid beneficiaries should not omplete EVV during a visit.

How do I use EVV?

our provider agency or fiscal intermediary chooses how ou report information. Their method could be:

- a mobile app on a smart phone or tablet
- a fixed object (called a fob) placed in the Medicaid beneficiary's home
- a telephone (usually a landline) if the Medicaid beneficiary allows you to use their telephone

How do I get trained on an EVV system?

Your provider agency or fiscal intermediary will train you on how to use their EVV system, how to collect EVV data in different situations, and how to send your EVV data to their EVV system.

Your provider agency or fiscal intermediary will also help you if you experience technical issues, including problems with the EVV system and with the device you use to capture EVV data.

Do I have to use an EVV system?

Yes, EVV data collection is required from caregivers that provide personal care or consumer directed personal assistance services in a Medicaid beneficiary's home.

Your provider agency or fiscal intermediary must ensure that EVV data is captured in a compliant manner. Your provider agency or fiscal intermediary will tell you how to capture EVV data in the event your device is unable to be used during a visit.

Who can I talk with if I have questions or concerns?

If you have questions or concerns about EVV or how you should collect or report information, please contact your provider agency or fiscal intermediary.

Where can I learn more?

If you would like to learn more about EVV, please visit: https://www.health.ny.gov/health_care/medicaid/redesign/evv/index.htm .

If you have general questions about New York State's EVV rules, you can send them to: EVVHelp@health.ny.gov .

xx/xx/20xx

Caregiver Mobile App

Downloading the App

The HHAeXchange Mobile App is available for download through the App Store or Google Play. The App is available for both iPhone and Android devices. To locate and download the App, enter the keyword **HHA Exchange** in the search bar of the App Store or Google Play (illustrated in the image).

Carégivers are responsible for downloading and installing the application on their personal mobile device. Once registered, Caregivers must provide credentials as well as ID numbers to the Agency for further setup and linking to the HHAX system.

HHAeXchange Mobile App

Signing Up and Registering

Creating an account for the Mobile App is a two-step process, as follows:

1. **Sign up** by creating login credentials.
2. **Register** by entering additional demographic information.

Sign Up

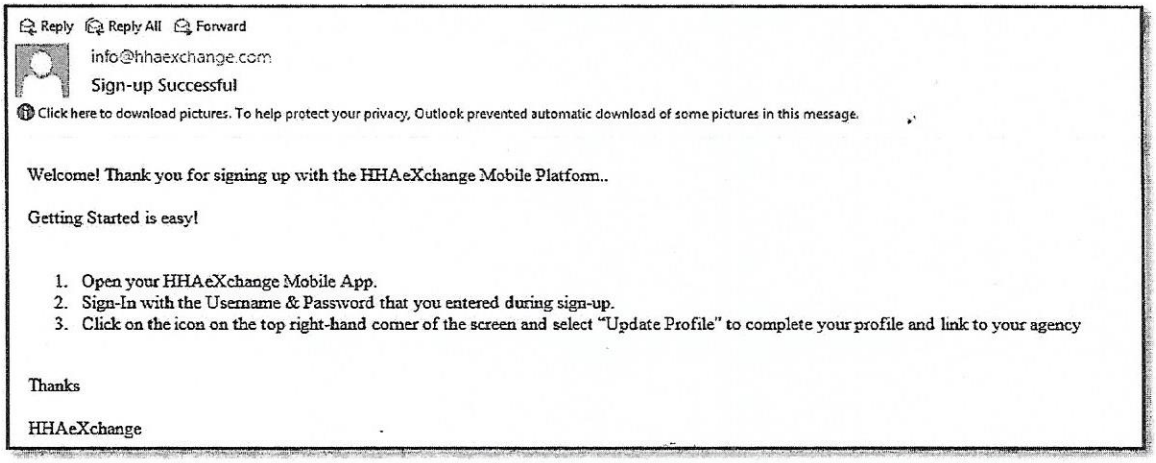
Once the App has downloaded, press **Sign Up** on the bottom left of the main screen. The App prompts for the following:

- An **Email Address**
- A **Password** (minimum of 8 letters, 1 capital, and 1 numeric value)

Once credentials are completed and confirmed, select **Sign Up** to log in to the App.

Sign Up Screen

Upon successfully creating an account, the system issues a verification email:



Reply Reply All Forward

info@hhaexchange.com

Sign-up Successful

Click here to download pictures. To help protect your privacy, Outlook prevented automatic download of some pictures in this message.

Welcome! Thank you for signing up with the HHAeXchange Mobile Platform..

Getting Started is easy!

1. Open your HHAeXchange Mobile App.
2. Sign-In with the Username & Password that you entered during sign-up.
3. Click on the icon on the top right-hand corner of the screen and select "Update Profile" to complete your profile and link to your agency

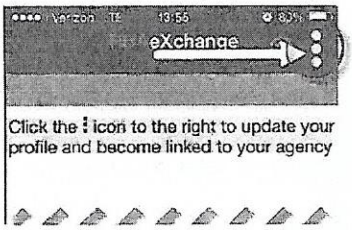
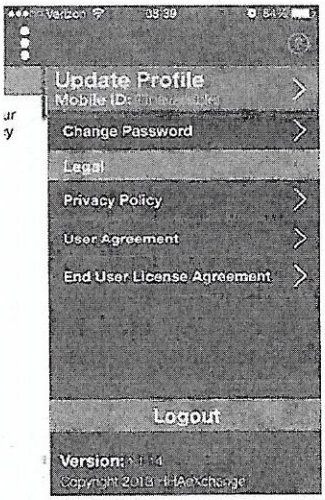
Thanks

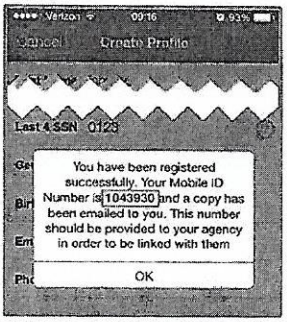
HHAeXchange

Successful Sign Up Email

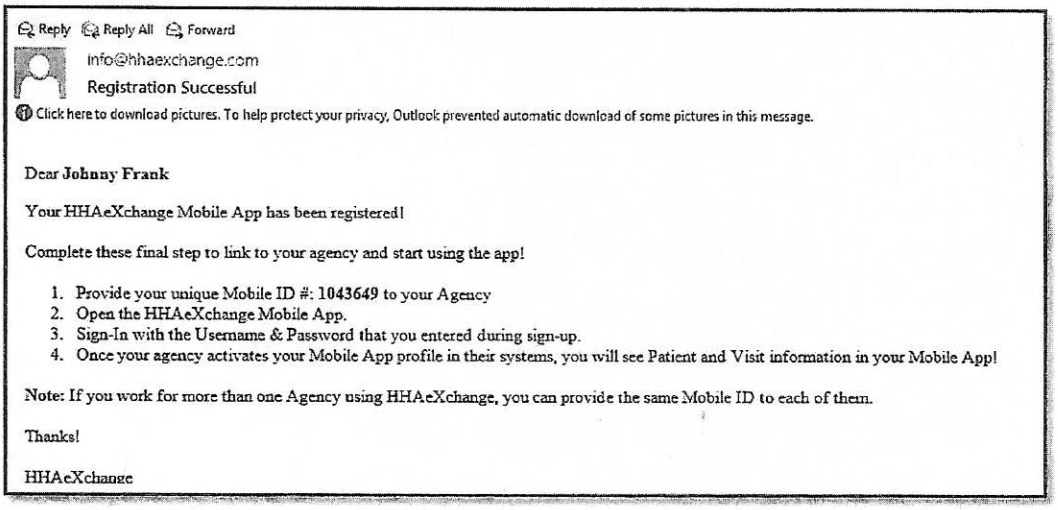
Register

Follow the steps outlined below to register on the HHAX Mobile App.

Step	Action
1	Log in to the App upon receiving the verification email.
2	Review the *Terms of User Agreement* and select the ***Agree*** button.
3	The Main Screen opens. Click the ***three-dot icon*** (on the top-right corner) as prompted by the message. Select the **Update Profile** option.  

Step	Action
4	Complete all the fields on the **Create Profile** page. Click the ***Create*** button to create the Profile. ***Note:*** *Values must match the information on record in HHAX. The Mobile App does not link correctly if any of these values do not match.* 
5	If all the information is entered correctly, a message appears containing the **Mobile ID**. 

The HHAX system sends a second email after successful registration. This message contains the **Mobile ID** as well as instructions on how to log in and use the Mobile App:



Reply Reply All Forward

info@hhaexchange.com

Registration Successful

Click here to download pictures. To help protect your privacy, Outlook prevented automatic download of some pictures in this message.

Dear **Johnny Frank**

Your HHAeXchange Mobile App has been registered!

Complete these final step to link to your agency and start using the app!

1. Provide your unique Mobile ID #: **1043649** to your Agency
2. Open the HHAeXchange Mobile App.
3. Sign-In with the Username & Password that you entered during sign-up.
4. Once your agency activates your Mobile App profile in their systems, you will see Patient and Visit information in your Mobile App!

Note: If you work for more than one Agency using HHAeXchange, you can provide the same Mobile ID to each of them.

Thanks!

HHAeXchange

Successful Registration Email

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

New York State Electronic Visit Verification (EVV) Medicaid Program Overview and Next Steps

WHAT IS ELECTRONIC VISIT VERIFICATION (EVV)?

Electronic Visit Verification, or EVV, is an electronic system that verifies when provider visits occur and captures the date and time of the visit, the location of the visit, the person who received the services, the person who provided the services, and the services provided. In most cases, a signature or voice verification from the individual receiving the services can also be captured.
The 21st Century Cures Act (the Cures Act) was signed into law on December 13, 2016, mandating that states implement Electronic Visit Verification (EVV) for all Medicaid-funded personal care services (PCS) and home health care services (HHCS) that require an in-home visit by a provider.

The following are the compliance deadlines established by the Cures Act:

- Personal Care Services – 1/1/2021*
- Home Health Care Services – 1/1/2023

*NYS received a Good Faith Effort Extension, extending the deadline from 2020 to 2021 for Personal Care Services.

Failure to meet these deadlines will result in decreased federal funding to the State Medicaid program from Centers for Medicare and Medicaid Services (CMS).

The goals of EVV are to ensure timely service delivery for members, including real-time service gap reporting and monitoring, reduce the administrative burden associated with paper timesheet processing and generate cost savings from the prevention of fraud, waste, and abuse. It aims to strengthen quality assurance by improving the health and welfare of individuals through validation of delivery of services.

The Cures Act requires that EVV systems capture the following six data points:

- Service type
- Individual receiving the service
- Date of service
- Location of service delivery
- Individual providing the services
- Begin and end times of service

WHO IS SUBJECT TO EVV?

The Cures Act requires that any Medicaid-funded personal care services (PCS) and home health care services (HHCS) that begin or end in the home be subject to EVV. Any provider billing Medicaid for personal care services that begin or end in the home for the following services, is subject to EVV:

- 1905(a)(24) State Plan Personal Care Benefit
  - Consumer Directed Personal Assistance (CDPA)
  - Personal Care Assistance (PCA I & II)

HEALTH STATUS UPDATE – RISK ASSESSMENT CHECKLIST CHANGES

Name:_____Birthplace:_____Home Phone:_____
Address:_____
Number,Street City/Town State ZIP

In order for you to remain in compliance, the state requires that you update your health information every year

PLEASE CIRCLE THE APPROPRIATE ANSWERS TO EACH QUESTION BELOW
SINCE YOUR LAST HEALTH REPORT HAVE YOU:

1. Bad any injury surgery……**yes no**
2. Suffered from depression……**yes no**
3. Become dependent upon alcohol or drugs……**yes no**
4. Been exposed to a communicable disease……**yes no**
5. Current or planned immunosuppression including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist, chronic steroids, or other immunosuppressive medication……**yes no**
6. Had close contact with someone who has TB…….....**yes no**
6. Experience impairment of sight, hearing or speech…….....**yes no**
7. Taken prescription medications for a chronic condition……..**yes no**
8. Been examined by a physician for a routine check-up…….....**yes no**
   If **"yes"** date: __/__/_____
9. TB or LTBI History and Treatment……..
   If "yes" please show documentation/results of prior TB, either a TST or IGRA blood test (if available)
10. Tuberculosis Control/Symptom Review:
    Do you have symptoms of :
    - Fever……**yes no**
    - Chills or Drenching Night sweats for no known reason……...**yes no**
    - Unexplained weight loss……...**yes no**
    - Unexplained fatigue for more than 3 weeks……**yes no**
    - Persistent shortness of breath……**yes no**
    - Coughing up blood……**yes no**
    - Productive cough for more than 3 weeks……..**yes no**
    - Chest pain……..**yes no**

If you answered **YES** to any question #1 through #10, please explain below:

_____

_____

To the best of my knowledge, I have answered all of the questions above honestly and accurately

DATE:__/__/____ SIGNATURE:_____

FOR OFFICE USE ONLY:

TO BE COMPLETED BY THE REGISTERED NURSE

QUESTIONS	COMMENTS
1. Have you had any pain, discomfort or symptoms on a continuing basis for which you have not been treated by a physician?	
2. Have you had any condition, which has prevented you from performing your duties?	

☐ This person's responses indicate that his/her condition is essentially unchanged since the last physical report.

☐ This person's responses indicate the need for a follow-up report by a physician.

DATE: ___ /___/ _____ RN SIGNATURE: _____