LIVE-IN CAREGIVER ATTESTATION

Oakland Community Health Network

Live-in caregivers employed by beneficiaries or agency providers are exempt from using Electronic Visit Verification (EVV). Exemptions must be approved by OCHN, the Approving Entity.
The following criteria must be met for the caregiver to qualify for the EVV live-in caregiver exemption:

- The caregiver must live in the same home as the beneficiary; and
- The home must be the caregiver's permanent and primary residence.

Live-in caregivers who do not meet the above criteria must use EVV to document personal care services.

INSTRUCTIONS

1. Use **two** of the following proofs of residency to verify the caregiver and beneficiary live at the same permanent, primary residence. Documents must include the live-in caregiver's name and current home address. Electronic copies are acceptable.

   - Valid Michigan driver's license
   - Valid Michigan state identification
   - Utility bill or credit card bill issued within the last 90 days
   - Account statement from a bank or other financial institution issued within the last 90 days
   - Mortgage, lease or rental agreement (Lease and rental agreements must include the landlord's telephone number)
   - Pay stub or earnings statement issued within the last 90 days
   - Life, health, auto or home insurance policy
   - Michigan title and registration
   - Federal, state or local government documents, such as receipts, licenses or assessments

2. Complete this form using the following instructions.

   SECTION 1: Fill in the caregiver's first and last name, and home address. The address must be the caregiver's current, primary and permanent address.

   SECTION 2: Fill in the beneficiary's first and last name, Medicaid ID number and home address. The address must the beneficiary's current, primary and permanent address.

   SECTION 3: The caregiver must provide a handwritten signature and the date of signature. The OCHN representative must review the form and attached documentation, sign and date the attestation form and check "Approved" or "Denied" with a reason for denial, if applicable.

HOW TO SUBMIT THIS FORM: Complete this form and submit it along with the documents to OCHN Customer Services. This form can be submitted in person or all documents can be scanned and uploaded and emailed to CustomerService@Oaklandchn.org. Contact your beneficiary's supports/care coordinator, or case manager, or OCHN Customer Services for assistance turning this form in.

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SECTION 1 – PRINT CAREGIVER INFORMATION

Purpose of Attestation (Check One): ☐ Initial Request ☐ Address Change ☐ Annual Renewal			
First Name	Last Name	Phone Number	
Street Address	City	State	Zip Code

SECTION 2 – PRINT BENEFICIARY INFORMATION

First Name	Last Name	Medicaid ID #	
Street Address	City	State	Zip Code

SECTION 3 – ATTESTATION

I attest that I live with and provide personal care services to the beneficiary named above. I have provided the required proofs of address and agree to provide updated attestation every year or upon request to maintain live-in caregiver status and be exempt from Electronic Visit Verification (EVV) requirements. I also agree to notify OCHN, the approving entity, fiscal intermediary within 10 calendar days if my living arrangement changes and I no longer live with the beneficiary named above. I understand that failure to provide necessary updated documentation will result in me being required to use EVV.

Live-In Caregiver Signature	Date Signed

FOR OCHN USE ONLY

I attest that the caregiver documented above provided at least two proofs of residency listed on the instructions page of this form. Based on my review of the documents provided, the caregiver is:

☐ Approved for the EVV live-in caregiver exemption.

☐ Denied Reason for Denial:

Name of Organization/Program of Approving Entity	
OCHN Staff Printed Name	
OCHN Staff Signature	Date

OCHN and The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

AUTHORITY: Title XIX of the Social Security Act and Administrative Rule 400.1104(a)
COMPLETION: Is voluntary but is required if Medical Assistance program payment is desired.