Electronic Visit Verification (EVV)

HHAeXchange FOB Device Request Form

Service Recipient Information	
Name:	**Date of Request:**
Address:	**Provider Agency:**
Telephone:	**Provider Agency Phone:**
Medicaid ID#:	**Provider Agency E-mail:**
Program:	**Provider Agency Tax ID:**

Please choose all that apply: (A minimum of two conditions must be met in order to approve)

☐ **Staff member is unable to utilize the HHAeXchange App**

☐ **Service Recipients home does not have a landline**

☐ **Family refuses to allow staff to use landline**

Please list staff member(s) who do not have mobile device and will be using FOB device for member:

Shipping & Installation Information

FOB Shipping address:

Name of person responsible for the receipt and installation of the FOB:

Responsible party's Telephone and E-mail:

****For WV DHHR Use Only****

Reviewer Name:

Email:

Approval Status: ☐ **Approved** ☐ **Denied** **Date of Determination:**

FOB Device#: **Seal ID #:**

FOB Deactivation Date: **FOB Return Date:**