DEPARTMENT OF HUMAN SERVICES

DHS-4469-ENG 11-21

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Individual Personal Care Assistant (PCA) Enrollment Application

Complete all fields to enroll an individual personal care assistant or complete your request using the Minnesota Provider Screening and Enrollment (MPSE) portal. If submitting by fax, complete this form online, print and then fax to Minnesota Health Care Programs (MHCP). An incomplete form will delay processing of this application. Check one of the following:

◯ New hire (requires new background study and completion of PCA training)

◯ Rehire (requires new background study and completion of PCA training) – PREVIOUS EMPLOYMENT END DATE: _____

◯ Previous background study conducted for managed care organizations (MCO) (new background study not required)

Individual PCA Information

PROVIDER TYPE **38 - INDIVIDUAL**	**SOCIAL SECURITY NUMBER**	**UMPI** (if requesting reinstatement)
LEGAL NAME (FIRST)	**FULL MIDDLE NAME**	**LAST NAME**
DATE OF BIRTH	**Is the person 18 years old or older?** ◯ Yes ◯ No* *May affiliate with only one agency	PHONE NUMBER
Has this person continued to be employed by your agency or MCO without a break in employment? ◯ Yes ◯ No		

Individual PCA Address

ADDRESS (RESIDENTIAL ADDRESS ONLY – DO NOT ENTER A P.O. BOX)			
CITY	**STATE**	**ZIP CODE**	COUNTY OF RESIDENCE

Individual PCA Training Information

INDIVIDUAL PCA TRAINING COMPLETION DATE	INDIVIDUAL PCA TRAINING CERTIFICATION NUMBER

Individual PCA Background Study Information

BACKGROUND STUDY NUMBER	APPLICATION NUMBER	FACILITY ID

Individual PCA Provider Statement

I have reviewed and certify the information provided on this form is true and correct to the best of my knowledge. **I will notify the MHCP Provider Eligibility and Compliance of any additions or changes to the information.**

By signing this form, I acknowledge I have read and understand the Data Privacy Notice (DHS-6287) (PDF). I also authorize MCHP to use the information you collect about me according to the Privacy Notice.

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

NAME OF INDIVIDUAL PCA (print or type)	**SIGNATURE OF INDIVIDUAL PCA**	**DATE SIGNED**

Organization Affiliation Information

You may affiliate or enroll the individual PCA named on this form if he or she is 18 years old or older with other agencies you directly own without completing another application and agreement. Do you want to affiliate this individual PCA with any other agencies you own? ◯ Yes ◯ No

Organization Information

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

ORGANIZATION OR AGENCY NAME		FACILITY NPI OR UMPI
ORGANIZATION FAX NUMBER	ORGANIZATION PERSONNEL COMPLETING FORM	ORGANIZATION PERSONNEL SIGNATURE

Next Steps

Read, sign and date the Individual Support Worker (CDCS, CSG, PCA, CFSS) Provider Agreement (DHS-4611) (PDF) and return it with this application.

Upload the application and agreement to the Minnesota Provider Screening and Enrollment (MPSE) portal or fax to 651-431-7465. MHCP will process only complete requests.