MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Personal Care Assistance (PCA) Program Responsible Party Agreement and Plan

Personal care assistance (PCA) agencies must have each responsible party or their delegate complete the following agreement annually to ensure they are aware of their roles and responsibilities. You must keep a copy of the completed agreement in the member's file and provide a copy to the member and his or her responsible party or delegate.

Completed by Responsible Party

RESPONSIBLE PARTY LAST NAME	FIRST NAME	MI	RELATIONSHIP TO MEMBER
MEMBER LAST NAME	FIRST NAME	MI	MEMBER MHCP ID NUMBER

I agree to be the responsible party for the named member for the following time period: (MM/DD/YYYY)

to (MM/DD/YYYY) and agree to (initial each; electronic initials accepted):

_____ Attend assessments for PCA services for the member to help the member make informed choices

_____ Determine if the member's health and safety are assured with the current PCA services

_____ Help develop the PCA care plan with the qualified professional

_____ Actively participate in planning and direction of PCA services

_____ Sign the PCA time sheets after services are provided to verify the services

_____ Monitor the PCA weekly to ensure the care plan is followed and the care outcomes are met as described here.

_____ Be accessible to the member and PCA when services are provided as described here.

RESPONSIBLE PARTY PLAN TO MEET THE IDENTIFIED REQUIREMENTS (Be specific - attach additional pages as needed)

Acknowledgement and Signature (check each box)

- ☐ I am at least 18 years of age
- ☐ I am not the owner or manager of the PCA provider agency
- ☐ I am not a personal care assistant for this member
- ☐ I am not the qualified professional for this member
- ☐ I am not a staff member of the PCA provider agency or I am related to this member by blood, marriage or adoption

I understand that I am responsible for and have agreed to all of the duties outlined on this form.

Completed and Signed by Responsible Party

RESPONSIBLE PARTY SIGNATURE		DATE		PHONE NUMBER
STREET ADDRESS	CITY		STATE	ZIP CODE

The PCA agency is required to make a referral to the Minnesota Adult Abuse Reporting Center (MAARC) for any failure to provide the support as required by the member.

Completed by Agency

AGENCY CONTACT NAME	TITLE	
AGENCY NAME		DATE