Minnesota Department of **Human Services**

DHS-4469-ENG 8-10

Minnesota Health Care Programs

Individual PCA Enrollment Application

Please complete this form online, print and then fax to MHCP. Complete at least all **bolded** fields to enroll an individual PCA. We will return incomplete forms to you.

☐ New hire

☐ Rehire

☐ Previously used for Managed Care Organization claims only

Individual PCA Information

PROVIDER TYPE **38 – INDIVIDUAL**	**LEGAL NAME (FIRST)**	**MIDDLE**	**LAST**	**SOCIAL SECURITY NUMBER**
ADDRESS (RESIDENTIAL ADDRESS ONLY – DO NOT ENTER A PO BOX)		PHONE NUMBER ( )		**NPI/UMPI** (IF REQUESTING REINSTATEMENT)
CITY	**STATE**	**ZIP CODE**	COUNTY OF RESIDENCE	**DATE OF BIRTH** __ __/__ __/__ __ __ __
DATE DHS TRAINING COMPLETED __ __/__ __/__ __ __ __	TRAINING CERTIFICATION NUMBER	**IS THE INDIVIDUAL 18 YEARS OR OLDER?** ☐ YES ☐ NO* *May affiliate with only one agency		
Has this individual maintained continuous employment with your agency since this BGS was completed? ☐ YES ☐ NO EMPLOYMENT END DATE: __ __/__ __/__ __ __ __				**BGS NUMBER/REQUEST ID**

Individual PCA Provider Statement

I have reviewed and certify the information provided above is true and correct to the best of my knowledge. **I will notify the Minnesota Department of Human Services Provider Enrollment of any additions and/or changes to the information.**

By signing this form, I acknowledge I have read and understand the Application and Background Study Privacy Notice. I also authorize the Minnesota Department of Human Services to use the information collected in accordance with the Privacy Notice.

NAME OF PCA (PLEASE PRINT OR TYPE)	**SIGNATURE OF PCA**	**DATE SIGNED** __ __/__ __/__ __ __ __

Group Affiliation Information

You have the option to affiliate/enroll the individual PCA named above, if 18 years or older, with other agencies you own without completing another application and agreement. Do you want to affiliate the above named individual PCA with any other agency(ies) you own? ☐ YES ☐ NO (If yes, enter information below.)

ORGANIZATION/AGENCY NAME	AGENCY NPI/UMPI	STUDY ID

Agency Information

AGENCY NAME		**AGENCY NPI/UMPI**
AGENCY FAX NUMBER ( )	**AGENCY PERSONNEL COMPLETING FORM**	**AGENCY SIGNATURE**

Next Steps

Read, sign and date the Minnesota Health Care Programs Provider Agreement Individual Personal Care Assistant form (DHS-4611), and return it with this application.

Fax both the application and agreement to (651) 431-7462.
Only faxed requests will be processed