Clear Form

Minnesota Department of **Human Services**

DHS-5716-ENG 5-13

Minnesota Health Care Programs (MHCP)

Individual PCA Information Change Form

Complete at least all **bolded** fields to update an individual PCA record. We will return incomplete forms to you. Type or print clearly. Fax completed form to 651-431-7462. NOTE: PCA affiliation with an additional agency requires completion and submission of Individual PCA Enrollment Application (DHS-4469) and Individual PCA Provider Agreement (DHS-4611).

PCA Agency Information

AGENCY NAME		**AGENCY NPI/UMPI**
END AFFILIATION (Agency Signature Required) LAST DATE WORKED: __ __/__ __/__ __ __ __	FIRST DATE NO LONGER EMPLOYED: __ __/__ __/__ __ __ __	COMPLETION OF PCA TRAINING (Agency or PCA signature required) DATE PASSED __ __/__ __/__ __ __ __
AGENCY FAX NUMBER - -	**AGENCY PERSONNEL COMPLETING FORM**	AUTHORIZED AGENCY SIGNATURE

CERTIFICATION NUMBER _____

☐ Change PCA Name – A name change request must be accompanied by court documentation, marriage license or divorce decree, current updated driver's license or social security number, etc. (Agency or PCA signature required)

☐ Change PCA Address (Agency or PCA signature required)

☐ Term PCA (PCA signature not required) – Receiving PCA services currently
EFFECTIVE DATE __ __/__ __/__ __ __ __

☐ Term PCA (PCA signature not required) – PCA is on the Office of Inspector General OIG Exclusions list
EFFECTIVE DATE __ __/__ __/__ __ __ __

Individual PCA Information

PREVIOUS NAME (if applicable)	**CURRENT LEGAL NAME (FIRST)**	**FULL MIDDLE**	**LAST**
ADDRESS (RESIDENTIAL ADDRESS ONLY - DO NOT ENTER A PO BOX)			**NPI/UMPI**
CITY		**STATE**	**ZIP CODE**
COUNTY OF RESIDENCE		**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH** __ __/__ __/__ __ __ __

Group Disaffiliation Information

You may disaffiliate the above-named PCA with other agencies you own.

Organization/Agency Name	Agency NPI/UMPI	Study 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.**

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