

Background Study & PCA ID # Enrollment Instructions

As your PCA Choice Agency, we are required by the Minnesota Department of Human Services (DHS) to **process a Criminal Background Study on ALL PCA's BEFORE THEY WORK ANY HOURS.** This is a state law we strictly adhere to, with no exceptions. Even if the PCA has already had a Background Study done recently with another provider, we still MUST process a new Background Study before they work for us. Also, if a PCA has a gap in active employment with us, we must submit a new Background Study before being re-instated as an active PCA. *Typically a Background Study takes 3-5 business days to be completed, it can take longer for non-residents of MN. We do not guarantee completion timelines of any Background Study.*

DHS and Minnesota Health Care Programs (MHCP) require that all PCAs enroll with MHCP to receive an Individual PCA Provider ID (UMPI) Number. This requirement means that any PCA provider/agency you work for must list your Individual PCA Provider ID (UMPI) Number when billing MHCP for the PCA services you provide to your client(s).

New and existing PCAs are required to complete these forms to be an eligible PCA for any provider/agency. The necessary forms are included. If the PCA works for any other PCA agencies, there is space on the forms where they must be listed. Consumers are asked to guide their PCAs to follow the steps below and submit the completed forms. **Before completing these forms please review the "PCA Application and Background Study Privacy Notice"**

- 1. Complete & Sign the 1-page "Background Study Release Form"**
- 2. Complete & Sign the 1-page "MHCP Individual PCA Enrollment Application" (DHS-4469)**
Note: Ability Care Partners will complete the last row of the Individual PCA Information section regarding the Background Study.
- 3. Review and Sign the 3-page "Minnesota Health Care Programs Provider Agreement Individual Personal Care Assistant (PCA)" (DHS-4611).**
- 4. Mail your completed forms to Ability Care Partners and we will submit them to the DHS. DO NOT SEND THESE FORMS DIRECTLY TO DHS, we need to review and sign as your agency.**
NOTE: You may fax us these forms to process them faster, but we will need the originals mailed to us immediately.

The DHS will process Individual PCA Provider ID Number applications as soon as possible (estimated 2-3 weeks). After passing the Background Study, PCAs are able to work while their Individual PCA Provider ID Number application is being processed by DHS.

Important Reminder: PCAs are not allowed to work until we have notified the Consumer and/or the PCA.

If you have any questions or concerns in completing the forms, contact us via email or telephone.

PCA Application and Background Study Privacy Notice

The Minnesota Department of Human Services (DHS) asks that you give private information about yourself. The Minnesota Government Data Practices Act (Minnesota Statutes 13.04, subd. 2) requires that we let you know the following:

Why does DHS ask for this information?

DHS has to conduct Background Studies (BGS) on all providers who provide direct contact services (Minnesota Statutes 256B.0651). BGS are done according to Minnesota Statutes chapter 245C. DHS will use the information we ask for in this application and on the BGS to:

- Review criminal conviction records that are held by the Minnesota Bureau of Criminal Apprehension (BCA)
- Review records of proven mistreatment of minors and vulnerable adults
- Prevent, detect and eliminate false claims of time card submissions or billing
- Determine if you are qualified to provide personal care services

DHS may ask you for more information, including your fingerprints, to complete your BGS. When DHS does a BGS, the correctional system, the Minnesota Department of Health (MDH), and county agencies will report to DHS any:

- New criminal convictions for disqualifying crimes
- Proven mistreatment of minors and vulnerable adults

What happens if I do not give DHS this information?

If you do not let DHS do a BGS, DHS will deny your application and your employer will not be paid for the services you provide (Minnesota Statutes 245C.09).

What happens if I give DHS this information?

If an applicant's BGS has a status of "Not Disqualified" or "Disqualified Set Aside," DHS will process the person's application.

If DHS finds out that a person is sanctioned by the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services or disqualified by the Division of Licensing, DHS will deny the person's application.

Who else can get this information?

The information you give DHS can be shared with the Minnesota BCA. If DHS believes that other agencies may have information about a disqualification, DHS can share with or get information from:

- Agencies with criminal record information systems in other states, and juvenile courts
- County agencies
- County attorneys
- County sheriffs
- Courts, including juvenile court
- Federal Bureau of Investigation
- Health-related licensing boards
- Local police
- Minnesota Department of Health
- Minnesota Department of Corrections
- Office of the Attorney General

If you have a disqualification, DHS will tell your employer or prospective employer only that you do not qualify. DHS will not tell your employer why you do not qualify, unless it is because you refused to cooperate with the BGS or because you were found to have seriously mistreated a minor or vulnerable adult.

DHS can also share information with the following:

- Minnesota Department of Employee and Economic Development
- Minnesota Department of Revenue
- U.S. Department of Health and Human Services and all other agencies named above

The information about you received in your application and as part of a BGS is classified as private data and, except for the agencies noted above, cannot be shared without your consent.

Background Study Release Form

PRIVACY NOTICE

1. Purpose and intended use of the information: Minnesota Statutes, section 144.057, requires the Department of Human Services (DHS) to conduct background studies on individuals providing direct contact services with patients and residents in hospitals; boarding care homes; outpatient surgical centers; nursing homes; licensed home care agencies; residential care homes; and board and lodging establishments that are registered to provide supportive or health supervision services. The background studies are to be completed according to the requirements in Minnesota Statutes, chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090 (Rule 11). The information requested on this form will be used to perform a background study of you that will include, but may not be limited to, a review of criminal conviction records held by the Bureau of Criminal Apprehension (BCA) and records of substantiated maltreatment of vulnerable adults and children. The Department may also later require you to submit additional information if it is determined necessary to complete your background study. For all individuals who are affiliated with a facility regulated by DHS or the Department of Health, the corrections system will report new criminal convictions for disqualifying crimes to DHS.

2. Whether you may refuse or are legally required to provide the information: Minnesota Statutes, section 144.057 and section 245A.04 require that all individuals working in positions allowing direct contact (as defined in Minnesota Statutes, section 245A.04) with persons receiving services from the programs referenced above provide sufficient information to ensure an accurate background study.

3. Known consequences that may arise from supplying the information: Individuals who are found to have histories with particular characteristics as identified in Chapter 245A and Rule 11, may be disqualified. Individuals who are not found to have disqualifying histories will not be disqualified.

4. Known consequences that will arise from refusing to supply the requested information: Only items identified as "optional" may be left blank. Refusal to provide the information necessary to ensure an accurate and complete background study will result in your disqualification.

5. Identification of other agencies or entities authorized to receive this information: The information you provide on this form will be shared with the BCA. If DHS has reasonable cause to believe that other agencies may have information pertinent to a disqualification, the information may also be shared with county attorneys, county sheriffs, courts, county agencies, local police, the FBI, criminal records information systems in other states, and juvenile courts. All background study results will be shared with the Department of Health, but may only be shared with other sources with your consent. If you are found to have a disqualifying characteristic, the facility that initiated your background study will be told only that you are disqualified and will not be told what the information was that caused your disqualification. If your facility transmits this information to DHS electronically, people who operate the electronic data communication system may have access to the information on this form. Electronic communication initiated by DHS will be limited to either that a form has been received or that an individual is not disqualified.

The following individual has applied for employment with Ability Care Partners, Inc. for a Personal Care Attendant (PCA) or Qualified Professional (QP) position.

Last Name: _____

Middle Name: _____

First Name: _____

Maiden, Alias or Former Name(s):

Date of Birth: _____ / _____ / _____

Address: _____

City: _____ State: _____

Zip Code: _____ - _____

Current County of Residence:

Counties of Residence within the past 5 years:

Sex: [] Male [] Female

MN Drivers License/ID # _____

Social Security Number: _____ - _____ - _____

By completing this form and signing below, the applicant authorizes the Minnesota Bureau of Criminal Apprehension to disclose all criminal history records/information to the Minnesota Department of Human Services and Ability Care Partners, Inc. (PCA Choice Provider) for the purpose of employment with this agency.

Applicant Signature

Date

For more information regarding the background study process (requirements, disqualifications, disclosures, appeals, etc.) please visit: <http://www.revisor.leg.state.mn.us/stats/245C/>



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.

- Checkboxes for New hire, Rehire, and Previously used for Managed Care Organization claims only.

Individual PCA Information

Form with fields for PROVIDER TYPE (38 - INDIVIDUAL), LEGAL NAME (FIRST, MIDDLE, LAST), SOCIAL SECURITY NUMBER, ADDRESS, PHONE NUMBER, NPI/UMPI, CITY, STATE, ZIP CODE, COUNTY OF RESIDENCE, DATE OF BIRTH, DATE DHS TRAINING COMPLETED, TRAINING CERTIFICATION NUMBER, IS THE INDIVIDUAL 18 YEARS OR OLDER?, Has this individual maintained continuous employment with your agency since this BGS was completed?, 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.

Form with fields for 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.)

Table with 3 columns: ORGANIZATION/AGENCY NAME, AGENCY NPI/UMPI, STUDY ID.

Agency Information

Form with fields for AGENCY NAME (ABILITY CARE PARTNERS INC.), AGENCY NPI/UMPI (1629249826), AGENCY FAX NUMBER ((612) 395-5593), 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



Minnesota Health Care Programs

Provider Agreement – Individual Personal Care Assistant (PCA)

As a participating provider in health service programs administered by the Minnesota Department of Human Services (the Department), the Provider agrees to:

- A. Submit documentation to your employer that fully discloses the extent of services provided to individuals under these programs, in accordance with Minnesota Rules, parts 9505.2160 to 9505.2245.
B. Furnish the Department, the Secretary of the U.S. Department of Health and Human Services (DHHS), or the Minnesota Medicaid Fraud Control Unit with such information as it may request regarding payments claimed for services provided under these programs.
C. Comply with all federal and state statutes and rules relating to the delivery of services to individuals and to the submission of claims for such services.
D. Accept as payment in full, amounts paid in accordance with schedules established by the Department, except where payment by the recipient has been authorized by the Department.
E. Make full disclosure of any convictions(s) of program crimes as required by 42 CFR §455.106.
F. Comply with all federal statutes, implementing regulations and guidance prohibiting discrimination on the basis of race, color, national origin, sex, age, religion and disability in any program or activity receiving federal financial assistance from DHHS; and to comply with the Minnesota Human Rights Act.
G. Render to recipients services of the same scope and quality as would be provided to the general public, within Minnesota Health Care Programs (MHCP) guidelines.
H. Comply with the provisions of any fully executed agreement and/or addendum required by the Department, which is incorporated herein by reference.
I. Comply with the advance directive requirements as required by 42 CFR §§489.1 and 417.436.
J. Properly handle and safeguard protected information collected, created, used, maintained, or disclosed on behalf of the Department. For purposes of this Agreement, "protected information" means data subject to any of the following laws:
1. The Minnesota Government Data Practices Act (MGDPA), Minnesota Statutes Chapter 13, in particular §13.46 ("welfare data");
2. The Minnesota Medical Records Act, Minn. Stat. §144.335;
3. The Health Insurance Portability and Accountability Act ("HIPAA"), including but not limited to the requirements of the Privacy Rule and the Security Regulations, 45 CFR Part 160 and Part 164, subparts A and E.
4. Federal law and regulations that govern the use and disclosure of substance abuse treatment records, 42 U.S.C.S. § 290dd-2 and 42 CFR § 2.1 to § 2.67; and
5. Any other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information.

PROVIDER INITIALS

NAME OF PCA UMPI

K. Comply with the laws described in section J. This includes the Provider:

1. Not using or further disclosing protected information created, collected, received, stored, used, maintained or disseminated in the course or performance of this Agreement other than as necessary to perform its obligations under this Agreement, or as required by law, either during the period of this Agreement or hereafter. See, respectively, 45 C.F.R. §§ 164.502(b) and 164.514(d), and Minn. Stats. § 13.05 subd. 3.
2. Using appropriate administrative, physical, and technical safeguards to prevent use or disclosure of the protected information other than as provided for by this Agreement and to ensure the confidentiality, integrity, and availability of any electronic protected health information (PHI) that it creates, receives, maintains, or transmits on behalf of the Department. Provider will not transmit PHI over the Internet or any other unsecure or open communications channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent than those described in 45 CFR § 164.312. If the Provider stores or maintains PHI in encrypted form, the provider shall, at the Department's request, promptly provide the Department with the key or keys to decrypt such information. The Provider shall not forward previously encrypted data to any other party, unless otherwise required by this Agreement.
3. Mitigating, to the extent practicable, any harmful effects known to the Provider of a use, disclosure, or breach of security with respect to protected information by the Provider in violation of this Agreement.

L. Agree that this Agreement may be immediately terminated at the discretion of the Department if it determines that the Provider has violated a material term of the Agreement, including but not limited to, non-compliance by the Provider with the HIPAA Privacy Rule and Security Standards. If termination is not feasible, the Department shall report the breach to the Secretary of DHHS.

Upon termination of this Agreement, all of the protected information provided by the Department to Provider, or created or received by the Provider on behalf of the Department, that the Provider still maintains in any form, including information that is in the hands of subcontractors or agents of the Provider, shall be destroyed or returned to the Department, and the Provider shall retain no copies of such information. If it is infeasible to return or destroy the information, the Provider shall provide the Department notification of the conditions that make return or destruction infeasible, and shall extend the protections of this Agreement to such information and limit further use and disclosure of such information to those purposes that make return or destruction infeasible, for as long as the Provider maintains the information.

M. Agree that any ambiguity in this Agreement shall be resolved to permit the Department to comply with HIPAA, MDGPA, and other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information and other state and federal laws and regulations.

Upon signature, this Provider Agreement supersedes and replaces all former Provider Agreements the Provider has with the Department.

An individual applicant must personally sign the Provider Agreement. Please sign and date below, initial page 1, and return both page 1 and page 2 of this agreement. **Please retain a copy of the provider agreement for your files, and return the original to the Department of Human Services.**

NAME OF PCA (TYPE OR PRINT)	TITLE	
SIGNATURE OF PCA	DATE	
	_ _ / _ _ / _ _ _ _	

Please return page 1 and page 2 of this document

Agreement Instructions

As a Non pay-to provider, you are providing health care services to individuals. We require your enrollment in the Minnesota Health Care Programs (MHCP) so that you are represented on the claim as the person who provided the services. Knowing that a qualified individual provided the service ensures the safety of the people that the Minnesota Department of Human Services serves. It also allows the Department to perform auditing and tracking of services which protects against double-billing and other types of fraud. Before enrollment is approved, MHCP must make certain that:

1. There is no legal or other reason why you shouldn't provide these services,
2. You understand what is necessary to properly provide these services, and
3. You understand the need to protect the privacy of the people you care for.

To help ensure that each of these conditions is met, MHCP requires that you agree to the terms in the attached Provider Agreement. In general, this agreement requires that you:

- A. Provide documents to your employer about the services you provide.
- B. Provide documents to MHCP or other state and federal agencies related to the services you provide, when requested.
- C. Comply with federal and state laws about the services you provide.
- D. Accept payment made to your employer as payment in full for the services you provide. You cannot ask for nor accept additional payment from the client.
- E. Disclose any criminal convictions you have related to Medicare, Medicaid, or title XX services.
- F. Not discriminate against individuals because of their race, color, national origin, sex, age, religion or disability when you provide these services.
- G. Provide the same quality of service to persons receiving public assistance as those who don't receive such assistance.
- H. If you are enrolled to provide and bill for other services, you must continue to follow the requirements of the agreement you signed when you enrolled for those services. The terms of that agreement are different than the terms in the attached agreement.
- I. Comply with federal requirements about advance directives. An advance directive is written instruction, such as a living will, to give a patient control over medical treatment decisions.
- J. Properly protect private information about the people to whom you provide services, especially their health information.
- K. Don't disclose the private information of someone for whom you provide services, unless it is needed for your work. This includes not discussing someone's private information unless your job requires it. Also, ensure that the information could not be accessed by someone who does not have permission to see it. This includes not leaving paperwork out where others can see it, and not sending private information over the internet.
- L. Understand that this agreement may be canceled if you violate its terms. If this agreement is canceled, you must properly dispose of any private information you have about the people you serve so that it is not discovered by someone who does not have permission to see it.
- M. Understand that by signing this agreement, you are agreeing to protect any private information you come in contact with in your job. When you protect private information, you are complying with federal and state laws, and you help the Department comply with these laws, as well.

This is a basic description of the terms of this agreement. By signing this agreement, you are agreeing to be legally bound by all of its terms. If you have questions about it, you should get answers to them before signing this agreement. If you need or want legal advice, you should contact your own attorney. For more information, please call (651) 431-2700.