



Minnesota Health Care Programs (MHCP)

Individual PCA Relationship Acknowledgment

Complete this form for each individual PCA provider to indicate the individual PCA provider's relationship with the recipient for whom they provide care. The PCA provider agency must keep a copy of this form in the PCA provider agency's file and recipient's medical record. It is a federal crime to provide false information on PCA billings for MHCP payment.

PCA NAME Last (please print) First Middle NPI/UMPI

RECIPIENT NAME Last (please print) First Middle MHCP ID #

- checkboxes for relationship types: The above named individual PCA provider is not related to the above named recipient, The above named individual PCA provider is related to the above named recipient as a(n): Adult child, Grandchild, Grandparent, Parent/adoptive parent of adult, Sibling, Other relationship

If the individual PCA provider is related to the recipient in one of the following ways, the individual PCA cannot provide services for this recipient.

- Paid legal guardian • Parent of recipient under 18 • Responsible party • Spouse • Stepparent of recipient under 18

If the individual PCA provider is related to the recipient as a licensed family foster care provider, the individual PCA may not be able to provide services for this recipient. Contact your lead agency for direction.

By signing below:

- I verify the relationship entered above is correct
■ I will notify the PCA provider agency of any changes to the information

INDIVIDUAL PCA PROVIDER SIGNATURE DATE

RECIPIENT SIGNATURE DATE

RESPONSIBLE PARTY NAME RESPONSIBLE PARTY SIGNATURE DATE

I have reviewed and certify the information provided above is true and correct to the best of my knowledge. This PCA provider agency will submit claims to MHCP indicating the appropriate relationship between the individual PCA provider and the recipient.

PCA AGENCY NAME PCA AGENCY NPI/UMPI
NAME OF PERSON AUTHORIZED TO REVIEW FOR PCA AGENCY (please print) SIGNATURE DATE