Clear Form

Minnesota Department of **Human Services**

DHS-5716-ENG 9-10

Minnesota Health Care Programs

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**
REMOVE PCA FROM HEALTH CARE GROUP AFFILIATION (Agency Signature Required) EFFECTIVE: __ __/__ __/__ __ __ __	TERMINATE PCA FROM ENROLLMENT WITH MHCP (Agency Signature Required) EFFECTIVE: __ __/__ __/__ __ __ __	COMPLETION OF PCA TRAINING (Agency or PCA signature required) EFFECTIVE: __ __/__ __/__ __ __ __
AGENCY FAX NUMBER ( )	**AGENCY PERSONNEL COMPLETING FORM**	AUTHORIZED AGENCY SIGNATURE

☐ 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)

Individual PCA Information

PREVIOUS NAME (if applicable)	**CURRENT LEGAL NAME (FIRST)**	**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** __ __/__ __/__ __ __ __	**IS THE INDIVIDUAL 18 YEARS OR OLDER?** ☐ YES ☐ NO	
Has this individual maintained continuous employment with your agency since this BGS was completed? ☐ YES ☐ NO EMPLOYMENT END DATE: __ __/__ __/__ __ __ __			**STUDY NUMBER/REQUEST ID**
DATE DHS TRAINING WAS COMPLETED __ __/__ __/__ __ __ __	TRAINING CERTIFICATE NUMBER		

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** __ __/__ __/__ __ __ __