V-CARE HOME HEALTH, INC.

DHS-4611-ENG 8-09

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

V-CARE HOME HEALTH, INC.

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 Afiliation 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 651-793-7659

Only faxed requests will be processed