Clear Form Data
FILLABLE FORM

Minnesota Department of **Human Services**

DHS-5856-ENG 9-09

Minnesota Health Care Programs (MHCP)

Personal Care Assistance (PCA) Program Responsible Party Agreement and Plan

Personal care assistance (PCA) agencies must have each responsible party or their delegate complete the following agreement annually to ensure they are aware of their roles and responsibilities. You must keep a copy of the completed agreement in the recipient's file and provide a copy to the recipient and their responsible party or delegate.

Completed by Responsible Party

RESPONSIBLE PARTY NAME (Last/First/MI)	RELATIONSHIP TO RECIPIENT
RECIPIENT NAME (Last/First/MI)	RECIPIENT MHCP ID NUMBER

I agree to be the responsible party for the above named recipient for the following time period:
_____ (MM/DD/YYYY) to _____ (MM/DD/YYYY) and agree to (initial each):

_____ Attend assessments for PCA services for the recipient to help the recipient make informed choices
_____ Determine if the recipient's health and safety are assured with the current PCA services
_____ Help develop the PCA care plan with the qualified professional
_____ Actively participate in planning and direction of PCA services
_____ Sign the PCA time sheets after services are provided to verify the services
_____ Monitor the PCA weekly to ensure the care plan is followed and the care outcomes are met as described below
_____ Be accessible to the recipient and PCA when services are provided as described below

RESPONSIBLE PARTY PLAN TO MEET THE ABOVE REQUIREMENTS (Be specific - attach additional pages as needed)

Acknowledgement and Signature (check below)

☐ I am at least 18 years of age
☐ I am not the owner or employee of the PCA provider agency

I understand that I am responsible for and have agreed to all of the duties outlined above.

Completed and Signed by Responsible Party

RESPONSIBLE PARTY SIGNATURE			DATE
ADDRESS			
CITY	STATE	ZIP CODE	PHONE NUMBER ( )

The PCA agency is required to make a referral to the county common entry point for any failure to provide the support as required by the recipient.

Completed by Agency

AGENCY CONTACT NAME	TITLE
AGENCY NAME	DATE