Prime Choice Home Care
888 County Road D West, Suite 300, New Brighton, MN 55112
Office Phone: 651-460-0551 | **Fax:** 651-262-0015
Email: primechoice.hc@gmail.com | **General Inquiry:** info@primechc.com **Website:** https://primechc.com

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Welcome to Prime Choice Home Care!

We're excited that you're considering joining our team. Please take the time to complete the forms included in this packet. These forms are required for all applicants and will help us move forward with your application process.

Instructions for Applicants

1. **Complete All Forms:** Fill out each form in this packet accurately and completely.
2. **Submit Your Forms:** Return the completed forms to primechoice.hc@gmail.com.
3. **Next Steps:** If you move forward in the hiring process, you will:
    - Undergo a **background check** as required by Minnesota 245D waiver rules.
    - Complete **onboarding training** and **orientation** to prepare for your role.

Important Notes

- All the information provided will be kept confidential and used solely for employment purposes.
- If you have any questions or need assistance, please contact us at 651-460-0551

Thank you for choosing Prime Choice Home Care!
We look forward to the possibility of working with you.

Prime Choice Home Care
888 County Road D West, Suite 300, New Brighton, MN 55112
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APPLICATION FOR EMPLOYEE

Federal and State laws prohibit discrimination in employment because of sex, race, creed, religion, national origin, age, handicap, marital status, status with regard to public assistance or veterans employment. We are an equal opportunity employer.

PERSONAL INFORMATION Date_____

Name_____ **Social Security #** _____
Last First Middle

Other surnames that I have used:_____

Present Address_____
Street City State Zip

Permanent Address_____
Street City State Zip

Home Phone #:_____ **Alternate Phone #:**_____

How did you hear about this position?_____**Referred By**:_____

Are you legally entitled to work in the United States? ☒ YES ☐ NO **Are you at least 18 years of age?** ☐ YES ☐ NO

U.S. Military or Naval Service_____Rank_____Present Membership in National Guard or Reserves? ☐ YES ☐ NO

EMPLOYMENT DESIRED

Position: ☐ RN ☐ LPN/LVN ☐ Homemaker ☐ Home Health Aide ☐ Staffing ☐ Clerical ☐ Personal Care Attendant ☐ Other_____

Have you passed Competency Testing? ☐ YES ☐ NO Do you have a Certificate? ☐ YES ☐ NO

Do you have a current Driver's License? ☐ YES ☐ NO Do you currently have a car? ☐ YES ☐ NO

Have you ever applied to this Company before? ☐ YES ☐ NO Where?_____When?_____

PROFESSIONAL LICENSES, CERTIFICATION, AND REGISTRATIONS

Do you have any professional licenses, certifications and/or registrations? ☐ YES ☐ NO

License/Certificate/ Registration #:	Type	State Issued	Date Expires	Status (List Active, Inactive, Restricted, Conditional or Pending)

REFERENCES

Give below the names of three **work related** references.

NAME	ADDRESS	COMPANY/POSITION	PHONE

EDUCATION

	NAME AND LOCATION OF SCHOOL	YEARS ATTENDED	GRADUATED	DEGREE/CERTIFICATION
HIGH SCHOOL			☐ Yes ☐ No	
COLLEGE			☐ Yes ☐ No	
COLLEGE			☐ Yes ☐ No	
ADDITIONAL TRAINING				

FORMER EMPLOYERS

List below your complete employment history for the last five years, starting with the most recent position first.
Attach additional pages if necessary.

DATE MONTH AND YEAR	NAME AND ADDRESS OF EMPLOYER SUPERVISOR'S NAME	SALARY	POSITION	REASON FOR LEAVING
FROM				
TO	May we contact? ☐ YES ☐ NO			
FROM				
TO	May we contact? ☐ YES ☐ NO			
FROM				
TO	May we contact? ☐ YES ☐ NO			
FROM				
TO	May we contact? ☐ YES ☐ NO			

I authorize investigation of all statements contained in this application. I understand that misrepresentation or omission of facts called for is cause for rejection or dismissal. Further, I understand and agree that my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time, with or without cause, and with or without any prior notice.

I hereby agree that, as a condition of employment by the Agency, I will promptly inform the Agency in writing of any criminal convictions, in any jurisdiction (including all pleas of guilty), other than minor traffic offenses, of which I am convicted after today.

VOLUNTARY SELF-IDENTIFICATION INFORMATION

Prime Choice Home Care is an Equal Opportunity/Affirmative Action Employer. All qualified applicants will receive consideration for employment without regard to sex, race, color, national origin or ancestry, age, handicap, marital status, source of income, class, physical characteristics, sexual orientation or political beliefs.

As an employer, we comply with government regulations and affirmative action responsibilities. Solely to help us comply with government record keeping, reporting and other legal requirements, please complete this Voluntary Self-Identification Information form. This data is for analysis and affirmative action only and submission of this information is voluntary. This data will be kept in a confidential file separate from your Application for Employment.

Date_____

Position Applied For_____

Gender:

- ☐ Male
- ☐ Female
- ☐ Choose not to respond

Race/Ethnic Background:

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ Black / African or African American
- ☐ Hispanic / Latino
- ☐ White / Caucasian
- ☐ Two or More Races
- ☐ Choose not to respond

Veteran Status:

- ☐ Vietnam era veteran
- ☐ Disabled veteran
- ☐ Other veteran
- ☐ Non-veteran
- ☐ Choose not to respond

Disability Status*:

- ☐ Disabled
- ☐ Not disabled
- ☐ Choose not to respond

Date_____ Signature_____

* According to the American with Disabilities Act, the term "disability" means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of that individual, a record of such an impairment, or being regarded as having such an impairment.

Prime Choice Home Care

Background Information and Release Form

Minnesota Law requires that we secure the following information from any prospective employee who may be involved in duties requiring contact with clients in their homes. It is very important that you provide complete and accurate information. Failure to do so may bring adverse consequences, including the loss of any employment with **Prime Choice Home Care**. I authorize Prime Choice Home Care, the Department of Human Services, the Office of Inspector General and the MN Bureau of Criminal Apprehension to conduct a background investigation as part of the employment screening and selection process.

Please complete all the information in this application in order to process the background check

Background information					
Last Name		First		M.I.	
Street Address				Apartment/Unit #	
City		State		ZIP	
Phone					
Date of Birth (MM/DD/YY		Social Security No.			
Gender		Race			
DRIVER'S LICENSE #/STATE ID				STATE ISSUED	
Other Names Used by Applicant					

I hereby authorize all individuals, institutions, and entities with which I have been associated, who have knowledge concerning information requested in this form to consult with and release relevant information to Prime Choice Home Care, and designees

I hereby release Prime Choice Home Care., its agents and designees, and all other individuals, institutions and entities providing information in accordance with the authorization contained herein from liability for the acts performed in good faith and without malice in connection with the investigation of this form and the release and exchange of information authorized above. This release shall be in addition to any other applicable immunity provided by law for investigatory activities.

I hereby agree that, as a condition of employment by Prime Choice Home Care, I will promptly inform the agency in writing of any criminal conviction, in any jurisdiction (including all pleas of guilty), Other than minor traffic offenses, of which I am convicted after today. I am informed of the content of the Background Study Privacy Notice. I understand that Prime Choice Home Care will run a background check through the Department of Human Services, the Office of Inspector General and the MN Bureau of Criminal Apprehension.

Signature:	Date:
PRINT FULL NAME:	

office use only			
THE FOREGOING INFORMATION COLLECTED BY		INFORMATION COLLECTED ON	/ /

Clear Form

Minnesota Department of **Human Services**

DHS-4611-ENG 4-15

Minnesota Health Care Programs

Provider Agreement – Individual Support Worker (CDCS, CSG, 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 affiliated agency that fully discloses the extent of services provided to individuals under these programs. The documentation must be legible and meet the requirements of Minnesota Statutes Section 256B.0659, subdivision 12 for all individual support workers in CDCS, CSG, and PCA.

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 C.F.R. § 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 C.F.R. §§ 489.100 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 Health Records Act § 144.291 and § 144.298;
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 C.F.R. 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 C.F.R. § 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.

	DIRECT SUPPORT WORKER INITIALS

NAME OF SUPPORT WORKER	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 C.F.R. § 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 SUPPORT WORKER **(TYPE OR PRINT)**	TITLE
SIGNATURE OF SUPPORT WORKER	DATE

Please return page 1 and page 2 of this document

Agreement Summary

As an individual support worker, 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.