PERSONAL CARE SERVICES PROGRAM
PROVIDER/ENROLLMENT AGREEMENT

Instructions:

- *This form is to be completed in triplicate.*
- *This form must be completed prior to enrollment for **each** service provider/client relationship.*
  Part I is to be completed by the service provider
- *Part II is to be completed by the client or authorized representative as long as the authorized representative is **NOT the service provider.***
- *Part III is to be completed by the county.*
- *The original form is to be maintained by the county and a copy given to the provider and the recipient.*

PART I - SERVICE PROVIDER

SERVICE PROVIDER NAME				SOCIAL SECURITY NUMBER
ADDRESS (Street, City, Zip)				PHONE ( )
DATE OF BIRTH (Month, Day, Year)	SEX	ETHNIC ORIGIN	RELATIONSHIP TO CLIENT	START OF SERVICE (Month, Day, Year)

CERTIFICATION STATEMENT

- I certify that all claims, which I submit, for services to clients of the Personal Care Services Program will be provided as authorized for the client.
- I certify that all information submitted to the county will be accurate and complete to the best of my knowledge.
- I understand that payment of these claims will be from federal and/or state funds and that any false statement, claim, or concealment of information may be prosecuted under federal and/or state laws.
- I agree that services will be offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

SERVICE PROVIDER'S SIGNATURE	DATE

PART II - CLIENT CERTIFICATION

I certify that the service provider named above is qualified to provide personal care services for me as authorized by the county.

CLIENT'S NAME	CASE NUMBER
CLIENT'S SIGNATURE (Or Authorized Representative)	DATE

PART III - RECORD RETENTION

On behalf of the service provider, the county shall keep all records which are necessary to fully disclose the extent of services to the client for a minimum of three years from the date of service; and on request shall furnish the records for audit to the State of California or the U.S. Department of Health and Human Services or their duly authorized representatives.

AUTHORIZED COUNTY REPRESENTATIVE'S SIGNATURE	SERVICE WORKER NUMBER	DATE

PART IV - HEALTH SERVICES APPROVAL

The Department certifies that the person named above will be an enrolled Medi-Cal provider of personal care services.

California Department of Health Services