PrimeWest HEALTH™

Individual PCA/CFSS Information Change Form

Forms must be downloaded before they can be filled out and submitted. To download a form, right-click on the name of the form, choose "Save target as…" (in Internet Explorer) or "Save link as…" (in Chrome and Firefox), select a folder on your computer to save it to, and click the "Save" button. After the form has finished downloading, navigate to the folder it was saved to and double-click it to open it in Adobe Reader. If you do not have Adobe Reader, you can download it here.

Complete all applicable fields to update an individual Personal Care Assistant (PCA) or Community First Services and Supports (CFSS) provider record. We will return incomplete forms to you. Type or print clearly. Please email the completed form to **credentialing@primewest.org** or fax it to **1-320-335-5313**. NOTE: To add a PCA or CFSS provider to an additional agency, complete and submit the Personal Care Assistant (PCA) Application or the Community First Services and Supports (CFSS) Application.

Agency Information

AGENCY NAME	AGENCY FAX NUMBER

AGENCY TAX ID	AGENCY NPI/UMPI

PCA/CFSS Provider Name Change – A name change request must include an effective date. (Agency or PCA/CFSS provider signature required)

PREVIOUS NAME (IF APPLICABLE)	CURRENT LEGAL NAME (FIRST)	MIDDLE	LAST

UMPI	EFFECTIVE DATE OF NAME CHANGE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	IS THE INDIVIDUAL 18 YEARS OR OVER?
		☐ YES ☐ NO

HAS THIS INDIVIDUAL MAINTAINED CONTINUOUS EMPLOYMENT WITH YOUR AGENCY SINCE THEIR BACKGROUND STUDY WAS COMPLETED?

☐ YES ☐ NO EMPLOYMENT END DATE

Remove PCA/CFSS Provider (PCA /CFSS provider signature not required; agency signature is required)

LEGAL NAME (FIRST)	MIDDLE	LAST

UMPI	REMOVE PCA/CFSS PROVIDER FROM AGENCY (Agency Signature Required)
	EFFECTIVE DATE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	REASON FOR REMOVING PCA/CFSS PROVIDER FROM AGENCY

Continued on next page

Remove PCA /CFSS Provider Affiliation for Additional Sites		
AGENCY NAME	AGENCY NPI/UMPI	EFFECTIVE DATE
AGENCY NAME	AGENCY NPI/UMPI	EFFECTIVE DATE

Individual PCA/CFSS Provider Statement

I have reviewed and certify the information provided above is true and correct to the best of my knowledge. **I will notify PrimeWest Health of any additions and/or changes to the information.**

NAME OF PCA/CFSS PROVIDER OR AGENCY PERSONNEL (PLEASE PRINT OR TYPE)	
SIGNATURE OF PCA/CFSS PROVIDER OR AGENCY PERSONNEL	**DATE SIGNED**