Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-6189C-ENG 1-20

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Adult Companion Services Providers Applicant Assurance Statement

Provider information

PROVIDER NAME	NPI or UMPI

This Assurance Statement is an addendum to the provider's MHCP Provider Agreement.

Definition of Adult Companion Services

Refer to Covered and Noncovered Services section in the home and community-based waiver services section of the MHCP Provider Manual to review the policy information and definition for this service.

Applicant Assurance Statement

By initialing the requirement and signing this form, I, the applicant named on this form, assure that my organization meets the following requirement:

_____ **Corporation for National and Community Service grantee under the Senior Companion Program** (submit documentation that shows proof that your organization is a Senior Companion program grantee from the Corporation for National and Community Service.)
Note: Senior Companion Program grantees must undergo criminal history checks through the Corporation for National and Community Service and are exempt from the background study requirements of Minnesota Statute 245C.

This assurance statement must be signed by an officer with authority to bind the entity (CEO, president). A signed copy of this form must be retained in your files.

AUTHORIZED OFFICER NAME (please print)	TITLE
SIGNATURE	EFFECTIVE DATE
CONTACT NAME (please print)	PHONE NUMBER

Upload this signed Applicant Assurance Statement with required MHCP HCBS and AC Provider Enrollment documents through the online Minnesota Provider Screening and Enrollment (MPSE) portal or fax to 651-431-7493.