

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

HCBS Programs Service Request Form

You can complete this request with MHCP in either one of the following ways:

1. Electronically by using our online system, the [Minnesota Provider Screening and Enrollment \(MPSE\) portal](#).
 - New providers use:
 - [MPSE Registration](#)
 - Existing MHCP enrolled providers, log in to your [MN-ITS account](#). If you never registered your MN-ITS account, your login information is on your original "Welcome" letter.

or

2. Use this form to type or neatly print your request to provide the service(s) indicated or to notify MHCP that you are no longer providing the service(s) indicated. Complete the first and last page of this form and any other pages that show a service selected. You do not need to fax all pages of this document.
 - Select the service(s) that you want to provide or that you are no longer providing.
 - If you are requesting approval to provide services, select the service credential code to indicate how you are qualified to do each service.
 - If you are requesting approval to provide services, submit proof of your qualifications with this form.
 - Fax the completed form and any attachments to MHCP at 651-431-7493.

Select the HCBS program(s) you are enrolling to provide, the program(s) for which you are adding services, or the program(s) for which you no longer provide a service:

- HCBS Waiver (Brain Injury [BI], Community Alternative Care [CAC], Community Access for Disability Inclusion [CADI], Development Disabilities [DD] and Elderly Waiver [EW])
- Alternative Care (AC)
- Moving Home Minnesota (MHM)
- Essential Community Supports (ECS)

Choose one of the following:

- New enrollment
- Reenrollment (after termination)
- Add services to an existing provider record: EFFECTIVE DATE: _____
- Remove services from an existing record: EFFECTIVE DATE: _____
- Revalidation

Organization Information

PROVIDER NAME			NPI or UMPI
STREET ADDRESS		CITY	STATE ZIP CODE
REQUESTED EFFECTIVE DATE	CREDENTIALING CONTACT NAME		PHONE NUMBER

Service Credentials

Service description	Select the credential that qualifies you for this service	Specialty code	COS
Adult Day Services (ECS, Waiver and AC)	<p>Home and Community-Based Settings Provider Assurance Statement (DHS-7618) (PDF) AND one of the following:</p> <p><input type="radio"/> (AD) Adult Day Care license under Minn. Rules 9555.9600–9555.9730 and Minn. Stat. 245A.01–245A.17 LICENSE NUMBER: _____</p> <p><input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment and a signed Adult Day Services Provider Assurance Statement [DHS-6189AA] (PDF))</p>	AD	102
Adult Day Services, Family Adult Day Services (Waiver and AC)	<p>Home and Community-Based Settings Provider Assurance Statement (DHS-7618) (PDF) AND one of the following:</p> <p><input type="radio"/> (AF) Adult Foster Care license LICENSE NUMBER: _____</p> <p><input type="radio"/> (FA) Family Adult Day Services license under Minn. Stat., section 245A.143. The home must be the primary residence of the license holder. LICENSE NUMBER: _____</p>	AD	102
Adult Day Services, Bath (Waiver and AC)	<p>Home and Community-Based Settings Provider Assurance Statement (DHS-7618) (PDF) AND one of the following:</p> <p><input type="radio"/> (AD) Adult Day Care license under Minn. Rules 9555.9600–9555.9730 and Minn. Stat. 245A.01–245A.17 LICENSE NUMBER: _____</p> <p><input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment and a signed Adult Day Services Provider Assurance Statement [DHS-6189AA] (PDF))</p> <p><input type="radio"/> (FA) Family Adult Day Services license under Minn. Stat., section 245A.143. The home must be the primary residence of the license holder. LICENSE NUMBER: _____</p>	AB	102
Assistive Technology - Equipment (DD Waiver Only)	<p>Choose one of the following:</p> <p><input type="radio"/> (AA) HCBS Lead Agency Provider Enrollment Request Form (DHS-6383) (PDF)</p> <p><input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment and signed Assistive Technology Provider Assurance Statement [DHS-6189D] (PDF))</p> <p><input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)</p>	AT	033
Assistive Technology - Assessment (DD Waiver Only)	<p>Assistive Technology Provider Assurance Statement (DHS-6189D) (PDF) AND one of the following:</p> <p><input type="radio"/> (20) Physicians license under Minn. Stat. chapter 147</p> <p><input type="radio"/> (39) Physical therapist registration under Minn. Stat., section 148.70</p> <p><input type="radio"/> (29) American Occupational Therapy Association registration as an occupational therapist</p> <p><input type="radio"/> (NA) Certification through California State University Northridge's Assistive Technology Program</p> <p><input type="radio"/> (RH) Certification through the Rehabilitation Engineering and Assistive Technology Society</p> <p><input type="radio"/> (SL) Certification of clinical competence in speech-language pathology from the American Speech-Language-Hearing Association</p>	AE	033

Service description	Select the credential that qualifies you for this service	Specialty code	COS
Caregiver Living Expenses (BI, CAC, CADI and DD)	<p>Choose one of the following:</p> <p><input type="radio"/> (AA) HCBS Lead Agency Provider Enrollment Request Form (DHS-6383) (PDF)</p> <p>Must also be enrolled, or enrolling in at least one of these services: Adult Companion (BI and CADI), Independent living skills training (BI, CAC and CADI), Individualized home supports (BI, CAC and CADI), Extended home care nursing (CAC), Personal Support (DD), Supported living services (DD)</p> <p>or one of the following:</p> <p><input type="radio"/> (PA) Enrolled Individual PCA UMPI: _____</p> <p><input type="radio"/> (FS) Financial Management Services (FMS) NPI/UMPI: _____</p> <p>OR</p> <p><input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)</p>	LC	105
Case Management Aide (Waiver, AC or ECS)	<p>Choose one of the following:</p> <p><input type="radio"/> (AA) HCBS Lead Agency Provider Enrollment Request Form (DHS-6383) (PDF)</p> <p><input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)</p>	CA	044
Case Management, Conversion (AC)	<p>Choose one of the following:</p> <p><input type="radio"/> (AA) HCBS Lead Agency Provider Enrollment Request Form (DHS-6383) (PDF)</p> <p><input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)</p>	CV	044
Case Management Mandatory (Consumer Directed Community Supports)	<p>Choose one of the following:</p> <p><input type="radio"/> (AA) HCBS Lead Agency Provider Enrollment Request Form (DHS-6383) (PDF)</p> <p><input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)</p>	CM	044
Case Management, Ongoing (Waiver, AC, ECS, MHM)	<p>Choose one of the following:</p> <p><input type="radio"/> (AA) HCBS Lead Agency Provider Enrollment Request Form (DHS-6383) (PDF)</p> <p><input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)</p> <p>For MHM, must also complete:</p> <p><input type="checkbox"/> (DA) Approved as Moving Home Minnesota – Transition Planning, Transition Coordination and Demonstration Case Management – Provider Assurance Statement (DHS-3879) (PDF)</p>	CO	044
Chore Services (Waiver, AC, ECS)	<p>Choose one of the following:</p> <p><input type="radio"/> (AA) HCBS Lead Agency Provider Enrollment Request Form (DHS-6383) (PDF)</p> <p><input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment and signed Chore Service Provider Assurance Statement [DHS-6189F] (PDF))</p> <p><input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)</p> <p><input type="radio"/> (SP) Pest Control Applicator meeting the standards in Minn. Stat., Chapter 18B and a signed Chore Service Provider Assurance Statement (DHS-6189F) (PDF)</p>	CS	093

Service description	Select the credential that qualifies you for this service	Specialty code	COS
Adult Companion Services (Waiver, AC, ECS)	<input type="checkbox"/> (23) Chapter 144A Homecare license LICENSE NUMBER: _____ (Must have a current [57] basic license or [58] comprehensive license with HCBS designation on the license and 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF]) <input type="checkbox"/> (24) Unrelated individual serving members of one family (Must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF]) <input type="checkbox"/> (27) Related individual serving one family member (Must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z]) (EW/AC only) <input type="checkbox"/> (CN) Companion Care Provider approved through Corporation for National and Community Service (Must complete and submit the Adult Companion Services Provider Assurance Statement [DHS-6189C] [PDF]) <input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____	CN	094
Community Living Assistance (CLA) (ECS program only)	<input type="checkbox"/> (57) Basic Home Care license LICENSE NUMBER: _____ <input type="checkbox"/> (58) Comprehensive Home Care license LICENSE NUMBER: _____ <input type="checkbox"/> (AA) HCBS Lead Agency Provider Enrollment Request Form (DHS-6383) (PDF) <input type="checkbox"/> (LA) Lead Agency (County or Tribal Human Service)	CY	109
Customized Living (including 24 hours Customized Living) (BI, CADI and EW)	Customized Living Provider Assurance Statement (DHS-6189X) (PDF) and Home and Community-Based Settings Provider Assurance Statement (DHS-7618) (PDF) WITH one of the following: <input type="radio"/> (C1) (58) Comprehensive home care license LICENSE NUMBER: _____ Registered as Housing with Services Establishment under 144D LICENSE NUMBER: _____ <input type="radio"/> (C2) (58) Comprehensive home care license LICENSE NUMBER: _____ Registered as Housing with Services Establishment under 144D LICENSE NUMBER: _____ That is a setting of one to five unrelated people living together in a residential unit, not licensed as Adult Foster Care, and must comply with Minnesota Rules, part 9555.6205, subparts 1 to 3; part 9555.6215, subparts 1 and 3; and part 9555.6225, subparts 1, 2, 6 and 10, and in which the residence is not the primary residence of the license holder. <input type="radio"/> (C3) (58) Comprehensive home care license LICENSE NUMBER: _____ Registered as Housing with Services Establishment under 144D LICENSE NUMBER: _____ That is a setting of five or more people licensed by the Minnesota Department of Health as a board and lodge; Minn. Stat., section 157.15 to 157.17 For BI and CADI waivers: <input type="radio"/> (C9) (58) Comprehensive home care license LICENSE NUMBER: _____ Housing with Services Establishment under 144D REGISTRATION NUMBER: _____	CH CG CL CF	108

Service description	Select the credential that qualifies you for this service	Specialty code	COS
24-Hour Customized Living Licensed Adult Foster Care (under 65 years old) (BI and CADI)	Customized Living Provider Assurance Statement (DHS-6189X) (PDF) and Home and Community-Based Settings Provider Assurance Statement (DHS-7618) (PDF) WITH the following: <input type="checkbox"/> (L1) (58) Comprehensive Home Care license LICENSE NUMBER: _____ and Housing with services REGISTRATION NUMBER: _____ and Adult Foster Care license in which the residence is not the primary residence of the license holder LICENSE NUMBER: _____	HS HF	108
Discretionary Services (AC only)	<input type="checkbox"/> (DA) DHS approved (compliance with MHCP waiver provider enrollment and HCBS Lead Agency Enrollment Request Form [DHS-6383] [PDF] signed by a lead agency) <input type="checkbox"/> (LA) Lead Agency (County or Tribal Human Service)	DO	109
Day Training and Habilitation (DD Waiver Only)	Home and Community-Based Settings Provider Assurance Statement (DHS-7618) (PDF) and the following: <input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____ and (09) Day Services Facility Satellite license LICENSE NUMBER: _____	DD NP	019
Day Training and Habilitation Transportation (DD Waiver Only)	Home and Community-Based Settings Provider Assurance Statement (DHS-7618) (PDF) and the following: <input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____ and (09) Day Services Facility Satellite license LICENSE NUMBER: _____	DT	019
24-Hour Emergency Assistance (non-equipment) (BI, CAC, CADI and DD)	Choose one of the following: <input type="radio"/> (23) Chapter 144A Homecare license LICENSE NUMBER: _____ (Must have a current [57] basic license or [58] comprehensive license with HCBS designation on the license and 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF]) <input type="radio"/> (24) Unrelated individual serving members of one family (Must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF]) <input type="radio"/> (27) Related individual serving one family member (Must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF]) <input type="radio"/> (CP) Chapter 245D license LICENSE NUMBER: _____	EA	094 & 107
Personal Emergency Response System (PERS), Purchase (Waiver, AC, MHM)	Personal Emergency Response System Provider Assurance Statement (DHS-6189CC) (PDF) AND one of the following: <input type="radio"/> (47) Pharmacies NPI: _____ <input type="radio"/> (60) Home health agency NPI: _____ <input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF) <input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment) <input type="radio"/> (DD) Medical suppliers NPI: _____ <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)	PU	116

Service description	Select the credential that qualifies you for this service	Specialty code	COS
Personal Emergency Response System (PERS), Installation (Waiver, AC, MHM)	Personal Emergency Response System Provider Assurance Statement (DHS-6189CC) (PDF) AND one of the following: <input type="radio"/> (47) Pharmacies NPI: _____ <input type="radio"/> (60) Home health agency NPI: _____ <input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF) <input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment) <input type="radio"/> (DD) Medical suppliers NPI: _____ <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)	IN	116
Personal Emergency Response System (PERS), Service Fee (Waiver, AC, MHM)	Personal Emergency Response System Provider Assurance Statement (DHS-6189CC) (PDF) AND one of the following: <input type="radio"/> (47) Pharmacies NPI: _____ <input type="radio"/> (60) Home health agency NPI: _____ <input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF) <input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment) <input type="radio"/> (DD) Medical suppliers NPI: _____ <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)	SR	116
Employment Services – exploration, development and support (BI, CAC, CADI and DD)	<input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____	SE	104
Environmental Accessibility Adaptations – Home Modifications Installation (Waiver, AC, MHM)	Choose one of the following: <input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF) <input type="radio"/> (DA) DHS Approved Limited installations – special skill only (compliance with MHCP waiver provider enrollment and a signed Environmental Accessibility Provider Assurance Statement [DHS-6189G] [PDF]) <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service) <input type="radio"/> (RB) Residential building contractor as defined in Minn. Stat., section 326B.802, subd. 11. Must be licensed as a residential building contractor by the commissioner and a signed Environmental Accessibility Provider Assurance Statement (DHS-6189G) (PDF)	MD	033
Environmental Accessibility Adaptations – Home Modifications Assessment (Waiver, AC, MHM)	Environmental Accessibility Provider Assurance Statement (DHS-6189G) (PDF) AND one of the following: <input type="radio"/> (29) Occupational therapists that are currently registered by the American Occupational Therapy Association AND at least one year of experience with home modification evaluation <input type="radio"/> (AS) Certified Accessibility Specialist AND at least one year of experience with home modification evaluation <input type="radio"/> (CA) Certified Aging in Place Specialist AND at least one year of experience with home modification evaluation <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service) <input type="radio"/> (39) Physical therapists AND at least one year of experience with home modification evaluation	HE	033
Environmental Accessibility Adaptations – Vehicle Modifications Installation (Waiver, AC, MHM)	Environmental Accessibility Provider Assurance Statement (DHS-6189G) (PDF) AND one of the following: <input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF) <input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment and a copy of the Certified Returned Receipt from registration with National Highway Traffic Safety Administration [NHTSA]) <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)	VA	116

Service description	Select the credential that qualifies you for this service	Specialty code	COS
Environmental Accessibility Adaptations – Vehicle Modifications Assessment (Waiver, AC, MHM)	<p>Environmental Accessibility Provider Assurance Statement (DHS-6189G) (PDF) AND one of the following:</p> <ul style="list-style-type: none"> <input type="radio"/> (DR) Certified Driver Rehabilitation Specialist <input type="radio"/> (DY) Five years of full-time experience in the field of driver rehabilitation <input type="radio"/> (DF) Four year undergraduate degree in a health related field and <ol style="list-style-type: none"> 1) One year of full-time experience in the degree area of study 2) Supervision by an OT with a Specialty Certification in Driving and Community Mobility, a Certified Driver Rehabilitation Specialist or a person with two years of full-time experience in the field of driver rehabilitation and 3) Continued education in the area of driver mobility and rehabilitation through the Association for Driver Rehabilitation Specialists, Rehabilitation Engineering and Assistive Technology Society or the American Occupational Therapy Association or any program that has been approved by these entities <input type="radio"/> (OS) Occupational therapists (OT) with a Specialty Certification in Driving and Community Mobility 	VE	116
Family Caregiver Coaching, Counseling and Family Memory Care (EW, AC, ECS Caregiver Support and Education)	<p>EW and AC Family Caregiver Training and Education Provider Assurance Statement (DHS-6189H) (PDF) AND one of the following:</p> <ul style="list-style-type: none"> <input type="radio"/> (HC) Health care professional such as PHN, RN, physician, social worker, rehabilitation therapist, gerontologists and pharmacists. Providers must meet all licensing, certification or credentialing requirements specific to their profession or practice, and will provide services within the scope of their respective practice. In addition, providers will have at least one year of experience in providing home care or long term care to elderly or at least one year of providing training, education or counseling to caregivers of elderly persons <input type="radio"/> (OR) Care or support related organization (e.g., non-profit social service agencies or organizations, Alzheimer's Association) who meet the requirements for health care professionals outlined in HC FMC's must meet training requirements as per 6189H <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service) 	CT	034
Family Caregiver Training and Education (EW, AC, ECS Caregiver Support and Education)	<p>EW and AC Family Caregiver Training and Education Provider Assurance Statement (DHS-6189H) (PDF) AND one of the following:</p> <ul style="list-style-type: none"> <input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF) <input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment) <input type="radio"/> (DD) Medical equipment supplier who meet the requirements for health care professionals outlined in HC <input type="radio"/> (HC) Health care professional such as PHN, RN, LPN, physician, social worker, rehabilitation therapist, gerontologists and pharmacists. Providers must meet all licensing, certification or credentialing requirements specific to their profession or practice, and will provide services within the scope of their respective practice. In addition, providers will have at least one year of experience in providing home care or long-term care to elderly or at least one year of providing training, education or counseling to caregivers of elderly persons <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service) <input type="radio"/> (OR) Care or support related organization (for example, non-profit social service agencies or organizations, Alzheimer's Association) who meet the requirements for health care professionals outlined in HC <input type="radio"/> (VT) Vocational and technical college offering HHA and nursing assistant training who meet the requirement for health care professionals outlined in HC 	CT	034

Service description	Select the credential that qualifies you for this service	Specialty code	COS
Family Training (BI, CAC, CADI and DD)	Family Training & Counseling Provider Assurance Statement (DHS-6189I) (PDF) AND one of the following: <input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF) <input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment) <input type="radio"/> (DD) Medical equipment supplier <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)	79	034
Family Counseling (BI, CAC, CADI and DD)	Family Training & Counseling Provider Assurance Statement (DHS-6189I) (PDF) AND one of the following: <input type="radio"/> (14) Social workers NPI: _____ <input type="radio"/> (15) Nutritional therapists NPI: _____ <input type="radio"/> (20) Physicians NPI: _____ <input type="radio"/> (26) Mental health professionals NPI: _____ <input type="radio"/> (29) Occupational therapists NPI: _____ <input type="radio"/> (39) Physical therapists NPI: _____ <input type="radio"/> (64) Registered nurses NPI: _____ <input type="radio"/> (69) Public Health Nurse NPI: _____ <input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF) <input type="radio"/> (RT) Respiratory therapists NPI: _____ <input type="radio"/> (SL) Speech-language pathologists NPI: _____	78	034
Foster Care, Adult (Family) (BI, CAC, CADI, EW)	Home and Community-Based Settings Provider Assurance Statement (DHS-7618) (PDF) AND one of the following: For BI, CAC, CADI and EW: <input type="radio"/> (LC) Adult Foster Care license LICENSE NUMBER: _____ and (CP) Chapter 245D license LICENSE NUMBER: _____ For EW only: <input type="radio"/> (FF) Certified by the county Must meet the requirements of Minnesota Rules, parts 9555.5105 to 9555.6265, and Minn. Stat., section 245A.03, and Minn. Stat., section 256B.0919, subd. 1, 2 and 3. Must also submit a completed HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF) . <input type="radio"/> (AF) Adult Foster Care license LICENSE NUMBER: _____ under Minnesota Rules, parts 9555.5050 to 9555.6265, and Minn. Stat., section 245A.03, in which the home is the primary residence of the license holder.	FF	103
Foster Care, Adult (Corporate) (BI, CAC, CADI and EW)	Home and Community-Based Settings Provider Assurance Statement (DHS-7618) (PDF) AND one of the following: For BI, CAC, CADI and EW: <input type="radio"/> (CP) Chapter 245D license LICENSE NUMBER: _____ and (CR) CRS Satellite license LICENSE NUMBER: _____ For EW only: <input type="radio"/> (EW) Adult Foster Care license LICENSE NUMBER: _____ under Minn. Rules, parts 9555.5050 to 9555.6265 and 2960.3000 to 2960.3230, and Minn. Stat., section 245A.03 in which the home is NOT the primary residence of the license holder.	FA	103
Foster Care, Child (Family and Corporate) (BI, CAC, CADI)	Home and Community-Based Settings Provider Assurance Statement (DHS-7618) (PDF) AND the following: <input type="checkbox"/> (CF) Child Foster Care license LICENSE NUMBER: _____ and <input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____	FK	103

Service description	Select the credential that qualifies you for this service	Specialty code	COS
Home Delivered Meals (Waiver and AC)	<input type="checkbox"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment and signed Home Delivered Meals Provider Assurance Statement [DHS-6189J] [PDF])	HD	095
Homemaker Services (basic cleaning) (Waiver, AC, ECS)	<p>Choose one of the following:</p> <p><input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF)</p> <p><input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)</p> <p>OR complete the Homemaker Provider Assurance Statement (DHS-6189K) (PDF) and choose one of the following:</p> <p><input type="radio"/> (23) Chapter 144A Homecare license LICENSE NUMBER: _____ (Must have a current [57] basic homecare license or [58] comprehensive homecare license with HCBS designation on the license and 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF])</p> <p><input type="radio"/> (24) Unrelated individual serving members of one family (must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF])</p> <p><input type="radio"/> (27) Related individual serving one family member (must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF])</p> <p><input type="radio"/> (57) Basic Homecare license LICENSE NUMBER: _____</p> <p><input type="radio"/> (58) Comprehensive Homecare license LICENSE NUMBER: _____</p> <p><input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment)</p> <p><input type="radio"/> (CP) Chapter 245D license LICENSE NUMBER: _____</p>	HM	096
Homemaker Service (Home Management) (Waiver, AC, ECS)	<p>Homemaker Provider Assurance Statement (DHS-6189K) (PDF) AND one of the following:</p> <p><input type="radio"/> (23) Chapter 144A Homecare license LICENSE NUMBER: _____ (Must have a current [57] basic homecare license or [58] comprehensive homecare license with HCBS designation on the license and 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF])</p> <p><input type="radio"/> (24) Unrelated individual serving members of one family (must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF])</p> <p><input type="radio"/> (27) Related individual serving one family member (must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF])</p> <p><input type="radio"/> (CP) Chapter 245D license LICENSE NUMBER: _____</p>	HM	096
Homemaker Service (Activities of Daily Living Assistance) (Waiver, AC, ECS)	<p>Homemaker Provider Assurance Statement (DHS-6189K) (PDF) AND one of the following:</p> <p><input type="radio"/> (23) Chapter 144A Homecare license LICENSE NUMBER: _____ (Must have a current [57] basic homecare license or [58] comprehensive homecare license with HCBS designation on the license and 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF])</p> <p><input type="radio"/> (24) Unrelated individual serving members of one family (must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF])</p> <p><input type="radio"/> (27) Related individual serving one family member (must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF])</p> <p><input type="radio"/> (CP) Chapter 245D license LICENSE NUMBER: _____</p>	HM	096

Service description	Select the credential that qualifies you for this service	Specialty code	COS
Housing Access Coordination (BI, CAC, CADI and DD)	<input type="checkbox"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment and signed Housing Access Coordination Provider Assurance Statement [DHS-6189L] [PDF])	HA	022
Independent Living Skills Training (BI, CAC and CADI)	<input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____	IC	109
Independent Living Skills, Individual Therapy (BI Waiver Only)	Independent Living Skills Therapy Provider Assurance Statement (DHS-6189M) [PDF] AND one of the following: <input type="radio"/> (AT) Registered with National Association for Art Therapists: Graduate from master's program in art therapy or related degree plus 21 additional graduate level art therapy credits, completed internship of 700 hours, and have a minimum of 100 hours of supervised direct client contact hours <input type="radio"/> (MT) Board certified as a Music Therapist: Graduate from an institution accredited by the American Music Therapy Association, and credentialed under the Certification Board for Music Therapists (CBMT) <input type="radio"/> (TR) Certified as Therapeutic Recreation Specialist: Graduate from an accredited baccalaureate program, complete internship of 360 hours under supervision of certified therapeutic recreation specialist, and pass the National Council for Therapeutic Recreation Certification exam	II	109
Independent Living Skills, Group Therapy (BI Waiver Only)	Independent Living Skills Therapy Provider Assurance Statement (DHS-6189M) [PDF] AND one of the following: <input type="radio"/> (AT) Registered with National Association for Art Therapists: Graduate from master's program in art therapy or related degree plus 21 additional graduate level art therapy credits, completed internship of 700 hours, and have a minimum of 100 hours of supervised direct client contact hours <input type="radio"/> (MT) Board certified as a Music Therapist: Graduate from an institution accredited by the American Music Therapy Association, and credentialed under the Certification Board for Music Therapists (CBMT) <input type="radio"/> (TR) Certified as Therapeutic Recreation Specialist: Graduate from an accredited baccalaureate program, complete internship of 360 hours under supervision of certified therapeutic recreation specialist, and pass the National Council for Therapeutic Recreation Certification exam	IG	109
In-Home Family Support (child and adult, in a person's or family's home only) (BI, CAC, CADI, and DD)	<input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____	IF	110
Individual Community Living Support (ICLS) (EW and AC)	Choose one of the following: <input type="radio"/> (23) Chapter 144A Homecare license LICENSE NUMBER: _____ (Must have a current [57] basic license or [58] comprehensive license with HCBS designation on the license and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF]) <input type="radio"/> (24) Unrelated individual serving members of one family (Must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF]) <input type="radio"/> (27) Related individual serving one family member (must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] [PDF]) <input type="radio"/> (CP) Chapter 245D license LICENSE NUMBER: _____	IL	109

Service description	Select the credential that qualifies you for this service	Specialty code	COS
Individualized Home Supports (IHS) (BI, CAC, and CADI)	Individualized Home Supports Provider Assurance Statement (DHS-3747) (PDF) AND the following: <input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____	IH	109
Night Supervision (BI, CAC, CADI and DD)	Choose one of the following: <input type="radio"/> (23) Chapter 144A Homecare license LICENSE NUMBER: _____ (Must have a current [57] basic license or [58] comprehensive license with HCBS designation on the license and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] (PDF)) <input type="radio"/> (24) Unrelated individual serving members of one family (Must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] (PDF)) <input type="radio"/> (27) Related individual serving one family member (must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] (PDF)) <input type="radio"/> (CP) Chapter 245D license LICENSE NUMBER: _____	NS	094
Nutritional Services (AC only)	AC Nutritional Services Provider Assurance Statement (DHS-6189B) (PDF) AND one of the following: <input type="radio"/> (LN) Licensed nutritionist <input type="radio"/> (LD) Licensed dietician <input type="radio"/> (15) Other professionals who meet license exemptions as per 148.632 and performance incidental to practice as one of the following: <input type="radio"/> (RD) Registered dietician <input type="radio"/> (RN) Registered nurse <input type="radio"/> (65) Adult Nurse Practitioner	NT	092
Personal Support (BI, CAC, CADI and DD)	Choose one of the following: <input type="radio"/> (23) Chapter 144A Homecare license LICENSE NUMBER: _____ (Must have a current [57] basic license or [58] comprehensive license with HCBS designation on the license) and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] (PDF)) <input type="radio"/> (24) Unrelated individual serving members of one family (Must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] (PDF)) <input type="radio"/> (27) Related individual serving one family member (must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] (PDF)) <input type="radio"/> (CP) Chapter 245D license LICENSE NUMBER: _____	PS	094
Positive Support Analyst (formerly known as Behavior Supports) (BI, CAC, CADI and DD)	Positive Supports Provider Assurance Statement (DHS-7807) (PDF) AND the following: <input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____	BN	035
Positive Support Professional (formerly known as Behavior Supports) (BI, CAC, CADI and DD)	Positive Supports Provider Assurance Statement (DHS-7807) (PDF) AND the following: <input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____	BP	035
Positive Support Specialist (formerly known as Behavior Supports) (BI, CAC, CADI and DD)	Positive Supports Provider Assurance Statement (DHS-7807) (PDF) AND the following: <input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____	BS	035

Service description	Select the credential that qualifies you for this service	Specialty code	COS
Prevocational Services (BI and CADI only)	Home and Community-Based Settings Provider Assurance Statement (DHS-7618) (PDF) AND the following: <input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____	PV	102
Crisis Respite (BI, CAC, CADI and DD)	<input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____	CR	107
Crisis Respite Specialized Staff (BI, CAC, CADI and DD)	Crisis Respite Specialized Staff Provider Assurance Statement (DHS-7886) (PDF) AND the following: <input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____	CP	107
Respite Care Services, In Home (Waiver, AC, MHM)	Choose one of the following: <input type="radio"/> (23) Chapter 144A Homecare license LICENSE NUMBER: _____ (Must have a current [57] basic license or [58] comprehensive license with HCBS designation on the license and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] (PDF)) <input type="radio"/> (24) Unrelated individual serving members of one family (Must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] (PDF)) <input type="radio"/> (27) Related individual serving one family member (must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] (PDF)) <input type="radio"/> (CP) Chapter 245D license LICENSE NUMBER: _____	RI	107
Respite Care Services, Out of Home (Waiver, AC, MHM)	Choose one of the following: <input type="radio"/> (23) Chapter 144A Homecare license LICENSE NUMBER: _____ (Must have a current [57] basic license or [58] comprehensive license with HCBS designation on the license) and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] (PDF)) <input type="radio"/> (24) Unrelated individual serving members of one family (Must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] (PDF)) <input type="radio"/> (27) Related individual serving one family member (Must complete and submit the 245D Exclusions Provider Assurance Statement [DHS-6189Z] (PDF)) <input type="radio"/> (87 and CP) Camp Certified by American Camp Association and Chapter 245D license <input type="radio"/> (CP) Chapter 245D license LICENSE NUMBER: _____ OR Complete and submit the 245D Exclusions Provider Assurance Statement (6189Z) (PDF) and be one of the following settings (indicate): <input type="checkbox"/> (AF, EW, LC) Adult Foster Care license <input type="checkbox"/> (HO) Certified Hospitals <input type="checkbox"/> (06, 07, 08) Certified Nursing Facilities <input type="checkbox"/> (C1-C9, L1, L2) Customized Living and 24-Hour Customized Living Supports <input type="checkbox"/> (03) Residential hospice facility as defined in Minn. Statutes, section 144A.75, subdivisions 6 and 13) ONLY for BI, CAC, CADI, or DD waivers	RO	107
Specialist Service (BI, CAC, CADI and DD)	<input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____	SS	105

Service description	Select the credential that qualifies you for this service	Specialty code	COS
Specialized Equipment and Supplies (Waiver, AC)	Specialized Equipment and Supplies Provider Assurance Statement (DHS-6189T) (PDF) AND one of the following: <input type="radio"/> (47) Pharmacies <input type="radio"/> (60) Home health agencies <input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF) <input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment) <input type="radio"/> (DD) Medical suppliers <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)	SU	032
		SX	116
Structured Day (BI Waiver Only)	Home and Community-Based Settings Provider Assurance Statement (DHS-7618) (PDF) AND the following: <input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____	SD	106
Supported Living Services (SLS), Adult (in home) (DD Waiver Only)	Home and Community-Based Settings Provider Assurance Statement (DHS-7618) (PDF) AND the following: <input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____	SL	105
Remote Support - Supported Living Services (SLS), Adult (DD Waiver Only)	Must be enrolled, or enrolling in Supported Living Services (SLS) Adult and complete the following: Remote Support - Supported Living Services Provider Assurance Statement (DHS-7706) (PDF) WITH the following: <input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____	RE	105
Supported Living Services (SLS), Adult, Adult Foster Care (out of home) (DD Waiver Only)	Home and Community-Based Settings Provider Assurance Statement (DHS-7618) (PDF) AND one of the following: <input type="radio"/> (CP) Chapter 245D license LICENSE NUMBER: _____ and (LC) AFC license LICENSE NUMBER: _____ <input type="radio"/> (CP) Chapter 245D license LICENSE NUMBER: _____ and (CR) CRS Satellite license LICENSE NUMBER: _____	SC	105
Supported Living Services (SLS), Child (out of home) (DD Waiver Only)	Home and Community-Based Settings Provider Assurance Statement (DHS-7618) (PDF) AND the following: <input type="checkbox"/> (CP) Chapter 245D license LICENSE NUMBER: _____ and (CF) Child Foster Care license LICENSE NUMBER: _____	SA	105
Transitional Services (Elderly Waiver)	Choose one of the following: <input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF) <input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment and signed Transitional Service Provider Assurance Statement (DHS-6189W) (PDF)) <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)	TS	022
Transitional Services, Deposits/Moving Expenses (BI, CAC, CADI and DD)	Choose one of the following: <input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF) <input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment and signed Transitional Service Provider Assurance Statement (DHS-6189W) (PDF)) <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)	TS	022
Transitional Services, Furniture (BI, CAC, CADI and DD)	Choose one of the following: <input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment and signed Transitional Service Provider Assurance Statement (DHS-6189W) (PDF)) <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)	TF	022

Service description	Select the credential that qualifies you for this service	Specialty	
		code	COS
Transitional Services, Household Supplies (BI, CAC, CADI and DD)	<p>Choose one of the following:</p> <p><input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment and signed Transitional Service Provider Assurance Statement [DHS-6189W] [PDF])</p> <p><input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)</p>	TH	022
Transportation (One-way Trip) (Waiver and AC)	<p>Waiver Transportation Provider Assurance Statement (DHS-6189Y) (PDF) AND one of the following:</p> <p><input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF)</p> <p><input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment)</p> <p><input type="radio"/> (CS) Certified special transportation DOT CERTIFICATION NUMBER: _____</p> <p><input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)</p> <p><input type="radio"/> (ZW) Common carriers</p>	TW	126
		TR	036
Transportation, Mileage (Commercial) (Waiver and AC)	<p>Waiver Transportation Provider Assurance Statement (DHS-6189Y) (PDF) AND one of the following:</p> <p><input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF)</p> <p><input type="radio"/> (CS) Certified special transportation DOT CERTIFICATION NUMBER: _____</p> <p><input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)</p> <p><input type="radio"/> (ZW) Common carriers</p>	TM	036
Transportation, Mileage (Noncommercial) (Waiver and AC)	<p>Waiver Transportation Provider Assurance Statement (DHS-6189Y) (PDF) AND one of the following:</p> <p><input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF)</p> <p><input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment)</p> <p><input type="radio"/> (CS) Certified special transportation DOT CERTIFICATION NUMBER: _____</p> <p><input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)</p> <p><input type="radio"/> (ZW) Common carriers</p>	TN	126

Additional services for Moving Home Minnesota (MHM)

Service description	Select the credential that qualifies you for this service	Specialty	
		code	COS
Overnight Assistance	<p><input type="checkbox"/> (DA) Overnight Assistance Assurance Statement DHS-6808 (PDF)</p>	NS	094
Specialized Supplies and Equipment, MHM	<p>Specialized Supplies and Equipment Provider Assurance Statement (DHS-6189T) (PDF) AND one of the following:</p> <p><input type="radio"/> (47) Pharmacies</p> <p><input type="radio"/> (60) Home health agencies</p> <p><input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment)</p> <p><input type="radio"/> (DD) Medical suppliers</p> <p><input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)</p>	SV	116
		TS	022
Transitional Services Coordination	<p>Choose one of the following:</p> <p><input type="radio"/> (DA) DHS Approved as MHM – Transition Planning, Transition Coordination and Demonstration Case Management – Provider Assurance Statement (DHS-3879) (PDF)</p> <p><input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)</p>	TS	022

Service description	Select the credential that qualifies you for this service	Specialty code	COS
Transitional Services, Furniture	Choose one of the following: <input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment and signed MHM – Transition Planning, Transition Coordination and Demonstration Case Management – Provider Assurance Statement (DHS-3879) (PDF)) <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)	TF	022
Transitional Services, Household Supplies	Choose one of the following: <input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment and signed MHM – Transition Planning, Transition Coordination and Demonstration Case Management – Provider Assurance Statement (DHS-3879) (PDF)) <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)	TH	022
Membership Fees	Choose one of the following: <input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment and signed MHM – Transition Planning, Transition Coordination and Demonstration Case Management – Provider Assurance Statement (DHS-3879) (PDF)) <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)	MP	043
Comprehensive Community Support Services	Choose one of the following: <input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment and signed MHM – Transition Planning, Transition Coordination and Demonstration Case Management – Provider Assurance Statement (DHS-3879) (PDF)) <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)	CY	109
Pre-discharge Case Consultation and Collaboration	Choose one of the following: <input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF) <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)	CX	109
Post-discharge Case Consultation and Collaboration	Choose one of the following: <input type="radio"/> (AA) HCBS Lead Agency Enrollment Request Form (DHS-6383) (PDF) <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)	CX	109
Tools, Clothing, and Equipment Necessary for Employment	Choose one of the following: <input type="radio"/> (DA) DHS Approved (compliance with MHCP waiver provider enrollment and signed MHM – Transition Planning, Transition Coordination and Demonstration Case Management – Provider Assurance Statement (DHS-3879) (PDF)) <input type="radio"/> (LA) Lead Agency (County or Tribal Human Service)	ES	032

Provider Statement

I certify that the information provided on this form is accurate, complete and truthful. I will notify MHCP Provider Eligibility and Compliance of any changes to this information. I acknowledge that any misrepresentations in the information submitted to MHCP, including false claims, statements, documents or concealment of a material fact, may be cause for denial or termination of participation as a Medicaid provider.

AUTHORIZED PROVIDER REPRESENTATIVE (type or print clearly)		
AUTHORIZED PROVIDER REPRESENTATIVE SIGNATURE (required)	TITLE	DATE (mm/dd/yyyy)

Complete this request online using the [Minnesota Provider Screening and Enrollment \(MPSE\) portal](#) or fax the first and last page of this form and any other pages that show a service selected to 651-431-7493. You do not need to fax all pages of this document.