Registration for Supplemental Nursing Services Agency

In accordance with Minnesota Statutes, Section 13.41, **ALL DATA SUBMITTED ON THIS REGISTRATION FORM SHALL BE CLASSIFIED PUBLIC INFORMATION UPON ISSUANCE OF A REGISTRATION CERTIFICATE.**

Please answer all questions completely and accurately to avoid unnecessary delay. Once completed mail to:

Minnesota Department of Health
Health Regulation Division
Federal Licensing and Certification Program
PO Box 64900
St. Paul, MN 55164-0900

The undersigned hereby registers to operate a Supplemental Nursing Services Agency subject to Minnesota Statutes, Chapters 144.057, 144A.70 - 74.

Identification

Each separate location of the business of a supplemental nursing services agency shall have a separate registration.

Agency Name _____

Agency Street Address _____
(P.O. Box address without a street address is unacceptable.)

Agency City/State/Zip _____

Telephone Number _____

Hours of Operation _____

Administrator _____

Email Address _____

Name of county in which the agency is located _____

Name of county/counties in Minnesota in which the agency provides services _____

_____

_____

Ownership

Fill in the code that corresponds to the type of entity legally responsible for operating the facility.

Ownership Code_____

Governmental Non-Federal	Governmental Non-Profit	Non-Governmental for Profit	Other
11. State 12. County 13. City 14. City-County 15. Hospital district of Authority	20. Church-related 21. Nonprofit Corporation 22. Other Nonprofit Ownership	23. Individual 24. Partnership 25. Corporation 26. Group 28. Limited Liability Company 29. Business Trust 30. Housing and Redevelopment Employment	27. Tribal

Legal entity name of SNSA as it appears on the Minnesota Office of the Secretary of State. _____

_____

Federal ID # _____ State Tax ID # _____

President _____

Management Agent (if different from owner)

Name _____

Street Address _____

City, State, Zip_____

Specific Information

What other Minnesota health care facility licenses does the owner hold? Please list. _____

_____

What supplemental nursing services will be provided or procured in which type of health care facility? For each type of supplemental nursing service, indicate estimated total number of employees for each category and the type(s) of health care facility they are being supplied to.

"Health care facility" means a hospital, boarding care home, or outpatient surgical center licensed under sections 144.50 to 144.58; a nursing home or home care agency licensed under this chapter; an assisted living facility licensed under chapter 144G; or a board and lodging establishment that is registered to provide supportive or health supervision services under section 157.17.

Supplemental Nursing Services	**Total number of employees**	**Type of Health Care Facility** ***(Check all that apply)***
Registered Nurses		☐ Hospitals ☐ Nursing Homes ☐ Home Care ☐ Assisted Living
Licensed Practical Nurses		☐ Hospitals ☐ Nursing Homes ☐ Home Care ☐ Assisted Living
Nursing Assistants		☐ Hospitals ☐ Nursing Homes ☐ Home Care ☐ Assisted Living
Nurse Aides		☐ Hospitals ☐ Nursing Homes ☐ Home Care ☐ Assisted Living
Orderlies		☐ Hospitals ☐ Nursing Homes ☐ Home Care ☐ Assisted Living

Supplemental Nursing Service Agency Controlling Person Information Sheet.

Background studies must be submitted and cleared for all controlling persons through Minnesota Department of Human Services (DHS) Background Studies. Once MDH receives and processes this registration form, DHS Background Studies will contact you by email with information about the background study process and instructions to access your "in application" account.

A controlling person means a business entity, officer, program administrator, or director whose responsibilities include the direction of the management or policies of a supplemental nursing services agency. Controlling person also means an individual who, directly or indirectly, beneficially owns an interest in a corporation, partnership, or other business association that is a controlling person.

Per Minnesota Statues Chapter 245C.03, any controlling person holding a valid license issued by a health-related licensing board (HLB) who has undergone a background and a criminal history check under Minn. Statutes 214.075, shall not have a background study completed by the commissioner of human services (a NETStudy 2.0 background study).

Please provide the legal names, titles and addresses of all controlling persons and their percentage of ownership. If you need more space, make an additional copy of this page.

Legal name of controlling person: _____

Title: _____

Address (Street, City, State and Zip code): _____

Percentage of ownership (if for-profit): _____

MN HLB license issued by: _____

MN HLB license number: _____

Legal name of controlling person: _____

Title: _____

Address (Street, City, State and Zip code): _____

Percentage of ownership (if for-profit): _____

MN HLB license issued by: _____

MN HLB license number: _____

Legal name of controlling person: _____

Title: _____

Address (Street, City, State and Zip code): _____

Percentage of ownership (if for-profit): _____

MN HLB license issued by: _____

MN HLB license number: _____

Verification/Registration Fee

To the best of my knowledge, I certify that the information provided on this form is accurate and complete.

I understand that the Minnesota Department of Health may conduct an onsite visit at any time to examine records to validate that the information provided is true and correct.

The SNSA registered with the Minnesota Department of Health, declares that each temporary employee provided to health care facilities is an employee of the SNSA and is not an independent contractor.

All employees will meet the minimum licensing, training, and continuing education standards for the position in which the employee will be working.

Name (type or print) _____

Signature of authorized representative _____

Title _____

Date _____

The following must be received before your application is complete:

- Enclose the $2,035.00 annual registration fee made payable to the Minnesota Department of Health at the address listed below.
- A procedure that describes how the SNSA's records will be immediately available at all times to the Commissioner of Health and that all records will be retained for five calendar years.
- Articles of Incorporation or Articles of Organization.
- Current by-laws or operating agreement.
- An organizational chart.
- Evidence of medical malpractice insurance (professional liability insurance is acceptable).
- Evidence of employee dishonesty bond in the amount of $10,000.00.
- Evidence of current workers' compensation coverage as required by Minnesota Statutes, Sections 176.181 and 176.182.
- Name and address of the bank, savings bank, or savings association in which the SNSA will deposit all the SNSA's employees' income tax withholdings. If you believe you are not responsible for employee income tax withholding, you must provide the name and address of each employee for whom income taxes are not being withheld.

Minnesota Department of Health
Health Regulation Division
Federal Licensing and Certification Program
P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4200
health.SNSA.email.box@state.mn.us

09/08/2022
To obtain this information in a different format, call: 651-201-4200.