Application for Home Care Licensure –
General Instructions

General Instructions

This application form should be used by individuals and organizations seeking initial approval to operate as a licensed home care provider and by licensed providers seeking approval for a proposed change of ownership or transfer of operational control to a different entity pursuant to Minn. Stat. Sec. 144A.472, subd. 5.

Instructions to Attachments

Some sections in this application require the applicant to submit attachments. Identify each attachment in the upper right hand corner with the number or letter as indicated in the application.

You must submit agency-specific policies and procedures as listed in the checklist at the end of this application. These policies and procedures must be in compliance with Minnesota home care laws. A list of questions (Home Care Statutes Study Guide) that address these requirements is available on our website for applicant use.

Submission Requirements

Mail the completed application (including all required documents and fees) to:

Minnesota Department of Health
Health Regulation Division
Home Care and Assisted Living Program
P.O. Box 3879
St. Paul, Minnesota 55101-3879

Applications for changes of ownership must be received in our office at least 60 days prior to the effective date of the transfer of operations or sale transaction.

Acknowledgement of Application Received

HCALP will acknowledge receipt of the application in a letter or email to the applicant. Any required materials or documentation omitted from the application will be indicated. The acknowledgement letter/email will serve as notice as to whether the application appears complete or incomplete.

Review Process

As part of the review process, additional information may be requested. Answer all questions completely and accurately to avoid unnecessary delay. The department has up to 60 days from the date a completed application is received to issue a temporary license. Application materials will not be returned to applicants.

Whom to Contact for Assistance

Direct questions regarding the application to the Home Care and Assisted Living Program at: Health.homecare@state.mn.us or by phone: 651-201-5273.
Comprehensive Home Care Provider License Application Form

Type of Application (check one)

☐ Temporary License (new provider)

☐ Change of Ownership/Operator (CHOW)

Proposed effective date for change of ownership: ________________________________

Name of existing licensee: ______________________________________________________

Existing licensee’s federal tax ID: __________________________ HFID* # ___________________

* HFID = Health Facility ID number

A. Applicant Information

1. Assumed Name / “Doing Business As” Name (DBA): ________________________________

Physical Address: ________________________________________________________________

City: _____________________________ State: _______ Zip: _____________________________

County: ____________________________

Telephone: __________________________ Fax: ________________________________________

Mailing Address (if different from above): ____________________________________________

City: _____________________________ State: _______ Zip: _____________________________

2. Website (if applicable): ______________________________________________________

3. Office physically located within:

    _____ Commercial Business Building       _____ Private Home/Residence

    _____ Other Licensed Facility or Provider       _____ Other: ________________________

Oct-16 Comprehensive Home Care License Page 2
Office Hours

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<tr>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
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<th>Saturday</th>
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4. A home care provider must designate one agent who is **authorized to receive all notices and orders (including license renewal information, survey & complaint investigation results)**. This information will be mailed and/or emailed to the mailing address or email address provided. Applicants must provide an email address.

Agent: ________________________________________________Title: ____________________________
Telephone: _________________________ Email: ____________________________________________

Provide the name and contact information of the individual to contact for **questions regarding this application**:

☐ Check box if same as above (and add fax number)

Contact Name: ________________________________________________________________________
Telephone: ___________________________ Fax: ___________________________
Email: ________________________________________________

**Description of Other Licenses**

5. Indicate the other types of Minnesota-issued licenses the applicant/licensee holds. Answer each question and provide the license number for each license that applies:

a. Family Adult Foster Care: Yes___ No___ Pending ___ License #___________
b. Corporate Adult Foster Care: Yes___ No___ Pending ___ License #___________
c. Adult Day Care: Yes___ No___ Pending ___ License #___________
d. Home and Community-Based Services under 245D: Yes___ No___ Pending ___ License #_______
e. Personal Care Assistance Provider: Yes___ No___ Pending ___ License #_______
f. Other Minnesota Home Care Provider License Yes___ No___ License #__________________
g. Other______________________________________ License #__________________
h. Do you hold any other home health-related licenses issued by a different state? If so, please list current licenses:
____________________________________________________________________________________
____________________________________________________________________________________

6. Has an owner or managerial official of this applicant ever had a license revoked by the Minnesota Department of Health, the Minnesota Department of Human Services, or any state agency in any state or jurisdiction? Yes_______ No_______
If yes, please explain:  
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

B. Home Care Services

**Housing with Services (HWS)**

A HWS establishment registration is required of home care licensees if the licensee provides sleeping accommodations to one or more adult residents, at least 80 percent of whom are 55 years of age or older and provides, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services.

Refer to 144D.01 Subd. 4 and 144D.025 for complete definitions and exclusions before answering this question:

1. Will you provide services in a HWS setting as defined in the above statute?  ____ Yes  ____ No  
   
   If your answer is “yes” submit a HWS application as per the instructions found at:  

2. List all Housing with Services establishments to be served by this provider (if applicable).  
   
   For changes in ownership (CHOW), please enter:  
   “A” if adding this location as a HWS served since the last license renewal.  
   “R” if removing this location as a HWS served since the last license renewal.  
   “NC” if there has been no change.

<table>
<thead>
<tr>
<th>Enter A, R or NC</th>
<th>HWS HFID #</th>
<th>Name</th>
<th>Address</th>
<th>Number of Clients Served</th>
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3. Will you provide services to clients who do not live in a HWS setting? In other words, will you provide services to clients in their own homes, apartments or other dwellings that do not hold a HWS registration?  
   ____ Yes  ____ No  

4. List the number of clients served who do not live in an HWS setting:  ________ (CHOWs only)
Counties Served

5. List the counties where you intend to provide services. Do not list the counties where you do not intend to provide services: 

_________________________________________________________________________

Home Care Services Offered

6. The licensee (as described in Section C. Question 1) must provide at least one comprehensive home care service directly, meaning this service is either provided in its entirety by the individual listed in Section C.1 or the service is provided in its entirety by an employee of the licensee listed in Section C.1. Refer to MN Statute 144A.471 Subd. 2 for a definition of “direct home care service.” Services provided by contract are not direct services.

For every service that this provider offers, please enter:

"1" – if the services are provided directly by the licensee or licensee’s employees
"2" - if the services are provided by contract with another licensed provider
"3" - if the services are provided both directly by the licensee or licensee’s employees and by contract

_____ Advanced Practice Nurse Services
_____ Registered Nurse Services
_____ Licensed Practical Nurse Services
_____ Physical Therapy Services
_____ Occupational Therapy Services
_____ Speech Language Pathologist Services
_____ Respiratory Therapy Services
_____ Social Worker Services
_____ Services by a Dietitian or Nutritionist

_____ Medication Management Services*
_____ Delegated Tasks to Unlicensed Personnel*
_____ Hands-on assistance with transfers and mobility**
_____ Providing eating assistance for clients with complicating eating problems (i.e. difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube, parenteral or intravenous instruments)

_____ Complex or Specialty Healthcare Services (explain): **_____________________________________________________________________

*In order to consider Medication Management Services and Delegated Tasks to Unlicensed Personnel as services provided directly, the RN (or the licensed health professional, in the case of non-nursing delegated tasks to unlicensed personnel) must also be a direct employee of the licensee.

**Refer to the FAQs on the MDH website for definitions and clarification:
http://www.health.state.mn.us/divs/fpc/homecarelic2013faq.html
Other Services Offered:

"1" – if the services are provided **directly** by the licensee or licensee’s employees

"2" - if the services are provided by **contract** with another licensed provider

"3" - if the services are provided **both directly by the licensee or licensee’s employees and by contract**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ Assistance with dressing, self-feeding</td>
<td>_____ Providing verbal or visual reminders to the client to perform regularly scheduled treatments and exercises</td>
</tr>
<tr>
<td>oral hygiene, hair care, grooming, toileting, and bathing</td>
<td></td>
</tr>
<tr>
<td>_____ Providing standby assistance within arm’s reach for safety while</td>
<td>_____ Preparing modified diets ordered by a licensed health professional containers, or liquid or</td>
</tr>
<tr>
<td>performing daily activities</td>
<td>food to accompany the medication)</td>
</tr>
<tr>
<td>_____ Providing verbal or visual reminders to take regularly scheduled</td>
<td>_____ Housekeeping</td>
</tr>
<tr>
<td>medication (includes bringing clients previously set-up medication,</td>
<td>_____ Meal Preparation</td>
</tr>
<tr>
<td>medication in original containers, or liquid or food to accompany the</td>
<td>_____ Shopping</td>
</tr>
<tr>
<td>medication)</td>
<td></td>
</tr>
<tr>
<td>_____ Housekeeping</td>
<td></td>
</tr>
<tr>
<td>_____ Meal Preparation</td>
<td></td>
</tr>
<tr>
<td>_____ Shopping</td>
<td></td>
</tr>
</tbody>
</table>

7. If you are providing or will provide a service that requires a registered nurse (RN), provide the RN’s name, license number and mailing address.

| Name: ____________________________ | License #: ____________________________ |
| Address: __________________________________________________________ |                                                                 |
| City: _______________ State: _______ Zip: _________________________ |

| MDH use only: Date RN Background Study Completed: | Request ID: |

Questions 8-12 apply to Changes of Ownership

8. Has the current licensee provided home care services in the past 12 months?

   Yes: _____ No: _____ Provide the last date of service: ____________________________

9. Current source of home care income derived from the provision of home care services: (please check all that apply) (CHOWs only)

   _____ Private Pay
   _____ Private Insurance
   _____ Medical Assistance/Medicaid (Waiver money)
   _____ Medicare
   _____ Veterans Administration
   _____ Long Term Care Insurance
   _____ Other (specify) ______________________
10. Indicate the current number of clients served by age range:

- under 22
- 22–45
- 46–65
- 66–84
- 85+

11. Are you currently a Medicare-certified home health agency (HHA)? Yes: ___ No: ___

If yes, insert your Medicare number: 24- _______________________

12. If applicable, list the address and telephone number for each additional office location. Enter an A if adding this location, R if removing, and NC if there has been no change.

Other Office Locations

<table>
<thead>
<tr>
<th>Enter A, R or NC</th>
<th>Address</th>
<th>Phone</th>
</tr>
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Note: Multiple units of a provider must be separately licensed if the commissioner determines that the units cannot adequately share supervision and administration of services with the main office.

C. Licensee/Ownership Information

State law requires that all applicants for home care licensure must disclose the names, email and mailing addresses and telephone numbers of all owners and managerial officials, regardless of the nature of the entity applying for licensure. The purpose of this section is to collect information about the person(s) and/or entity responsible for the operation of this home care provider.

Provide the name of the legal entity if you have formed a business entity. Generally, this means you are operating as a business corporation, nonprofit corporation, limited liability company, partnership, or you are a government entity.

Provide the name of the individual if you are operating as a sole proprietorship, which means the business is owned and operated by an individual and in which there is no legal distinction between the owner and the business. Note that a sole proprietorship must still register with the Minnesota Office of the Secretary of State to use an assumed name, may have employees, and may obtain a federal tax ID from the Internal Revenue Service.

Note: The applicant/licensee must provide at least one home care service directly, meaning this service is either provided by the individual listed below (sole proprietorships) or the service is provided by an employee(s) of the legal entity/sole proprietor below. Services provided by contract are not direct services. Refer to MN. Stat. Sec. 144A.471, Subd. 2 for the "Determination of direct home care service."
1. Print the full legal entity name as it appears on file with the Minnesota Office of the Secretary of State – do not abbreviate. In the case of a sole proprietorship, print the full legal name of the owner.

Name: ____________________________________________

Federal Tax ID #: ___________________ State Tax ID #: ___________________

Parent Company

2. Is the applicant/licensee (entity listed in Section C, Number 1) a subsidiary of another organization? If yes, provide the information requested below:

Parent Organization Name: ___________________________________________________________

Parent Organization Federal Tax ID: ______________________

Parent Organization Address: __________________________________________________________

City/State/Zip: ______________________________________________________________________

3. Select the owner type that applies to this application. Then note the submissions required by the category checked and identify all submitted attachments by the indicated letter.

☐ Sole Proprietorship  ☐ For-Profit Corporation  ☐ Nonprofit Corporation

☐ For-Profit Limited Liability Company (LLC)  ☐ Nonprofit Limited Liability Company (LLC)

☐ Partnership  ☐ State  ☐ County  ☐ City  ☐ Tribal  ☐ Church  ☐ Health District or Authority

A. SOLE PROPRIETORSHIP
A Sole Proprietor must submit the following:
• Attachment A: Copy of the certificate of doing business under an assumed name (if applicable).

B. FOR-PROFIT CORPORATION
The corporation must submit the following:
• Attachment A: Copy of the certificate of doing business under an assumed name (if applicable).
• Attachment B: Copy of the certificate of incorporation.
• Attachment C: Complete list of all board members, officers, and principal stockholders indicating position or title of each and the number of shares of stock to be owned by each.
• Attachment D: Brief description of the organization structure of the agency, including a table of organization and relationship to any existing parent entity (if applicable).

C. NONPROFIT CORPORATION
The corporation must submit the following:
• Attachment A: Copy of the certificate of doing business under an assumed name (if applicable).
• Attachment B: Copy of the certificate of incorporation.
• **Attachment C:** Complete list of all board members, officers and members indicating position or title of each and a brief description of the membership interests, if applicable.

• **Attachment D:** Brief description of the organization structure of the agency, including a table of organization and relationship to any existing parent entity (if applicable).

**D. LIMITED LIABILITY COMPANY (For-profit or Nonprofit)**
The limited liability company (LLC) must submit the following:

• **Attachment A:** Copy of a certificate of doing business under an assumed name (if applicable).

• **Attachment B:** Copy of the most current Articles of Organization.

• **Attachment C:** Complete list of all board members, managers (including the Chief Manager), and members (owners) indicating position or title of each and the percent of ownership of each member (owner).

• **Attachment D:** If the LLC will be managed by managers who are not members, a copy of the existing management agreement between the LLC and the manager.

• **Attachment E:** Brief description of the organization structure of the agency, including a table of organization and relationship to any existing parent entity (if applicable).

**E. PARTNERSHIP**
The partnership must submit the following:

• **Attachment A:** Copy of the certificate of doing business under an assumed name (if applicable).

• **Attachment B:** Specification of type of partnership.

• **Attachment C:** Complete list of partners.

• **Attachment D:** Copy of the partnership agreement.

• **Attachment E:** Brief description of the organization structure of the agency, including a table of organization and relationship to any existing parent entity (if applicable).

**F. GOVERNMENT SUBDIVISION/TRIBAL**
A city, county, state or tribal licensee must submit the following:

• **Attachment A:** Copy of the certificate of doing business under an assumed name (if applicable).

• **Attachment B:** Brief description of the organization structure of the agency.

**G. CHURCH/HEALTH DISTRICT OR AUTHORITY**
A church or health district/authority must submit the following:

• **Attachment A:** Copy of the certificate of doing business under an assumed name (if applicable).

• **Attachment B:** Brief description of the organization structure of the agency.

**Applicant/Licensee Ownership Interests**

4. On the following page, provide the full legal name, title, address, phone number, and email address for all officers, directors, partners and owners of the licensee listed in Section C, Question 1. Also, include the percent of ownership or interest and indicate if the individual will have direct contact with home care clients. You can copy this page if additional space is needed.

Owners are individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider. An individual who has less than 5% of equity interest or voting stock is not considered an “owner” for purposes of this section.
D. Managerial Officials

Legal Name: ___________________________ Title: ___________________
Permanent Address (PO Box is not acceptable): _____________________________
City/State/Zip: ______________________________________________________________________
Telephone: ___________________________ Email Address: _____________________________
Owner/Member: ______% of ownership | Will this individual provide direct contact? Yes ____ No_____

**MDH use only:** Date Background Study Completed: ______ | Request ID: ______

Legal Name: ___________________________ Title: ___________________
Permanent Address (PO Box is not acceptable): _____________________________
City/State/Zip: ______________________________________________________________________
Telephone: ___________________________ Email Address: _____________________________
Owner/Member: ______% of ownership | Will this individual provide direct contact? Yes ____ No_____

**MDH use only:** Date Background Study Completed: ______ | Request ID: ______

Legal Name: ___________________________ Title: ___________________
Permanent Address (PO Box is not acceptable): _____________________________
City/State/Zip: ______________________________________________________________________
Telephone: ___________________________ Email Address: _____________________________
Owner/Member: ______% of ownership | Will this individual provide direct contact? Yes ____ No_____

**MDH use only:** Date Background Study Completed: ______ | Request ID: ______

Legal Name: ___________________________ Title: ___________________
Permanent Address (PO Box is not acceptable): _____________________________
City/State/Zip: ______________________________________________________________________
Telephone: ___________________________ Email Address: _____________________________
Owner/Member: ______% of ownership | Will this individual provide direct contact? Yes ____ No_____

**MDH use only:** Date Background Study Completed: ______ | Request ID: ______

D. Managerial Officials
Provide the name, title, address, phone number, and email address for all managerial officials. Also, indicate whether this individual will have direct contact with home care clients. “Managerial Official” means an administrator, director, officer, trustee, or an employee of a home care provider (however designated) who has the authority to establish or control business policy.

There is no need to submit information in this section for individuals who were already listed as owners in the previous section. Attach an additional sheet if necessary.

Legal Name: _____________________________________________ Title: _______________________
Permanent Address (PO Box is not acceptable): _____________________________________________
City/State/Zip: ________________________________________________________________________
Telephone: ___________________________ Email Address: _______________________________________
Type of Managerial Official (check one): ☐ Administrator ☐ Director ☐ Officer ☐ Trustee
☐ Other or Employee ________________ | Will this individual provide direct contact? Yes ___ No____

MDH use only: Date Background Study Completed: | Request ID:

Legal Name: _____________________________________________ Title: _______________________
Permanent Address (PO Box is not acceptable): _____________________________________________
City/State/Zip: ________________________________________________________________________
Telephone: ___________________________ Email Address: _______________________________________
Type of Managerial Official (check one): ☐ Administrator ☐ Director ☐ Officer ☐ Trustee
☐ Other or Employee ________________ | Will this individual provide direct contact? Yes ___ No____

MDH use only: Date Background Study Completed: | Request ID:

Legal Name: _____________________________________________ Title: _______________________
Permanent Address (PO Box is not acceptable): _____________________________________________
City/State/Zip: ________________________________________________________________________
Telephone: ___________________________ Email Address: _______________________________________
Type of Managerial Official (check one): ☐ Administrator ☐ Director ☐ Officer ☐ Trustee
☐ Other or Employee ________________ | Will this individual provide direct contact? Yes ___ No____

MDH use only: Date Background Study Completed: | Request ID:
2. Will there be another legal entity providing management services for this home care provider? If so, complete the following information:

Legal Entity Name: _________________________________________________________________

Permanent Address (PO Box is not acceptable): _______________________________________

City/State/Zip: ___________________________________________________________________

Telephone: ___________________________ Email Address: ________________________________

Type of Managerial Official (check one): □ Administrator □ Director □ Officer □ Trustee

□ Other or Employee ________________ | Will this individual provide direct contact? Yes ___ No____

MDH use only: Date Background Study Completed: | Request ID:

Submit a copy of the management agreement between the applicant and the entity providing management services.
E. Background Studies

Initial applicants and applicants for changes of ownership must submit background studies for all owners, managerial officials and the named RN. See MN Statute 144A.476.

As a part of the application process and upon receipt of the application, MDH will assign a health facility identification (HFID) number for applicants to submit background studies through the Department of Human Services for all owners and managerial officials, including the RN named in the application. Review the steps to initiate background studies using the Instructions for Conducting Background Studies with NETStudy 2.0.

If there are questions about any background study, the named individual in the study must contact the Background Study Administrator at dhs.backgroundstudyadmin@state.mn.us or (651) 431-6620. The background study process may take longer for out-of-state individuals.

F. Evidence of Workers’ Compensation Insurance

State law requires that the Commissioner of Health shall withhold the license for the operation of a health care provider until the applicant presents acceptable evidence of compliance with workers’ compensation coverage provisions. If the licensee listed in Section C Question 1 has employees it must have active workers’ compensation insurance and this licensee must be listed as the insured entity. If you have just made an application for workers’ compensation insurance, evidence of your application is not acceptable as evidence of coverage. You will not be issued a license to operate as a health care provider unless acceptable evidence of compliance with Minn. Statutes 176.181 and 176.182 is presented with this application.

Check the type of evidence of coverage that is included with this application.

- Certificate of Workers’ Compensation Insurance Coverage
  This document is to be supplied by an authorized workers’ compensation carrier pursuant to Minn. Statute 60A.06, Subd. 1(5b). The Certificate of Insurance must be in effect prior to the issuance of a license.

- Self-Insured Workers’ Compensation (Including Attachment “A”)
  This type of coverage is generally held by large organizations. The certificate is issued from the Commissioner of Commerce permitting an organization to self-insure pursuant to Minn. Statute 79A and Minn. Rules Chapter 2780. Questions regarding self-insurance should be directed to the Minnesota Department of Commerce.

- Self-Insured as a Government Entity
  Written confirmation from your Third Party Administrator or evidence of coverage from the Workers’ Compensation Reinsurance Association (WCRA) allowing you to self-insure as a Government Entity/Political Subdivision pursuant to Minn. Statute 176.81, Subd. 2. The Reinsurance Certificate must be renewed annually on a calendar year basis.
**I do not have an employee**

This option is only applicable if the home care provider does not have employees.

"Employee" must be defined by the definition located in Minn. Stat. 176.011, subd. 9.

If you do not plan to hire employees for your home care agency as of now, please confirm in writing by submitting a definitive signed letter. This letter must include your address and state that you are not planning to hire employees. If the situation changes and you hire employees, you agree to contact MDH.

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**G. Fees**

A fee must accompany all applications. An application without a fee is considered incomplete. All fees are nonrefundable. A fee of $30.00 will be charged for any payment rejected due to insufficient funds.

**Type of Application:**

- **Temporary License Applications:**
  
  Comprehensive License Application Fee: **$4,200**

- **Change of Ownership Applications:**
  
  Comprehensive License Application Fee: **$4,200**

- **License Renewal Applications:**
  
  Note: Renewal licenses must be completed online and not through this paper application. Contact our office at Health.homecare@state.mn.us for questions about renewing a license.

**Please make checks payable to:** Minnesota Department of Health
H. Managerial Official Verification

This section must be completed and signed by an owner or managerial official, which official will be held accountable for ensuring the licensee’s compliance with Minnesota home care laws.

Read the following statements, initial each, if true, and sign below.

I certify that I have read and understand the following Minnesota Statutes:

_____ Home Care Laws, Chapter 144A, Sections 144A.43 through 144A.484
_____ Housing with Services Establishment, Chapter 144D (if applicable)
_____ Assisted Living Services, Chapter 144G (if applicable)
_____ Reporting of Maltreatment of Minors, MN Statute Section 626.556
_____ Reporting of Maltreatment of Vulnerable Adults, MN Statute Section 626.557

_____ I understand that pursuant to Minnesota Statute 13.04, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets Minnesota Statute sections 144A.43 through 144A.484 requirements for temporary licenses and licenses. You are not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of your application or may be grounds for denying a temporary license or license. Information submitted to the Commissioner in this licensing application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, Offices of the Ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys’ offices, police, local or county public health offices.

_____ I understand that in accordance with Minnesota Statute 144.051, all data submitted on this application shall be classified as public information upon issuance of a temporary license or license. All data submitted are considered private until a license is issued.

I declare that I have examined this application and all attachments and, to the best of my knowledge and belief, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required.

Name (print or type): _________________________________________ Date: _______________
Signature: _________________________________________ Title: ________________________

(A Home Care Provider Change of Information Form can be found on the MDH website for this purpose.)
Checklist for Comprehensive Temporary License and Comprehensive Change of Ownership Applications

Applicants must fill out this checklist and include it with their application, along with the appropriate fee, and attachments, including all policies and procedures outlined below. Label the attachments as indicated. A list of questions (Home Care Statutes Study Guide) that address these requirements is available on our website for applicant use.

☐ Include a check or money order payable to: Minnesota Department of Health
  • Temporary comprehensive license application fee - $4,200
  • Change of ownership comprehensive license application fee - $4,200

☐ Attachment #1 - Include evidence of workers’ compensation insurance coverage.

Develop and include the following agency-specific policies and procedures (144A.472).
  ☐ Attachment #2 - Requirements for reporting of maltreatment of minors (626.556) and reporting of maltreatment of vulnerable adults (626.557).
  ☐ Attachment #3 - Requirements for instructors, training content and competency evaluations (144A.4795, Subd. 7).
  ☐ Attachment #4 - Training, orientation and competency evaluations of home care staff (144A.4795 & 144A.4796).
  ☐ Attachment #5 - Complaint and investigation process (144A.4791, subd. 11).
  ☐ Attachment #6 - Service plan implementation and revisions (144A.4791, subd. 9).
  ☐ Attachment #7 - Home care client bill of rights (144A.44 and 144A.4791, subd. 1).
  ☐ Attachment #8 - Tuberculosis prevention: control plan & risk assessment (144A.4798, subd. 1).
  ☐ Attachment #9 - Comprehensive assessment, monitoring, & reassessment (144A.4791, subd. 8).
  ☐ Attachment #10 - Supervision of unlicensed personnel performing delegated home care tasks (144A.4797).

☐ Attachment #11 - If you have liability insurance, please also include evidence of this coverage.

☐ Attachment #12 - Federal tax identification number (FEIN) documentation (IRS form SS-4)

☐ Attachment #13 – Bill of sale or transfer of ownership documents (for CHOWs, when available)

☐ Attachments A-E (as applicable) from Licensee/Ownership Information section

☐ Confirm if you are also submitting a Housing with Services application as per instructions on p. 4. Do not attach your HWS application here.

☐ Submit a copy of the management agreement between the applicant and the entity providing management services (if applicable).
Notice from Temporary Licensee of Providing Licensed Home Care Services

A temporary license is valid for up to 12 months from the effective date. During the temporary license year, the department will conduct an initial full survey of the temporary licensee and if the temporary licensee is in substantial compliance with home care laws, issue a license. If the temporary licensee does not provide licensed home care services during the 12-month period, no survey is conducted and the temporary license will expire.

Temporary licensees must notify the department as soon as you provide licensed home care services to your first client.

Home Care Provider / Agency Name: ________________________________________________

Health Facility ID (HFID): ________________ Date home care services started: _______________

Number of clients receiving home care services: _______________________________________

Check all the licensed home care services you are currently providing under this license.

Temporary Comprehensive License
☐ Advanced Practice, Registered or Licensed Practical Nurse Services
☐ Physical/Occupational Therapy, Speech Language Pathologist or Respiratory Therapy Services
☐ Social Worker, Dietician or Nutritionist Services
☐ Medication Management Services
☐ Delegated tasks to unlicensed personnel
☐ Hands-on assistance with transfers and mobility
☐ Providing eating assistance for clients with complicating eating problems
☐ Complex or Specialty Healthcare Services – Describe: ________________________________

Temporary Basic and Temporary Comprehensive Licenses
☐ Assistance with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing
☐ Standby assistance within arm’s reach for safety while performing daily activities
☐ Verbal or visual reminders to take regularly scheduled medication
☐ Verbal or visual reminders to the client to perform regularly scheduled treatments and exercises
☐ Preparing modified diets ordered by a licensed health professional

Integrated License: Home and Community-based Services Designation
If you have the integrated license designation check the services you are currently providing. (If you are providing these services but do not have the designation or a 245D license contact us for more information.)

☐ 24-hour emergency assistance
☐ Companion services
☐ Homemaker services
☐ Night supervision
☐ Respite care services
☐ Personal support
☐ Individual community living support (temporary comprehensive home care providers only)

This licensee’s current clients are paying for home care services by:
☐ Private Pay
☐ Private Insurance
☐ Medical Assistance/Medicaid (including waiver payments
  Billing codes: ____________________________________________________________
☐ Veterans Administration
☐ Long Term Care Insurance
☐ Other (specify) ____________________________________________________________________

I declare that the information provided in this document, to the best of my knowledge, is true, correct and complete.

Name: ______________________________________________________________________________
Title: __________________________________ Date: ________________________________________
Signature: ___________________________________________________________________________

Submit with this form a copy of
- Your service plan for at least one client (if completed)

Retain a copy of this document for your records.

Return to
Email: health.homecare@state.mn.us

Home Care and Assisted Living Program
Health Regulation Division
P.O. Box 3879
St. Paul, MN 55101-3879
www.health.state.mn.us/divs/fpc/homecare/

To obtain this information in a different format call 651-201-5273.