Home Care Provider Change of Information Form  
(For providers with comprehensive or basic home care licenses or home management registrations)

Minnesota home care statutes require that the Minnesota Department of Health (MDH) be notified within ten days in the event of changes to the information provided for a home care license. (See MN Statute 144A.472 Subd.6 for complete information.) You may use this form to notify us of changes.

Note: If you are a Medicare-certified Home Health Agency (HHA), you must complete additional information that can be found at: http://www.health.state.mn.us/divs/fpc/profinfo/lic/hamedicare/

Current Information on Record with MDH

*Provider’s Legal Name:______________________________________________________________

*Provider’s Doing Business As (DBA) Name:__________________________________________

*Health Facility ID (HFID – 5 digit #):_______________________________________________

*Agent:________________________________________________________________________

*Email:_________________________________________________________________________

*Mailing Address:________________________________________________________________

*City, State, & Zip:________________________________________________________________

*Phone:__________________________________________________________________________  *Medicare-Certified HHA: ☐ Yes  ☐ No

*Information is required to process changes of information.

Change of Company Name Information: (The legal name of a business is normally the registered with the Minnesota Secretary of State and is connected to the Federal Tax Employer Identification Number (FEIN) or individual Social Security Number (SSN). The business’ assumed name or “Doing Business As” name is the name that the business operates and advertised their services under.)

☐ New Legal Name for Company:_____________________________________________________

☐ New “Doing Business As” (DBA) Name:____________________________________________

   Effective Date of Changes:_______/_______/__________

__________________________________________________________________________
Change of Contact Information

☐ Change of Physical Address

Previous Address: 

__________________________________________________________

__________________________________________________________

__________________________________________________________

☐ Change of Mailing Address

☐ Both

New Address: 

__________________________________________________________

__________________________________________________________

__________________________________________________________

☐ New Phone #: ________________________________

☐ New Fax #: ________________________________

☐ New Email Address: ________________________________

Effective Date of Changes: ______ / ______ / ________

☐ Change of Workers’ Compensation: I have hired employees and now have workers’ compensation insurance. My evidence of workers’ compensation insurance is attached. (Attach certificate of insurance.)

Effective Date of Changes: ______ / ______ / ________

☐ Change of Responsible Registered Nurse (RN): (Do not report changes of all RNs.)

Previous RN’s Name: ________________________________

New RN’s Name: ________________________________ License #: __________________

Effective Date of Changes: ______ / ______ / ________

MDH Only: License Expiration Date: ________________________________

☐ Change in Agent (Both agents must sign below.)

Previous Agent Name: ________________________________

New Agent Name: ________________________________

New Agent’s Email: ________________________________

Owner/Board Member Name: ________________________________

Owner/Board Member Signature: __________________________ Date: __________________

Effective Date of Changes: ______ / ______ / ________

3/8/2016
☐ Change of Housing with Services

If you have changed the Housing with Services locations where you offer services, list below:

Added Location(s):_________________________________________ HFID(s):________
Added Location(s):_________________________________________ HFID(s):________
Dropped Location(s):_______________________________________ HFID(s):________
Dropped Location(s):_______________________________________ HFID(s):________
Effective Date of Changes:_______/_______/________

☐ Change of Branch Office Locations

If you have changed the Branch Office locations where you offer services, list below:

Added Location(s):_________________________________________ HFID(s):________
Added Location(s):_________________________________________ HFID(s):________
Dropped Location(s):_______________________________________ HFID(s):________
Dropped Location(s):_______________________________________ HFID(s):________
Effective Date of Changes:_______/_______/________

*Name of Agent on Record:

*Signature of Agent on Record:

*The agent and signatory must be an owner, board member, or agent currently listed in the MDH database in order for MDH to accept changes requested on this form.

Date:_______/_______/________

Return the completed document to: Home Care and Assisted Living Program
Minnesota Department of Health
PO Box 64900
St. Paul, MN 55164-0900
651-215-9697 (F)

If you have questions, contact us via our website “Contact Home Care” form at
http://www.health.state.mn.us/divs/fpc/homecare/ or call 651-201-5273.