Change of Information Form
FOR HOME CARE LICENSEES AND HOME MANAGEMENT REGISTRANTS

Minnesota home care statute requires licensed home care providers and registered home management providers to notify the Minnesota Department of Health (MDH) **within ten days** when there is a change on the license or registration. (See *Minnesota Statute 144A.472, Subd. 6* for complete information.) Use this form to notify MDH.

Note: If you are a Medicare-certified Home Health Agency (HHA), you must complete additional information. Contact Licensing and Certification at 651-201-4101 or health.fpc-web@state.mn.us or visit [Federal Certification Process for Home Health Agencies](http://www.health.state.mn.us/divs/fpc/profinfo/lic/hhamedicare/) for more information.

**Current Information on Record with MDH**

*Licensee’s Legal Name: ________________________________

*Licensee’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**

The legal name of a business is normally the name 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” (DBA) name is the name under which the business operates and advertises.

New Legal Name for Company: ________________________________

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

Effective Date of Changes: ___________ / ___________ / ___________
Change of Contact Information

☐ Change of Physical Address  ☐ Change of Mailing Address  ☐ Both

Previous Address: ____________________________________________

___________________________________________________________

___________________________________________________________

New Address: ____________________________________________

___________________________________________________________

___________________________________________________________

New Phone #: ____________________________  New Fax #: ____________________________

New Email Address: ____________________________________________

Effective Date of Changes: _______ / _______ / _______


Workers’ Compensation

I have hired employees and now have workers’ compensation insurance. Evidence of workers’ compensation insurance is attached. (Attach certificate of insurance.)

Effective Date of Changes: _______ / _______ / _______


Change of Registered Nurse (RN)

Report change of RN responsible for assessments, training of unlicensed personnel and delegation of tasks. Do not report other RN changes.

Previous RN’s Name: ____________________________________________

New RN’s Name: ____________________________________________  License #: ____________________________

Effective Date of Changes: _______ / _______ / _______

MDH Only: RN License Expiration Date: _______ / _______ / _______


Change in Agent (Note: A new agent cannot authorize adding his/her own name to the license.)

Previous Agent Name: ____________________________________________

New Agent Name: ____________________________________________

New Agent’s Email: ____________________________________________

Effective Date of Changes: _______ / _______ / _______
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 Office Locations

If you have changed office locations, 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: __________ / __________ / __________

*Authorizing official on record: ________________________________

*Signature of authorizing official: ________________________________

*The person authorizing changes to the license must be an owner, managerial official, board member, or agent who is currently listed in the MDH database in order for MDH to accept changes requested on this form.

Date: __________ / __________ / __________

Return the completed document to:  Email: health.homecare@state.mn.us
Home Care and Assisted Living Program
Minnesota Department of Health
PO Box 3879
St. Paul, MN  55101

Questions?

Telephone: 651-201-5273