

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 \(http://www.health.state.mn.us/divs/fpc/profinfo/lic/hhamedicare/\)](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