DEPARTMENT OF HEALTH
HOME CARE & ASSISTED LIVING PROGRAM

Notice from Temporary Licensee of Providing 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 home care services during the 12-month period, no survey will be conducted and the temporary license will expire.

Temporary licensees must notify the department within 5 days after beginning to provide home care services.

Home Care Provider / Agency Name:_____

Health Facility ID (HFID):_____Date home care services started: _____

Number of clients receiving home care services:_____

Check all the **home care services you are currently providing under this license.** The department may request evidence of that you are providing services.

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

This licensee's current clients are paying for home care services by:

☐ Private Pay

☐ Private Insurance

☐ Medical Assistance/Medicaid (Waiver money)

☐ 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: _____

Retain a copy of this document for your records.

Return to:

Email: health.homecare@state.mn.us

For Department Use Only:

Confirmed on: _____

Expiration Date: _____

Notified Survey Supervisor on: _____

Entered in:

☐ Paradise ☐ Access ☐ Excel

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/

03/01/2018

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