2018 Registration Form for Boarding and Lodging Establishments or Lodging Establishments Providing Special Services

In accordance with Minnesota Statute §13.41, ALL DATA SUBMITTED ON THIS APPLICATION SHALL BE CLASSIFIED PUBLIC INFORMATION.

Answer all questions completely and accurately to avoid unnecessary delay. All renewal registrations shall be submitted prior to the expiration date of the current registration certificate with:

Minnesota Department of Health
Health Regulation Division
PO Box 64900
St. Paul, MN 55164-0900

The undersigned hereby registers to operate a Boarding and Lodging Establishment Providing Special Services (BLSS) subject to Minnesota Statutes, Section 157.17.

Type of Application (check one)

☐ Initial License  ☐ Registration Renewal  ☐ Change of Ownership*

*If a change of ownership application, proposed effective date:________________________

A. Identification

1. Business/Establishment Name________________________________________________________

   Establishment Street Address________________________________________________________

   Establishment City/State/Zip________________________________________________________

2. Telephone Number:________________________

   After Hours Number:________________________

   Fax Number:________________________

   Email Address:________________________

3. Name of county in which facility is located __________________________________________
B. Ownership

1. Fill in the code which corresponds to the type of entity legally responsible for operating the BLSS establishment.

Ownership Code _______________

<table>
<thead>
<tr>
<th>GOVERNMENTAL NONFEDERAL</th>
<th>NONGOVERNMENTAL NONPROFIT</th>
<th>NONGOVERNMENTAL FOR PROFIT</th>
<th>OTHER</th>
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</thead>
<tbody>
<tr>
<td>13. City</td>
<td>22. Other Nonprofit Ownership</td>
<td>25. Corporation</td>
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<tr>
<td>14. City-County</td>
<td></td>
<td>26. Group</td>
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<tr>
<td>15. Hospital District or Authority</td>
<td></td>
<td>28. Limited Liability Company</td>
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<td>29. Business Trust</td>
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2. Give the name of the corporation, association, governmental unit, person or partners legally responsible for the operation of this facility.

________________________________________________________________________

Federal ID # __________________________ State Tax ID # __________________________

3. If a corporation, give the date and place of incorporation ______________________________

   Attach a Certificate of Authority to do business in Minnesota if incorporated in another state.

4. President ______________________________

5. Owner ______________________________
C. Other Licenses

1. What other licenses does the owner or legal entity hold?

   Answer each question and provide the license number for each license that applies:

   a. Board & Lodging or Lodging Establishment ☐ Yes ☐ No License #____________________

      (Please attach a copy of this license. MDH will not be able to issue your registration without a copy of your 2018 license.)

   b. Corporate Adult Foster Care ☐ Yes ☐ No License #____________________

   c. Home Care ☐ Yes ☐ No License #____________________

   d. Adult Foster Care ☐ Yes ☐ No License #____________________

   e. Housing with Services ☐ Yes ☐ No License #____________________

   f. Boarding Care Home ☐ Yes ☐ No License #____________________

   g. Nursing Home ☐ Yes ☐ No License #____________________

   h. Hospital ☐ Yes ☐ No License #____________________

   i. Hospice ☐ Yes ☐ No License #____________________

   j. DHS License under MN Statute 245A ☐ Yes ☐ No License #____________________

   k. Other______________________________ License #____________________

   l. Other______________________________ License #____________________

D. Services

1. What supportive services will be provided by the BLSS? Also list number of residents that receive these services:

   a. Providing social and recreational opportunities: ☐ Yes ☐ No # of Residents: ______

   b. Assisting with Transportation: ☐ Yes ☐ No # of Residents: ______

   c. Arranging for meeting and appointments: ☐ Yes ☐ No # of Residents: ______

   d. Arranging for medical or social services: ☐ Yes ☐ No # of Residents: ______

   e. Reminding residents to take medications that are self-administered:

      ☐ Yes ☐ No # of Residents: ______

   f. Providing storage for medications if requested: ☐ Yes ☐ No # of Residents: ______
2. What **health supervision services** will be provided by the BLSS? Also list number of residents that receive these services:
   a. Assistance in preparation and administration of medications other than injectables:
      ☐ Yes ☐ No # of Residents: ______
   b. Providing therapeutic diets:
      ☐ Yes ☐ No # of Residents: ______
   c. Taking vital signs:
      ☐ Yes ☐ No # of Residents: ______
   d. Providing assistance with dressing, grooming or bathing:
      ☐ Yes ☐ No # of Residents: ______
   e. Providing assistance with walking devices:
      ☐ Yes ☐ No # of Residents: ______

3. Please provide the name and license number of the licensed nurse responsible for monitoring the health supervision of residents.
   
   **Name:** ____________________________  **License #** ___________________________

   Number of hours licensed nurse services are provided each week by the above nurse: ___

**E. Resident Capacity on May 1, 2017**

1. Total number of licensed beds for all residents in the establishment? ______

2. Total number of licensed beds for residents receiving special services? ______

3. Current total number of occupied beds for residents receiving special services? ______

4. Current number of residents receiving special services who are age 55 or older? ______

**F. Employee Information**

1. Do you have a system in place for performing criminal background checks for all individuals who have direct contact with residents in this establishment that are registered to provide supportive or health supervision services under MN Statute 157.17?
   
   ☐ Yes  ☐ No
G. Verification

To the best of my knowledge, I certify that the information provided on this form is accurate and complete.

____________________________________  ______________________________
Date                                           Name

____________________________________
Title or Position

____________________________________
Name

____________________________________
Title or Position

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4117
www.health.state.mn.us

9/17- BLSSRENEWREG

To obtain this information in a different format, call: 651-201-4117.