2019 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 ______________

   | GOVERNMENTAL | NONGOVERNMENTAL | NONGOVERNMENTAL | OTHER |
   | NONFEDERAL   | NONPROFIT       | FOR PROFIT      |       |
   | 11. State    | 20. Church-related |
   | 13. City     | 22. Other Nonprofit Ownership |
   | 14. City-County |
   | 15. Hospital District or Authority |
   | 23. Individual |
   | 24. Partnership |
   | 25. Corporation |
   | 26. Group |
   | 27. Tribal |
   | 28. Limited Liability Company |
   | 29. Business Trust |

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 2019 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 names and license number of the licensed nurse responsible for monitoring the health supervision of residents.

   Name: ____________________________ License #: ________________

   Number of hours licensing nurse services is provide each week by the above nurse: _____

**E. Resident Capacity on May 1, 2018**

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.

_____________________________  ______________________________
Signature                      Signature

_____________________________  ______________________________
Name                           Name

_____________________________  ______________________________
Date                           Date

_____________________________  ______________________________
Title or Position              Title or Position

NOTE: If you have questions concerning this registration application, please email MDH at health.fpc-licensing@state.mn.us

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4101
www.health.state.mn.us

10/18- BLSSRENEWREG

To obtain this information in a different format, call: 651-201-4101.