



<u>For Dept. of Health Use Only</u>	
Fee Deposit #	_____
Deposit Date	_____
Initials	_____
SFM Date	_____

Protecting, Maintaining and Improving the Health of Minnesotans

APPLICATION FOR A LICENSE TO OPERATE A NURSING HOME

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

Please answer all questions completely and accurately to avoid unnecessary delay. This application shall be returned to the address noted below with the required fee 60 days prior to the expiration date of your current license.

**MINNESOTA DEPARTMENT OF HEALTH
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900**

The undersigned hereby makes application for license to operate a nursing home subject to the provision of Section 144A.01 - .17, Minnesota Statutes, and to the regulations adopted thereunder by the Commissioner of Health.

- A. Identification Date _____
1. Facility NAME and ADDRESS, Name _____
Street _____
City/Zip _____
2. Telephone Number: Area Code _____ Number _____ Fax Number: Area Code _____ Number _____
3. Name of county in which facility is located _____ E-Mail Address: _____
4. Name of person responsible for completion of this application _____
5. Name of administrator _____

- B. Ownership Ownership Code
1. Fill in the code which corresponds to the type of
entity legally responsible for operating the facility.

**GOVERNMENTAL
NONFEDERAL**

- 11. State
- 12. County
- 13. City
- 14. City-County
- 15. Hospital District or Authority

**NONGOVERNMENTAL
NONPROFIT**

- 20. Church Related
- 21. Nonprofit Corporation
- 22. Other Nonprofit Ownership
- OTHER**
- 27. Tribal

**NONGOVERNMENTAL
FOR PROFIT**

- 23. Individual
- 24. Partnership
- 25. Corporation
- 26. Group
- 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 the above is a corporation, association, governmental unit, give the legal name of the governing body, such as Board of Directors. _____
4. Give the date and place of incorporation. _____
5. President. _____
6. Secretary. _____

Licensed Beds (Insert the requested licensed bed capacity). Nursing Home _____

***** **VERIFICATION** *****

The law requires that an application on behalf of a corporation, association or governmental unit shall be made by any two officers thereof or by its managing agents. This requires two (2) signatures. All other applications require one (1) signature.

The applicant(s) state that the information contained on all parts of this application is complete and accurate.

Date	Name
	Title or Position
	Name
	Title or Position

***** **IMPORTANT** *****

NOTE: All applications must be accompanied by the appropriate fee based on the Total Number of Beds to be licensed. The fee is a \$183.00 base fee plus \$96.00 per bed (includes \$5.00 per bed for the nursing home advisory council fund).

This license renewal notice contains an electronic licensing surcharge. The Minnesota Office of Enterprise Technology (OET) recently sponsored and the Minnesota Legislature passed legislation requiring a 10% surcharge of no less than \$5.00 and no more then \$150.00 on each business, commercial, professional or occupational license. The funding from this surcharge will go to OET, which will establish an electronic licensing system for the state. The surcharge will be in place through June 30, 2015. See Laws of Minnesota 2009, Chapter 101, Article 2, Section 59.

Example: The license fee for a 60 bed facility would be as follows:

Base fee:	\$183.00
Number of beds	<u>\$5760.00</u>
	\$5943.00
Surcharge	<u>150.00</u>
Total	\$6093.00

Make remittance payable to "Commissioner of Finance, Treasury Division".

IF THIS IS AN APPLICATION TO RENEW A LICENSE, YOU MAY ELECT TO PAY THE LICENSURE FEE IN QUARTERLY PAYMENTS. PLEASE CHECK THE APPROPRIATE BOX BELOW:

- Full Payment Is Enclosed With This Application**
- Quarterly Payments Will Be Made, First Payment Is Enclosed**

AN APPLICATION COMPLETED FOR AN INITIAL LICENSE OR A CHANGE OF OWNERSHIP REQUIRES FULL PAYMENT WITH THE APPLICATION FORM.

NOTE: If you have questions concerning this license application, please contact (651) 201-4101.

MINNESOTA DEPARTMENT OF HEALTH
Division of Health Policy, Information and Compliance Monitoring
85 East Seventh Place, Suite 300, P.O. Box 64900
St. Paul, Minnesota 55164-0900

OWNERSHIP INFORMATION SHEET

Name of Facility: _____ City: _____

Zip Code: _____ County: _____ Date: _____

This form must be completed by all nursing homes, boarding care homes and supervised living facilities licensed by the Minnesota State Department of Health. This requirement is applicable to facilities of all categories of ownership - nonprofit corporation, city, county, district, state, proprietary, church, etc.

The requirement stems from Minnesota Rule 4655.1200, Subp. 2.A. of the Department of Health Nursing and Boarding Care Home Rules, and from Minnesota Rule 4665.0400, Subp. 2 of the Department of Health Supervised Living Facilities Rules.

Please provide the following information:

1. Full disclosure of each person having interest of ten (10) percent or more.
2. In case of corporate ownership*, the name and address of each officer and director.
3. If the home is organized as a partnership, the name and address of each partner.
4. If the home is operated by a lessee, the persons or business entities having an interest in the lessee organization and an executed copy of the lease agreement furnished.
5. If the home is operated by the holder of a franchise, disclosure of the franchise holder with an executed copy of the franchise agreement.

Name of Officers Directors, and Owners	Title (President, Director, Partner, Stockholder, etc.)	Address (Street, City, Zip)	% of Ownership (if proprietary)

* A licensee which is a corporation should submit with this application a copy of the Articles of Incorporation or governing body bylaws to the Department of Health. Please note that any amendments to either the Articles of Incorporation or the governing body bylaws are to be submitted to this Department as they occur.

Evidence of Compliance with Workers' Compensation Coverage Provisions

State law requires that the Commissioner of Health shall withhold the license for the operation of a health care provider until the applicant presents acceptable evidence of compliance with workers' compensation coverage provisions.

One of the following documents must accompany this application. Please check which document is attached.

1. ___ **Certificate of Insurance** supplied by an authorized Workers' Compensation carrier pursuant to Minn. Statute 60A,06, Subd. 1(5b). The Certificate should include the name of the licensee, the name of the corporation legally responsible for the licensee, or the name that the licensee is doing business as. The Certificate of Insurance must be in effect prior to the issuance of an initial license or have an effective date on or after the effective date of a renewal license.

2. ___ **"Certificate of Exemption"** from the Commissioner of Commerce permitting an organization to self-insure pursuant to Minn. Statute 79A and Minn. Rules Chapter 2780. The Certificate of Exemption is available to privately owned or publicly held companies and groups. The Certificate of Exemption must be renewed every five years. Questions regarding the Certificate of Exemption should be directed to the Minnesota Department of Commerce at (651)297-4815. **For multiple providers merged under one group, please include Attachment A with the Certificate of Exemption.**

3. ___ Written confirmation from your Third Part Administrator or evidence of coverage from the Workers' Compensation Reinsurance Association (WCRA) allowing you to **self-insure as a Government Entity/Political Subdivision** pursuant to Minn. Statute 176.81, Subd. 2. The Reinsurance Certificate must be renewed annually on a calendar year basis.

You cannot be issued a license and may not operate as a health care provider unless acceptable evidence of compliance with workers' compensation coverage provisions is provided.

05/11- FPC4012 NH