

For MDH Use Only	
Fee Deposit #	_____
Deposit Date	_____
Initials	_____

**HOME MANAGEMENT SERVICES
REGISTRATION FORM**

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

Please answer all questions completely and accurately to avoid unnecessary delay. All renewal registrations shall be filed 30 days prior to the expiration date of the current registration certificate with:

**MINNESOTA DEPARTMENT OF HEALTH
Health Regulation Division
Home Care and Assisted Living Program
P.O. Box 64900
St. Paul, Minnesota 55164-0900**

The undersigned hereby registers to operate a Home Management Service subject to the provision of Minnesota Statutes, Section 144A.43-144A.47, and the rules adopted thereunder.

- Initial Application Change of Ownership (CHOW)
 Renewal: Health Facility Identification (HFID) #: _____

A. Identification

1. Please correct NAME and ADDRESS Service Name or Doing Business As (DBA) Name:
on label if incorrect.

Street _____

City/State/Zip _____

Mailing Address:

Street _____

City/State/Zip _____

2. Telephone Number: Area Code _____ Number _____
Fax Number: Area Code _____ Number _____

3. Name of county in which service is located _____

B. Ownership

Ownership Code

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

- | | | |
|------------------------------------|-----------------------------------|------------------------------------|
| GOVERNMENTAL, NONFEDERAL | NONGOVERNMENTAL, NONPROFIT | NONGOVERNMENTAL, FOR PROFIT |
| 11. State | 20. Church Related | 23. Individual |
| 12. County | 21. Nonprofit Corporation | 24. Partnership |
| 13. City | 22. Other Nonprofit Ownership | 25. Corporation |
| 14. City-County | OTHER | 26. Group |
| 15. Hospital District or Authority | 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 service.

Federal Tax FEIN # _____ 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. **Agent & Title (Required):** _____
(Individual authorized to transact business with the Department of Health and upon whom all notices and orders shall be served.)

6. **Agent Email (Required):** _____

7. Attach evidence of workers' compensation coverage as required by Minnesota Statutes, Sections 176.181 and 176.182.

C. Home Management Services Offered

1. Please insert "1" if the home management task is provided directly by employee(s) of the license and "2" if the services are provided by contract with another provider.

_____ Housekeeping

_____ Meal Preparation

_____ Shopping

2. Has every person who provides home management services attended an orientation session that provides training on the home care bill of rights and an orientation on the aging process and the needs and concerns of elderly and disabled persons?

Yes _____ No _____

This orientation must be provided to persons who provide home management services within 120 days after beginning to provide services.

It is understood that the home care bill of rights applies to all clients who receive home management services and providers must be aware of and comply with the bill of rights provisions contained in Mn. Statute §144A.44, the Home Care/Hospice Law.

D. Verification/Registration Fee

Annual Registration Fee:

- \$20.00** for individuals
- \$50.00** for organizations

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

I enclose \$ _____, annual registration fee made payable to "Commissioner of Finance, Treasury Division".

Signature of Authorized Agent _____

Name (please print or type) _____

Title _____

Date _____

NOTE: If you have questions concerning this registration form, please call (651) 201-4101.

OWNERSHIP INFORMATION SHEET

Name of Provider: _____ City: _____ State: _____

Zip Code: _____ County: _____ Date Completed: _____

Please provide the names, titles and addresses of all officers, directors, owners and managerial employees and the percent of ownership if proprietary.

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