



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

Protecting, Maintaining and Improving the Health of Minnesotans

**REGISTRATION FORM
HOUSING WITH SERVICES ESTABLISHMENT
ASSISTED LIVING DESIGNATION
AND UNIFORM CONSUMER INFORMATION GUIDE**

In accordance with Minnesota Statutes, §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 submitted 30 days prior to the expiration date of the current registration certificate with:

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

The undersigned hereby registers to operate Housing with Services (HWS) Establishment subject to Minnesota Statutes, Chapter 144D.

A. Identification

1. Business/Establishment Name _____

Establishment Street Address _____

Establishment City/State/Zip _____

2. Telephone Number Area Code _____ Number _____

After Hours Number: Area Code _____ Number _____

Fax Number: Area Code _____ Number _____

Internet Access: Yes ____ No ____ E-mail Address: _____

3. Name of county in which establishment is located _____

B. Ownership

Ownership Code

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

- | | | |
|------------------------------------|-----------------------------------|---|
| 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 |
| | | 30. Housing and Redevelopment Authority |

2. Give the name of the legal entity responsible for the operation of HWS establishment.

Federal ID # _____ State Tax ID # _____

3. Name and mailing address of owners of establishment _____

4. 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.

5. President _____

6. Agent(s) _____
(Individual(s) authorized to transact business with the Department of Health and upon whom all notices and orders shall be served. Include address if different than establishment address. Please attach another sheet of paper if necessary).

Address _____ City, State, Zip _____

E-mail address _____ Phone _____

C. Management Agent (if different than owner)

Name: _____

Street Address _____ City, State, Zip _____

D. Attach names and addresses of owners, officers and members of governing body on the ownership information sheet or check here if not applicable.

____ Not Applicable

E. Registration Status

1. Required Registration. Will this HWS establishment provide sleeping accommodations to one or more adult residents, of which at least 80 percent of the adult residents are 55 years or older? Yes _____ No _____

Optional Registration. Will this HWS establishment provide sleeping accommodations to one or more adult residents, except that fewer than 80% of the adult residents are 55 years of age or older? Yes _____ No _____

Optional Registration. Will this HWS establishment provide sleeping accommodations to one or more adult residents who meet the State's definition of long-term homelessness? Yes _____ No _____

F. Resident Capacity

- 1. Total Maximum Resident Capacity _____
- 2. Maximum Resident Capacity by Building: (if applicable)
 - Building #1 Capacity _____ Building #5 Capacity _____
 - Building #2 Capacity _____ Building #6 Capacity _____
 - Building #3 Capacity _____ Building #7 Capacity _____
 - Building #4 Capacity _____ Building #8 Capacity _____
- 3. Number of Residents on May 1 of this year _____

G. Other Licenses

- 1. What other licenses does the owner and or legal entity hold? Answer each question and please provide the license number for each license that applies:
 - a. Family Adult Foster Care Yes___ No___ License #_____
 - b. Corporate Adult Foster Care Yes___ No___ License # _____
 - c. Home Care Yes___ No___ License #_____ License #_____ License #_____
 - d. Board & Lodging Establishment Yes___ No___ License #_____
 - e. Boarding Care Home Yes___ No___ License #_____
 - f. Nursing Home Yes___ No___ License #_____
 - g. Hospital Yes___ No___ License #_____
 - h. Hospice Yes___ No___ License #_____
 - i. Other_____ License#_____
 - j. Other_____ License#_____

H. What services will be offered or provided at the HWS establishment? Check all that apply:

1. **2 or more regularly scheduled supportive services:**

- a. Arranging for medical services for the resident: Yes ___ No ___
- b. Arranging for health-related services for the resident: Yes ___ No ___
- c. Arranging for social services for the resident: Yes ___ No ___
- d. Transportation for medical or social services appointments: Yes ___ No ___
- e. Handling or assisting with personal funds of residents: Yes ___ No ___
- f. Helping with personal laundry for the resident: Yes ___ No ___

2. **1 or more Health-related services:**

- a. Professional nursing services: Yes ___ No ___
- b. Administration of medications: Yes ___ No ___
- c. Performing routine delegated medical or nursing or assigned therapy procedures assisting with body positioning or transfers of clients who are not ambulatory, feeding of clients who, because of their condition, are at risk of choking: Yes ___ No ___
- d. Assistance with bowel and bladder control, devices, and training programs: Yes ___ No ___
- e. Assistance with therapeutic or passive range of motion exercises: Yes ___ No ___
- f. Providing skin care, including full or partial bathing and foot soaks: Yes ___ No ___
- g. During episodes of serious disease or acute illness, services performed for a client to assist nutritional needs, and to assist with the client's mobility including movement, change of location, and positioning and bathing, oral hygiene, dressing, hair care, toileting, bedding changes, basic housekeeping, and meal preparation: Yes ___ No ___
- h. Preparing modified diets, such as diabetic or low sodium diets: Yes ___ No ___
- i. Reminding clients to take regularly scheduled medications or perform exercises: Yes ___ No ___
- j. Household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease: Yes ___ No ___
- k. Household chores when the client's care requires the prevention of exposure to infectious disease or containment of infectious disease: Yes ___ No ___
- l. Assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the client is ambulatory, and if the client has no serious acute illness or infectious disease: Yes ___ No ___
- m. The central storage of medications: Yes ___ No ___

3. **If applicable, any health related service must be offered or provided through a licensed home care provider. If you answered yes to one or more health-related service you must list the name, address and license number of the home care provider(s):**

- a. This registered establishment is also licensed as a home care provider as:
(name) _____
(address, city, zip) _____
License # _____

b. Arranges for home care services with:

(name) _____

(address, city, zip) _____

License# _____

If a HWS establishment has one or more arranged home care providers, the establishment shall have that arranged home care provider deliver the following information in writing to a prospective resident, prior to the date on which the prospective resident executes a contract with the establishment or the prospective resident's move-in date, whichever is earlier:

- (1) the name, mailing address, and telephone number of the arranged home care provider;
- (2) the name and mailing address of at least one natural person who is authorized to accept service of process on behalf of the entity described in clause (1);
- (3) a description of the process through which a home care service agreement or service plan between a resident and the arranged home care provider, if any, may be modified, amended, or terminated;
- (4) the arranged home care provider's billing and payment procedures and requirements; and
- (5) any limits to the services available from the arranged provider.

Attach a copy of the above information.

I. Base Rate

- 1. Does the HWS establishment's base rate (rent) paid by the resident include the cost of supportive services that will be offered or provided as indicated in H1 above?
Yes_____ No_____
- 2. Does the HWS establishment's base rate (rent) paid by the resident include the cost of health related services that will be offered or provided as indicated in H2 above?
Yes_____ No_____
- 3. Does the HWS establishment's base rate (rent) paid by the resident include the cost of other services in addition to the supportive and health related services offered or provided as indicated in H1 and H2 above?
Yes_____ No_____

Please indicate other services by checking the appropriate box or entering below:

Meals	Yes___ No___	_____
Housekeeping	Yes___ No___	_____
Security	Yes___ No___	_____
_____		_____

J. Written Contract

A copy of the contract and individually executed contracts is available at the registered establishment for on-site inspection by the commissioner upon request at any time. I verify that this HWS establishment has entered into a signed, written contract, according to the requirements in Minnesota Statutes 144D.04, with each resident or resident representative and the contract includes:

1. the name, street address, and mailing address of the establishment;
2. the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;
3. the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;
4. the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;
5. a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;
6. the term of the contract;
7. a description of the services to be provided to the resident in the base rate to be paid by resident; including a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate;
8. a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;
9. a description of the process through which the contract may be modified, amended, or terminated;
10. a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;
11. the resident's designated representative, if any;
12. the establishment's referral procedures if the contract is terminated;
13. requirements of residency used by the establishment to determine who may reside or continue to reside in the housing with services establishment;
14. billing and payment procedures and requirements;
15. a statement regarding the ability of residents to receive services from service providers with whom the establishment does not have an arrangement;
16. a statement regarding the availability of public funds for payment for residence or services in the establishment; and
17. a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

Yes_____ No_____

K. Special Care Unit – Alzheimer’s or Related Disorder Verification

Does this HWS establishment have a special program or special care unit for residents with a diagnosis of probable Alzheimer’s disease or a related disorder or do you advertise, market, or otherwise promote the establishment as providing specialized care for Alzheimer’s disease or a related disorder? Yes _____ No _____

If yes, I verify that this HWS establishment has provided to each resident or authorized resident representative and the Office of Ombudsman for Long-Term Care, written disclosure of special program or special care unit containing the requirements in MN Statute 325F.72, Subd. 2 as stated below before entering into an agreement to provide care:

1. a statement of the overall philosophy and how it reflects the special needs of residents with Alzheimer's disease or other dementias;
2. the criteria for determining who may reside in the special care unit;
3. the process used for assessment and establishment of the service plan or agreement, including how the plan is responsive to changes in the resident's condition;
4. staffing credentials, job descriptions, and staff duties and availability, including any training specific to dementia;
5. physical environment as well as design and security features that specifically address the needs of residents with Alzheimer's disease or other dementias;
6. frequency and type of programs and activities for residents of the special care unit;
7. involvement of families in resident care and availability of family support programs;
8. fee schedules for additional services to the residents of the special care unit; and
9. a statement that residents will be given a written notice 30 days prior to changes in the fee schedule:

Yes_____ No_____

L. Assisted Living:

Verification Statement for HWS establishments regarding the use of the phrase “Assisted Living” pursuant to Minnesota Statute Section 144G.02. Subdivision 1.

This HWS establishment intends to use the phrase “assisted living” orally or in writing to advertise; market or otherwise describe, offer, or promote itself:

Yes_____ No_____

If yes you must answer questions 1 – 12.

Does HWS establishment that uses the phrase “Assisted Living” provide or make available the following through a licensed home care provider:

1. Assistance with self-administration of medication; or medication administration:

Yes_____ No_____

2. Assistance with at least 3 of the following seven activities of daily living:

- 1. Bathing Yes___ No___
- 2. Dressing Yes___ No___
- 3. Grooming Yes___ No___
- 4. Eating Yes___ No___
- 5. Transferring Yes___ No___
- 6. Continence Care Yes___ No___
- 7. Toileting Yes ___No___

3. Assessments of the physical and cognitive needs by a registered nurse:

Yes_____ No_____

4. Have and maintain a system for delegation of health care activities to unlicensed assistive health care personnel by a registered nurse, including supervision and evaluation of the delegated activities: Yes_____ No_____

5. Staff access to an on-call registered nurse 24 hours per day, seven days per week: Yes_____ No_____

Does this HWS establishment offer or provide to have the arranged home care provider conduct:

6. A nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a service agreement or service plan prior to the date on which a prospective resident executes a contract with a housing with services establishment or the date which a prospective resident moves in, whichever is earlier:

Yes_____ No_____

Does HWS establishment that uses the phrase “Assisted Living”:

7. Have and maintain a system to check on each assisted living client at least daily:

Yes_____ No_____

8. Provide a means for assisted living clients to request assistance for health and safety needs 24 hours per day, seven days a week, from the establishment or a person or entity with which the establishment has made arrangements: Yes_____ No_____

9. Offers to provide or make available the following supportive services: (i) two meals per day; (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the client, reasonable assistance with arranging transportation to medical and social services appointments, and the name of or other identifying information about the person or persons responsible for providing this assistance; (v) upon the request of the client, reasonable assistance with accessing community resources and social services available in the community, and the name of or other identifying information about the person or persons responsible for providing this assistance; and (vi) periodic opportunities for socialization: Yes_____ No_____
10. Have a person or persons available 24 hours per day, seven days per week, who is responsible for responding to the requests of assisted living clients for assistance with health or safety needs, who shall be: awake, located in the same building, or on a contiguous campus with the HWS establishment in order to respond within a reasonable amount of time; capable of communicating with assisted living clients; capable of recognizing the need for assistance; capable of providing either the assistance required or summoning the appropriate assistance; and capable of following directions: Yes_____ No_____
11. If total maximum resident capacity entered on Section F1 is 12 or fewer, please answer the following:
- Does this HWS establishment have:
- a. a person available 24 hours a day, seven days per week who shall be awake: Yes_____ No_____
- If no to 11a, does this HWS establishment follow the exemption from awake staff requirements by having:
- b. the person or persons available and responsible for responding to requests for assistance are physically present within the HWS establishment in which the assisted living clients reside: Yes_____ No_____
- c. a system in place that is compatible with the health, safety, and welfare of the establishment's assisted living clients: Yes_____ No_____
- d. a contract that includes a statement disclosing the establishment's qualification for, and intention to rely upon, this exemption from awake staff: Yes_____ No_____
- e. if answered no to question #11 a, please attach a statement describing how the HWS meets the conditions of the awake staff requirement.
- does the HWS establishment make this statement available to actual and prospective assisted living clients: Yes_____ No_____

12. Does the HWS establishment inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a HWS establishment or the date on which a prospective resident moves in, whichever is earlier: Yes_____ No_____

M. Uniform Consumer Information Guide Minnesota Statute 144G.06
Complete the Uniform Consumer Information Guide

N. Uniform Consumer Information Guide Availability to HWS Establishment Residents

Does the HWS establishment, as required under Section 144D.08, make available to all prospective and current HWS residents information consistent with the uniform format, Uniform Consumer Information Guide, and the required components adopted by the commissioner under section 144G.06. Yes_____ No_____

O. Certification/Registration Fee

Annual Registration Fee: \$155.00 for each HWS establishment address

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

Enclosed is the \$155 annual registration fee made payable to "Commissioner of Finance, Treasury Division".

An application on behalf of a corporation, association or governmental unit shall be signed by at least two authorized representatives, one of which shall be an officer of the owner.

Signature of Authorized Representative

Signature of Authorized Representative

Name (please print or type)

Name (please print or type)

Title

Title

Date

Date

NOTE: If you have questions concerning this registration form, please call 651-201-4101. A completed registration form and \$155.00 fee must be submitted for each address in which housing with services is arranged for, offered, or provided.

OWNERSHIP INFORMATION SHEET

Name of Provider: _____ City: _____ State: _____

Zip Code: _____ County: _____ Date Completed: _____

Please provide the names, titles and addresses of all owners, officers and/or members of the governing body and the percent of ownership if proprietary.

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