Minnesota Department of Health
HEALTH REGULATION DIVISION

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

Application for a License to Operate a Hospice Program

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. All renewal applications shall be filed 30 days prior to the expiration date of the current license with:

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

The undersigned hereby makes application to operate a hospice program subject to the provision of Minnesota Statutes, Section 144A.75, 144A.751-144A.756, and the rules adopted thereunder.

A. Type of Application (check one)

☐ Initial License ☐ License Renewal ☐ Change of Ownership*

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

B. Identification

1. Please correct name and address if incorrect:

   Name_____

   Street_____

   City/Zip_____

2. Telephone number _____ Fax number _____

3. Name of county in which facility is located _____

4. Email address _____

5. Name of person responsible for completion of this application _____

6. Name of administrator _____

C. Ownership

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

   Ownership Code _____

GOVERNMENTAL NONFEDERAL	NONGOVERNMENTAL NONPROFIT	NONGOVERNMENTAL FOR PROFIT	OTHER
11. State 12. County 13. City 14. City-County 15. Hospital District or Authority	20. Church-related 21. Nonprofit Corporation 22. Other Nonprofit Ownership	23. Individual 24. Partnership 25. Corporation 26. Group 28. Limited Liability Company 29. Business Trust	27. Tribal

2. Give the name of the corporation, association, governmental unit, person or partners legally responsible for the operation of this hospice.

   _____

   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. 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 hospice address.

   Address _____ City _____ State _____ Zip_____

6. Name of Medical Director _____

   Please check: ☐ Employee ☐ Contractor ☐ Volunteer

7. Name of Clinical Nurse Supervisor (Registered Nurse) _____

8. List other office locations. (Multiple units or satellites of a provider must be separately licensed if the commissioner determines that the units, because of distinct organizational structure or the distance between them and the provider's main office, cannot adequately share administration of services with the main office, or do not share the same management. A unit that relies on the primary licensee for supervision and administration of services is a unit of that license).

Address	City/State/Zip	Phone Number

D. Services Offered

Please insert a "1" if the hospice service will be provided directly by employees of the licensee and a "2" if the services will be provided by contracting with another provider for service. If services will be provided both directly and by contract, please insert a "3".

_____ Physician Services *

_____ Registered Nursing Services *

_____ Licensed Practical Nursing

_____ Respiratory Therapy

_____ Physical Therapy

_____ Occupational Therapy

_____ Speech Therapy

_____ Nutritional Counseling

_____ Counseling /Bereavement Services *

_____ Volunteer Services

_____ Medical Supplies & Equipment

_____ Home Health Aide Services

_____ Inpatient Services

_____ Medical Social Services *

_____ Other (explain)

* Required Services–Note: Two core services must be regularly provided by hospice employees.

NOTE: If you contract for hospice services with a business that is not subject to licensure under this chapter, does the contract state that the business must comply with the Hospice Licensure Law and Rules? (Mn. Rule 4664.0008, Subp. 2)

☐ Yes ☐ No ☐ N/A

E. Residential Hospice

Are you licensed as a residential hospice? ☐ Yes ☐ No

If yes, please answer the following questions.

1. Number of Licensed Residential Hospice Beds _____
2. Location of the Residential Hospice Beds

   Address _____

   City/Zip_____

F. Short-term Inpatient Care

List any hospitals, nursing homes or residential hospices that this hospice contracts with for short-term inpatient care. Refer to Mn. Rule 4664.0090, Subp. 3.

Name	Address	City/Zip	Type of License

G. Employee Information

1. Do you have a system in place for performing criminal background checks for all individuals who have direct contact with patients in their homes or in the community, including licensee, managerial officials, supervisors, direct care givers and volunteers in accordance with MN Statute 144.057?

   ☐ Yes ☐ No

2. Has every individual who provides direct care, supervision of direct care or management services, including the licensee, been oriented to hospice requirements as defined in Mn. Rule 4664.0140, Subpart 1?

   ☐ Yes ☐ No

H. Revenues

Revenues are defined in Mn. Rule 4664.0010, Subpart 8 of Minnesota's Hospice Licensure Rule.

Total revenue for the previous fiscal year:
Beginning Date _____ (mm/dd/yy) through End Date_____ (mm/dd/yy)

$ _____

Fees

NOTE: All applications must be accompanied by the appropriate fee based on the following fee schedule.

Previously, The Minnesota Office of Enterprise Technology (OET) required a 10% surcharge of no less than $5.00 and no more than $150.00 on each business, commercial, professional or occupational license.

Effective July 1, 2015, this surcharge is no longer required. Effective July 1, 2015, this surcharge is no longer required.

		License Fee
A.	For revenues greater than $1,500,000	$5,000.00
B.	For revenues greater than $1,275,000 and no more than $1,500,000	$4,375.00
C.	For revenues greater than $1,100,000 and no more than $1,275,000	$3,750.00
D.	For revenues greater than $950,000 and no more than $1,100,000	$3,125.00
E.	For revenues greater than $850,000 and no more than $950,000	$2,812.50
F.	For revenues greater than $750,000 and no more than $850,000	$2,500.00
G.	For revenues greater than $650,000 and no more than $750,000	$2,187.50
H.	For revenues greater than $550,000 and no more than $650,000	$1,875.00
I.	For revenues greater than $450,000 and no more than $550,000	$1,562.50
J.	For revenues greater than $350,000 and no more than $450,000	$1,250.00
K.	For revenues greater than $250,000 and no more than $350,000	$937.50
L.	For revenues greater than $100,000 and no more than $250,000	$625.00
M.	For revenues greater than $25,000 and no more than $100,000	$312.50
N.	For revenues no more than $25,000	$125.00

Please make checks payable to "Commissioner of Finance, Treasury Division."

I. Verification

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

I enclose $ _____ annual licensure 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 license application, please call (651) 201-4101.

Ownership Information Sheet for Hospice Providers

Legal Entity (same as Item C.2. on Page 2) _____ HFID# _____

Facility Name _____

Address _____

City _____ State _____ Zip Code _____ Phone _____

Date Completed_____ Administrator_____ Email Address _____

INITIAL AND CHANGE OF OWNdERSHIP APPLICANTS ONLY:
Please note that you must submit a background study using NETStudy through the Minnesota Department of Human Services for all owners and managerial officials. An owner is defined as an individual whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care or hospice provider. A managerial official is defined as an individual who has responsibility for the ongoing management or direction of the policies, services, or employees of the home care or hospice provider. Information regarding NETStudy may either be obtained from the Minnesota Department of Health website (http://www.health.state.mn.us) or by calling (651) 201-4101.

ALL APPLICANTS:
Please provide the names, titles and addresses of all officers, directors, owners and managerial employees, the percent of ownership if proprietary and check if the individual provides direct contact to home care or hospice clients on the next page.

Name of Officers, Directors, Owners, and Managerial Employees	Title (President, Director, Partner, Stockholder, etc.)	Address (Street, City, Zip)	Percent of Ownership (if proprietary)	Check if Individual Provides Direct Contact	**For MDH Use Only** Initial and CHOWS Date BGS Rec'd

Ownership Information

HFID # _____

Name of Officers, Directors, Owners, and Managerial Employees	Title (President, Director, Partner, Stockholder, etc.)	Address (Street, City, Zip)	Percent of Ownership (if proprietary)	Check if Individual Provides Direct Contact	**For MDH Use Only** Initial and CHOWS Date BGS Rec'd

Information and Referral Services Hospice Licensees

Minnesota Statutes 144A.755 directs the Commissioner of Health:

> to ensure that information and referral services relating to hospice care are available in all regions of the state. The commissioner shall collect and make available information about available hospice care, sources of payment, providers and the rights of patients. The commissioner may publish and make available:
>
> (1) general information describing hospice care in the state;
> (2) limitations on hours, availability of services, and eligibility for third party payments, applicable to individual providers; and
> (3) other information the commissioner determines to be appropriate."

Mn. Rule 4664.0310 of the Hospice Licensure Rules further states that the requested information shall be provided by the licensee.

The department has determined that the following information shall be collected to assure that information and referral services related to hospice services will be available in all regions of the state:

1. Hospice Name _____

   Address _____

   City/State/Zip _____

2. Please name the counties served _____

   _____

   _____

3. Current source of hospice income: (please check all that apply)

   ☐ Alternate Care Grants ☐ Medical Assistance
   ☐ Private Pay ☐ Title XX
   ☐ HMO ☐ Medicare
   ☐ Sliding Fee Social Service ☐ Veterans Administrator
   ☐ Insurance ☐ Title III

4. Schedule of Operation:

   Office Hours _____

   Days _____

   Service Hours - Days/Evenings/Nights _____

   Weekends _____

   Other (explain) _____

   _____

5. Have all personnel (including volunteers), who require direct contact with patients, met tuberculosis screening requirements consistent with MN Rule 4664.0290, Subp. 2?

   ☐ Yes ☐ No

6. Are you currently a Medicare-certified hospice?

   ☐ Yes ☐ No

   If yes, please insert your Medicare number: 24-_____

7. If you are not Medicare certified, do you plan to become certified within the next 12 months?

   ☐ Yes ☐ No

8. Do you provide your own training and competency evaluations for individuals performing home health aide tasks?

   ☐ Yes ☐ No

9. Have you submitted the sections entitled Identification and Contact Information, Program Demographics, Patient Volume, Patient Demographics, and Inpatient and Residential Facilities in the National Hospice and Palliative Care Organization National Data Set survey and submitted the survey to the National Hospice and Palliative Care Organization once in the 12 calendar months before your hospice provider's license renewal date?

   ☐ Yes ☐ No

   Note: Submittal of the above data is a condition of licensure effective as follows:

   CHECK THE APPROPRIATE LINE FOR YOUR HOSPICE

   ____ Hospice serving more than 440 patients per year – Effective 1/1/06

   ____ Hospice serving at least 300 patients per year – Effective 1/1/07

   ____ Hospice serving fewer than 300 patients per year – Effective 1/1/08

Initial Applicants Only:

1. Will you provide a written notice of charges for services as required in Mn. Rule 4664.0030, Subp. 3?

   ☐ Yes ☐ No

2. Describe your procedure for receiving, investigating, and resolving complaints consistent with MN Rule 4664.0050? _____

   _____

3. Which components of services are monitored and evaluated as a part of your Quality Assurance Plan as required by Mn. Rule 4664.0160? (Medicare certified hospices must meet Medicare requirement).

   _____

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) 296-4026. **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.

For more information, contact:
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900