

## Housing With Services Change of Information Form

A registered HWS establishment shall notify the commissioner within 30 days of any change in the business name or address of the establishment, the name or mailing address of the owner or owners, or the name or mailing address of the managing agent. Use this form to notify MDH.

[Minnesota Statute 144D.03, Subd.1 \(https://www.revisor.mn.gov/statutes/cite/144D.03\)](https://www.revisor.mn.gov/statutes/cite/144D.03)

### Current Information on Record with MDH

HWS Doing Business As (DBA) Name: \_\_\_\_\_

Legal Entity Name: \_\_\_\_\_

Agent Name: \_\_\_\_\_

Health Facility ID (HFID – 5 digit #): \_\_\_\_\_

HWS Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Effective Date of Changes: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### Change of HWS Establishment Name

The legal name of a business is normally the name registered with the Minnesota Secretary of State and is connected to the federal tax employer identification number (FEIN) or individual social security number (SSN). The business's assumed name or "doing business as" (DBA) name is the name under which the business operates and advertises.

New Legal Name for Company: \_\_\_\_\_

New "Doing Business As" (DBA)/Assumed Name: \_\_\_\_\_

### Change of Management Agent

Management Agent Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

## Change in Agent

"Agent" means the person upon whom all notices and orders shall be served and who is authorized to accept service of notices and orders on behalf of the owner or owners and the managing agent. A new agent cannot authorize adding his/her own name to the license.

Previous Agent Name: \_\_\_\_\_

New Agent Name: \_\_\_\_\_

New Agent's Email: \_\_\_\_\_

## Signature

Signature of Authorizing Official\*: \_\_\_\_\_

Printed Name of Authorizing Official: \_\_\_\_\_

\*Must be an owner, managerial official, board member, or agent who is **currently listed** in the MDH database in order for MDH to accept changes requested on this form.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Return the completed document to [Health.HWS@state.mn.us](mailto:Health.HWS@state.mn.us).

Questions? Call 651-201-4101.

Minnesota Department of Health  
Health Regulation Division  
P.O. Box 64900  
St. Paul, MN 55164-0900  
651-201-4101  
[www.health.state.mn.us](http://www.health.state.mn.us)

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