

Assisted Living Licensure Rules Variance Request

General Instructions

Use this variance request if the applicant for, or licensee of, either an assisted living facility license or an assisted living facility with dementia care license is requesting a rules variance under Minnesota Rules, part 4659.0080.

The commissioner may not grant a variance from a statute or court order.

This document contains references to statutory authority and other information. For example, a reference to Minnesota Statutes (Minn. Stat.) section 144G.12 could include a broad reference to the entire section (i.e., “144G.12”) or a detailed reference to a part of the section (i.e., “144G.12, subd. 1” refers to all of subdivision 1. A different reference type may include a specific subitem reference such as “144G.12, subd. 1(1).” This refers to specific item (1) of subdivision 1). If you have online access to the Office of Revisor of Statutes website, the references will contain a link to this site. If you are working from a printed document you can search for the statutory reference at the Office of Revisor of Statutes website.

Submitting the Request

Requestors should download the 20210801.ALL_Rules_Variance_Request_Form. Requestor should completely fill out the form and return a signed and dated copy to the Assisted Living Licensure email mailbox at: health.assistedliving@state.mn.us.

Keep a copy of your request. They will not be returned to applicants.

Submission of a rule variance request does not mean MDH has approved the request. MDH will either grant or deny the request and notify the requestor of its decision.

Review Process

MDH will acknowledge receipt of the waiver request in an email to the requestor.

As part of the acceptance process, additional information may be requested. If additional information is needed, MDH will contact you to request the additional information. Answer all questions completely and accurately to avoid unnecessary delay.

Once MDH determines it has all required information, signatures, and attachments to make a complete rule variance request, MDH will notify the requestor informing the person of the completed submission.

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Application and attachment materials will not be returned to the applicant.

Decision Process

Pursuant to Minn. Rules part 4659.0080, subp. 4 (<https://www.revisor.mn.gov/rules/4659.0080/#rule.4659.0080.4>), MDH has 60 days from the submission of a complete request to approve or deny the rule variance request. The rules variance request is deemed complete when MDH notifies the requestor via email confirmation of the completed submission.

MDH will notify the requestor and any other adversely affected person or entity of its approval or denial of the variance request. Pursuant to Minn. Rules part 4659.0080, subp. 4 (<https://www.revisor.mn.gov/rules/4659.0080/#rule.4659.0080>), if MDH denies the request, MDH will include its reasons for the denial in the notification.

Questions?

EMAIL: health.assistedliving@state.mn.us

Assisted Living Licensure Rule Variance Request

Request Type

Select your request type:

- New rule variance request
- Rule variance renewal

Proceed to Licensee Information Section.

Licensee Information

Provide the requested information below as it relates to the assisted living facility licensee or the assisted living facility with dementia care licensee.

- a. Assisted living facility or assisted living facility with dementia care license number:

- b. HFID number: _____

- c. Facility Name: _____

- d. Physical Address: _____

- e. City: _____ State: _____ Zip: _____

- f. County: _____

- g. Telephone: _____ Fax: _____

Proceed to Requestor's Contact Information Section.

Requestor's Contact Information

Provide the legal name and contact information of the individual MDH can contact regarding questions about this rule variance request, and of the Assisted Living Facility Director if the authorized contact and the Assisted Living Facility Director are not the same individual.

Authorized Contact

- a. Legal Name: _____

- b. Telephone: _____

- c. Email Address: _____

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Row	Affected Resident's Name	Living Unit Number	Resident's Phone Number	Representatives' Names and Phone Numbers (i.e., Resident's Legal and Designated Representatives) (and, optional: Case Manager Name and Phone Number)
1				
2				
3				
4				
5				
6				
7				
8				
9				

MINNESOTA DEPARTMENT OF HEALTH ASSISTED LIVING LICENSURE
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Row	Affected Prospective Resident's Name	Address	Phone Number and email	Representatives' Names and Phone Numbers (i.e. Resident's Legal and Designated Representatives) <i>(and, optional: Case Manager Name and Phone Number)</i>
1				
2				
3				
4				
5				
6				
7				

If you are applying for one variance to one rule or subpart, *proceed to Official Verification section.*

If you are applying for a variance to more than one rule or subpart, please complete a separate rules variance request for the additional rule variances requested. Then *proceed to Official Verification section.*

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Official Verification

Read the following statements, check each item acknowledging you have read, understand, and attest to each referenced material(s) or statement, and sign below.

I certify I have read and understand, and attest to the following:

- I understand in accordance with [Minn. Stat. section 144.051 Data Relating to Licensed and Registered Persons](#) (<https://www.revisor.mn.gov/statutes/cite/144.051>), all data submitted on this application shall be classified as public information upon issuance of a variance. All data submitted are considered private until MDH issues a license.
- I declare that, as the owner or authorized agent, I attest that I have read [Minn. Stat. chapter 144G](#) (<https://www.revisor.mn.gov/statutes/cite/144G>), and [Minnesota Rules, chapter 4659](#) (<https://www.revisor.mn.gov/rules/4659/>), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.
- I have examined this request and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. This information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required.
- If this variance request granted, I agree to comply with any alternative measures or conditions required by the Minnesota Department of Health.
- Owner or authorized agent signature of acknowledgment:
 - Legal name (print or type): _____
 - Signature: _____
 - Title: _____
 - Date: _____

MINNESOTA DEPARTMENT OF HEALTH ASSISTED LIVING LICENSURE
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This section to be completed by Minnesota Department of Health.

Rule Variance Decision

Approved **Effective Date** _____ **Expiration Date** _____

Alternative Measures or Conditions:

Signature

Date

Title

Denied

Reasons:

Signature

Date

Title

Appeal Process

Pursuant to [Minn. Rules part 4659.0080, subp. 8](#) (<https://www.revisor.mn.gov/rules/4659.0080/#rule.4659.0080.8>), a license applicant or licensee may appeal the denial, revocation or refusal to renew a variance by requesting a hearing from MDH.

The request must be made in writing to the commissioner and delivered personally or by mail within 10 calendar days after the license applicant or licensee receives the notice. If mailed, the request must be postmarked within ten calendar days after the license applicant or licensee receives the notice. The request for hearing must set forth in detail the reasons why the license applicant or licensee contends the decision of the commissioner should be reversed or modified. At the hearing, the applicant or licensee has the burden of proving by a preponderance of the evidence that the variance should be granted or renewed, except in a proceeding challenging the revocation of a variance, where the department has the burden of proving by a preponderance of the evidence that a revocation is appropriate.

Questions?

EMAIL: health.assistedliving@state.mn.us

For more information contact:

Minnesota Department of Health
Health Regulation Division
PO Box 64900
St. Paul, MN 55164-0900
651-201-4200 or 844-926-1061
health.assistedliving@state.mn.us
www.health.state.mn.us

06/30/2021

To obtain this information in a different format, call: 651-201-4200.