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Initials _____
SFM Date _____

2020 Registration Form for Boarding and Lodging Establishments or Lodging Establishments Providing Special Services

In accordance with Minnesota Statute §13.41, ALL DATA SUBMITTED ON THIS APPLICATION SHALL BE CLASSIFIED PUBLIC INFORMATION.

Answer all questions completely and accurately to avoid unnecessary delay. All renewal registrations shall be submitted prior to the expiration date of the current registration certificate with:

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

The undersigned hereby registers to operate a Boarding and Lodging Establishment Providing Special Services (BLSS) subject to Minnesota Statutes, Section 157.17.

Type of Application (check one)

- Initial License Registration Renewal Change of Ownership*

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

A. Identification

1. Business/Establishment Name _____
Establishment Street Address _____
Establishment City/State/Zip _____
2. Telephone Number: _____
After Hours Number: _____
Fax Number: _____
Email Address: _____
3. Name of county in which facility is located _____

B. Ownership

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

Ownership Code _____

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

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. Owner _____

C. Other Licenses

1. What other licenses does the owner or legal entity hold?
 Answer each question and provide the license number for each license that applies:
 - a. Board & Lodging or Lodging Establishment Yes No License # _____
(Please attach a copy of this license. MDH will not be able to issue your registration without a copy of your 2020 license.)
 - b. Corporate Adult Foster Care Yes No License # _____
 - c. Home Care Yes No License # _____
 - d. Adult Foster Care Yes No License # _____
 - e. Housing with Services Yes No License # _____
 - f. Boarding Care Home Yes No License # _____
 - g. Nursing Home Yes No License # _____
 - h. Hospital Yes No License # _____
 - i. Hospice Yes No License # _____
 - j. DHS License under MN Statute 245A Yes No License # _____
 - k. Other _____ License # _____
 - l. Other _____ License # _____

D. Services

1. What **supportive services** will be provided by the BLSS? Also list number of residents that receive these services:
 - a. Providing social and recreational opportunities: Yes No # of Residents: _____
 - b. Assisting with Transportation: Yes No # of Residents: _____
 - c. Arranging for meeting and appointments: Yes No # of Residents: _____
 - d. Arranging for medical or social services: Yes No # of Residents: _____
 - e. Reminding residents to take medications that are self-administered:
 Yes No # of Residents: _____
 - f. Providing storage for medications if requested: Yes No # of Residents: _____

2. What **health supervision services** will be provided by the BLSS? Also list number of residents that receive these services:
- a. Assistance in preparation and administration of medications other than injectables: Yes No # of Residents: _____
 - b. Providing therapeutic diets: Yes No # of Residents: _____
 - c. Taking vital signs: Yes No # of Residents: _____
 - d. Providing assistance with dressing, grooming or bathing: Yes No # of Residents: _____
 - e. Providing assistance with walking devices: Yes No # of Residents: _____
3. Please provide the names and license number of the licensed nurse responsible for monitoring the health supervision of residents.

Name: _____ License # _____

Number of hours licensing nurse services is provide each week by the above nurse: _____

E. Resident Capacity on May 1, 2019

- 1. Total number of licensed beds for all residents in the establishment? _____
- 2. Total number of licensed beds for residents receiving special services? _____
- 3. Current total number of occupied beds for residents receiving special services? _____
- 4. Current number of residents receiving special services who are age 55 or older? _____

F. Employee Information

1. Do you have a system in place for performing criminal background checks for all individuals who have direct contact with residents in this establishment that are registered to provide supportive or health supervision services under MN Statute 157.17?

Yes No

G.Verification

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

Signature

Signature

Name

Name

Date

Date

Title or Position

Title or Position

NOTE: If you have questions concerning this registration application, please email MDH at health.fpc-licensing@state.mn.us

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4101
www.health.state.mn.us

10/19- BLSRENEWREG

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