HOME MANAGEMENT SERVICES
REGISTRATION FORM

In accordance with Minnesota Statute §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 filed 30 days prior to the expiration date of the current registration certificate with:

MINNESOTA DEPARTMENT OF HEALTH
Health Regulation Division
Home Care and Assisted Living Program
P.O. Box 3879
St. Paul, Minnesota 55101

The undersigned hereby registers to operate a Home Management Service subject to the provision of Minnesota Statutes, Section 144A.43-144A.47, and the rules adopted thereunder.

☐ Initial Application       ☐ Change of Ownership (CHOW)
☐ Renewal: Health Facility Identification (HFID) #:_________

A. Identification
1. Please correct NAME and ADDRESS Service Name or Doing Business As (DBA) Name:
on label if incorrect.

Street________________________________________
City/State/Zip________________________________

Mailing Address:
Street________________________________________
City/State/Zip________________________________

2. Telephone Number: Area Code____ Number_____________________
Fax Number: Area Code____ Number_____________________

3. Name of county in which service is located________________________________________

For MDH Use Only
Fee Deposit #______________
Deposit Date _______________
Initials ___________________
B. Ownership

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

<table>
<thead>
<tr>
<th>GOVERNMENTAL, NONFEDERAL</th>
<th>NONGOVERNMENTAL, NONPROFIT</th>
<th>NONGOVERNMENTAL, FOR PROFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. City</td>
<td>22. Other Nonprofit Ownership</td>
<td>25. Corporation</td>
</tr>
<tr>
<td>14. City-County</td>
<td>OTHER</td>
<td>26. Group</td>
</tr>
<tr>
<td>15. Hospital District or Authority</td>
<td>Tribe</td>
<td>27. Tribal</td>
</tr>
<tr>
<td>16. Other Nonprofit</td>
<td></td>
<td>28. Limited Liability Company</td>
</tr>
<tr>
<td>17. Individual</td>
<td></td>
<td>29. Business Trust</td>
</tr>
</tbody>
</table>

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

________________________________________________________________________

Federal Tax FEIN # ____________________________   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 & Title (Required):

(Individual authorized to transact business with the Department of Health and upon whom all notices and orders shall be served.)

6. Agent Email (Required): _____________________________________________________

7. Attach evidence of workers' compensation coverage as required by Minnesota Statutes, Sections 176.181 and 176.182.

C. Home Management Services Offered

1. Please insert “1” if the home management task is provided directly by employee(s) of the license and “2” if the services are provided by contract with another provider.

   _____ Housekeeping
   _____ Meal Preparation
   _____ Shopping

2. Has every person who provides home management services attended an orientation session that provides training on the home care bill of rights and an orientation on the aging process and the needs and concerns of elderly and disabled persons?

   Yes _____  No _____

This orientation must be provided to persons who provide home management services within 120 days after beginning to provide services.

It is understood that the home care bill of rights applies to all clients who receive home management services and providers must be aware of and comply with the bill of rights provisions contained in Mn. Statute §144A.44, the Home Care/Hospice Law.
D. Verification/Registration Fee

Annual Registration Fee:

$20.00 for individuals
$50.00 for organizations

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

I enclose $ ____________, annual registration 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 registration form, please call (651) 201-4101.
OWNERSHIP INFORMATION SHEET

Name of Provider: _____________________________ City: __________________State: ________________

Zip Code: _____ County: ______________________ Date Completed: ______________________

Please provide the names, titles and addresses of all officers, directors, owners and managerial employees and the percent of ownership if proprietary.

<table>
<thead>
<tr>
<th>Name of Officers, Directors, Owners, and Managerial Employees</th>
<th>Title (President, Director, Partner, Stockholder, etc.)</th>
<th>Address (Street, City, Zip)</th>
<th>% of Ownership if proprietary (For profit)</th>
</tr>
</thead>
</table>