Application for Change of Ownership

COMPREHENSIVE HOME CARE LICENSE

General Instructions

This application is for individuals and organizations applying for a home care license due to a proposed change of ownership or transfer of a controlling interest to a different entity.

Statute references (with links to the Revisor’s website) occur throughout this application (e.g., 144A.472). Click on the link and scroll to the noted subdivision for information about the specific requirement(s). If you are working from a printed document you can search the statute reference at the Office of the Revisor of Statutes (https://www.revisor.mn.gov).

Instructions for Attachments

Some sections in this application require the applicant to submit attachments. Identify each attachment in the upper right corner with the number or letter as indicated in the application and checklist.

You must submit policies and procedures as listed in the checklist at the end of this application. These policies and procedures must be agency-specific and in compliance with Minnesota laws.

Keep a copy of the application and attachments for your records.

Submission

Mail the completed application (including all required documents and fees) to:

Minnesota Department of Health
Health Regulation Division
Home Care and Assisted Living Program
P.O. Box 3879
St. Paul, Minnesota 55101-3879

Completed applications for changes of ownership must be received in our office at least 60 days prior to acquiring ownership of or a controlling interest in a home care provider business.

Acknowledgement of Application Received

MDH will acknowledge receipt of the application in an email to the applicant and will indicate if additional information is needed. Incomplete or deficient applications may be rejected.

Review Process

As part of the review process, additional information may be requested. Answer all questions completely and accurately to avoid unnecessary delay. The department has 60 days from the date a completed application is received to issue or deny the license. Application materials will not be returned to applicants. License application fees are non-refundable.

Questions?
Contact Health.homecare@state.mn.us or 651-201-5273.
Application for Change of Ownership
COMPREHENSIVE HOME CARE LICENSE

Current Licensee Information
Name of existing licensee: ______________________________________________________________
Existing licensee’s health facility ID: _______________ Federal tax ID: __________________________
Proposed effective date for change of ownership: _________________________________________

Applicant Information
If you are using a home address for your business, please let the post office know the name of your
business to ensure mail delivery.
Assumed Name / “Doing Business As” Name (DBA): __________________________________________
Physical Address:______________________________________________________________________
City:  _______________________________________ State: __________ Zip:______________________
County: _____________________________________________________________________________
Telephone:  ________________________________ Fax:  _____________________________________
Mailing Address: ______________________________________________________________________
City:  _______________________________________ State: __________ Zip:______________________
Website (if applicable): _________________________________________________________________
Office physically located within: ☐ Commercial Business Building
☐ Private Home/Residence
☐ Other Licensed Facility or Provider
☐ Other: ______________________________________________

Office Hours

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<th>Sunday</th>
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<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
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<th>Saturday</th>
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Agent
A home care provider must designate one agent who is authorized to receive all notices and orders
(including license renewal information, survey and complaint investigation results). This information
will be mailed and/or emailed to the mailing address or email address provided. Applicants must provide
an email address.
APPLICATION FOR CHANGE OF OWNERSHIP:
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Agent: ______________________________________ Title: ______________________________________
Telephone: _________________________________ Email: ___________________________________

Provide the name and contact information of the individual to contact for questions regarding this application:

☐ Check box if same as above (and add fax number)

Name: ____________________________ Email: ____________________________
Telephone: ____________________________ Fax: ____________________________

Current Licensee Services

Has the current licensee provided home care services in the past 12 months?
☐ Yes ☐ No If yes, provide the last date of service: ____________________________

Payment Sources

List sources of income from the provision of licensed home care services by the current licensee: (check all that apply)

☐ Private Pay
☐ Private Insurance
☐ Medical Assistance/Medicaid (Waiver money)
☐ Medicare
☐ Veterans Administration
☐ Long Term Care Insurance
☐ Other (specify) ____________________________________________________________________

Current Clients

How many clients are being served by the current licensee? List the number of clients by age range.

_____ Under 22 years of age
_____ 22 – 45 years of age
_____ 46 – 65 years of age
_____ 66 – 84 years of age
_____ 85 + years of age

Medicare Certification

Is the current licensee a Medicare-certified home health agency (HHA)? ☐ Yes ☐ No
If yes, insert the Medicare number:
### Description of Other Licenses

Other Licenses and/or Enrollment

<table>
<thead>
<tr>
<th>License/Enrollment</th>
<th>Yes</th>
<th>No</th>
<th>Pending</th>
<th>License # or other ID</th>
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<tbody>
<tr>
<td>Family adult foster care</td>
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<td>Corporate adult foster care</td>
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<tr>
<td>Adult day care</td>
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<td>245D home and community-based services</td>
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<tr>
<td>Personal care assistance provider</td>
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<tr>
<td>Other Minnesota home care license(s)</td>
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<td>Other</td>
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Does applicant hold home health-related licenses from other states?  ☐ Yes  ☐ No

If yes, complete the information below. Add more pages if necessary.

<table>
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<tr>
<th>State</th>
<th>License type</th>
<th>License #</th>
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Has any owner or managerial official of this applicant ever had a license revoked by the Minnesota Department of Health, the Minnesota Department of Human Services, or any state agency in any state or jurisdiction? If yes, attach an addendum explaining the reason for the revocation.

☐ Yes  ☐ No

Has any owner or managerial official of this applicant ever had a temporary license or license denied, either at the application stage or on initial full survey, by the Minnesota Department of Health, the Minnesota Department of Human Services, or any state agency in any state or jurisdiction? If yes, attach an addendum explaining how the home care provider will manage the business differently if this change of ownership license is granted.

☐ Yes  ☐ No

### Service Locations

Will you serve clients in housing with services (HWS) establishments?  ☐ Yes  ☐ No

[Minnesota Statutes 144D Housing with Services Establishment](https://www.revisor.mn.gov/statutes/cite/144d)

List all HWS establishments (facility names and addresses) where you will serve clients. Check either “pending” or “active” to indicate if a HWS registration is active or if the application has been made and is
APPLICATION FOR CHANGE OF OWNERSHIP:
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Pending for this location. If you have the HWS health facility identification number (HFID), enter it in the space provided. If you do not have the HFID, leave that box blank. Attach separate page if needed.

<table>
<thead>
<tr>
<th>Pending</th>
<th>Active</th>
<th>HWS HFID</th>
<th>Facility Name</th>
<th>Address</th>
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Will you serve clients who do not live in a HWS establishment?  ☐ Yes  ☐ No

Other Office Locations

If you have additional office locations, list them here.

<table>
<thead>
<tr>
<th>Address</th>
<th>Telephone</th>
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Counties Served

List the counties where you intend to provide services. Do not list the counties where you do not intend to provide services:

___________________________________________________________________________________

Home Care Services

For each licensed home care service you will provide, enter 1, 2 or 3 in the left column per the instructions below. (144A.471, Subd. 2)

"1" – provide the service **directly** by the licensee or licensee’s employees
"2" – provide the service **by contract** with another licensed provider
"3" – provide the service **both directly by the licensee or licensee’s employees and by contract**

<table>
<thead>
<tr>
<th>Enter #</th>
<th>Comprehensive Home Care Services</th>
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<tbody>
<tr>
<td></td>
<td>Advanced practice nurse services</td>
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<td>Registered nurse services</td>
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<td>Licensed practical nurse services</td>
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<td></td>
<td>Physical therapy services</td>
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<td></td>
<td>Occupational therapy services</td>
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</table>
**APPLICATION FOR CHANGE OF OWNERSHIP:**
**COMPREHENSIVE HOME CARE LICENSE**

### Comprehensive Home Care Services

- Speech-language pathologist services
- Respiratory therapy services
- Social worker services
- Dietician or nutritionist services
- Medication management services*
- Delegation of tasks to unlicensed personnel*
- Hands-on assistance with transfers and mobility
- Treatment and therapies
- Eating assistance for clients with complicating eating problems (i.e. difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube, parenteral or intravenous instruments)
- Complex or specialty healthcare services**
  - Describe: ____________________________________________________________

### Basic Home Care Services

- Assistance with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing
- Standby assistance within arm’s reach for safety while performing daily activities
- Verbal or visual reminders to take regularly scheduled medication (includes bringing clients previously set-up medication, medication in original containers, or liquid or food to accompany the medication)
- Verbal or visual reminders to the client to perform regularly scheduled treatments and exercises
- Preparing modified diets ordered by a licensed health professional

### Home Management Services

- Shopping
- Housekeeping/other household chores
- Meal preparation

*To consider medication management services and delegation of tasks to unlicensed personnel as services provided directly, the RN (or the licensed health professional, in the case of non-nursing delegated tasks) must be a direct employee of the licensee.

**Refer to the frequently asked questions on the website for clarification:
Frequently Asked Questions for Providers of Home Care and Assisted Living Services
(https://www.health.state.mn.us/facilities/regulation/homecare/providers/faq.html)

**Registered Nurse/Other Licensed Health Professional**

Name: __________________________________________________ License #: ______________________
Address: ________________________________________________________________________________
City: ___________________________ State: _______________ Zip: _______________________________
Phone #: __________________________ Email: ______________________________________________

Does this RN/LHP work for other home care providers? ☐ Yes ☐ No  If yes, how many?

August 20
Ownership Information

State law requires that all applicants for home care licensure disclose the names, email and mailing addresses and telephone numbers of all owners and managerial officials, regardless of the nature of the entity applying for licensure. The purpose of this section is to collect information about the person(s) and/or entity responsible for the operation of this home care provider.

Business entities: List the name of the legal entity if you have formed a business. Generally, this means you are operating as a business corporation, nonprofit corporation, limited liability company, partnership or government entity. Print the full legal entity name as it appears on file with the Minnesota Office of the Secretary of State. Do not abbreviate.

Individuals: List the name of the individual if you are operating as a sole proprietorship. This means that the business is owned and operated by an individual and there is no distinction between the owner and the business. Sole proprietorships must still register with the Minnesota Office of the Secretary of State to use an assumed name (or “doing business as” or DBA name), may have employees and may obtain a federal tax ID from the Internal Revenue Service.

Note: The applicant/licensee must provide at least one home care service directly, meaning this service is either provided by the individual listed below (sole proprietorships) or the service is provided by an employee(s) of the legal entity/sole proprietor below. Services provided by contract are not direct services. Refer to 144A.471, Subd. 2 for information on "Determination of direct home care service."

Print the full legal entity name as it appears on file with the Minnesota Office of the Secretary of State. Do not abbreviate. In the case of a sole proprietorship, print the full legal name of the owner.

Legal Name: _________________________________________________________________________

Federal Tax ID #: ____________________________ State Tax ID #:  _____________________________

Parent Company

Is the applicant a subsidiary of another organization? If yes, provide the information requested below:

Parent Organization Name: _________________________________________________________________________

Parent Organization Federal Tax ID:  _____________________________________________________________

Parent Organization Address:  _____________________________________________________________

City/State/Zip: ________________________________________________________________________

Ownership Type

Select the owner type that applies to this application.

☐ Sole Proprietorship  ☐ State
☐ For-Profit Corporation  ☐ County
☐ Nonprofit Corporation  ☐ City
☐ For-Profit Limited Liability Company  ☐ Tribal
☐ Nonprofit Limited Liability Company  ☐ Church
☐ Partnership  ☐ Health District or Authority
According to the ownership type selection above, submit the documents listed below. Identify each attachment (in the upper right corner) with the letter indicated.

**SOLE PROPRIETORSHIP**
A: Copy of the certificate of doing business under an assumed name (if applicable).

**FOR-PROFIT CORPORATION**
A: Copy of the certificate of doing business under an assumed name (if applicable).
B: Copy of the certificate of incorporation.
C: Complete list of all board members, officers, and principal stockholders indicating position or title of each and the number of shares of stock to be owned by each.
D: Brief description of the organization structure of the agency, including a table of organization and relationship to any existing parent entity (if applicable).

**NONPROFIT CORPORATION**
A: Copy of the certificate of doing business under an assumed name (if applicable).
B: Copy of the certificate of incorporation.
C: Complete list of all board members, officers and members indicating position or title of each and a brief description of the membership interests, if applicable.
D: Brief description of the organization structure of the agency, including a table of organization and relationship to any existing parent entity (if applicable).

**LIMITED LIABILITY COMPANY (For-profit or Nonprofit)**
A: Copy of a certificate of doing business under an assumed name (if applicable).
B: Copy of the most current articles of organization.
C: Complete list of all board members, managers (including Chief Manager), and members (owners) indicating position or title of each and the percent of ownership of each member.
D: If the LLC will be managed by managers who are not members, a copy of the existing management agreement between the LLC and the manager.
E: Brief description of the organization structure of the agency, including a table of organization and relationship to any existing parent entity (if applicable).

**PARTNERSHIP**
A: Copy of the certificate of doing business under an assumed name (if applicable).
B: Specification of type of partnership.
C: Complete list of partners.
D: Copy of the partnership agreement.
E: Brief description of the organization structure of the agency, including a table of organization and relationship to any existing parent entity (if applicable).

**GOVERNMENT SUBDIVISION/TRIBAL**
A: Copy of the certificate of doing business under an assumed name (if applicable).
B: Brief description of the organization structure of the agency.

**CHURCH/HEALTH DISTRICT OR AUTHORITY**
A: Copy of the certificate of doing business under an assumed name (if applicable).
B: Brief description of the organization structure of the agency.
Ownership Interests

On this page, provide the full legal name, title, address, phone number, and email address for all officers, directors, partners, and owners of the applicant listed above. Include the percent of ownership or interest. Indicate if the individual will have direct contact with home care clients. Copy this page if additional space is needed.

Owners are individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider. An individual who has less than 5% of equity interest or voting stock is not considered an “owner” for purposes of this section. (144A.43, Subd. 17; 144A.476, Subd. 1(b))

<table>
<thead>
<tr>
<th>Legal Name</th>
<th>Title</th>
<th>Permanent Address</th>
<th>City/State/Zip</th>
<th>Telephone</th>
<th>Email Address</th>
<th>% of ownership</th>
<th>Will this individual provide direct contact?</th>
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Managerial Officials

"Managerial official" means an administrator, director, officer, trustee, or employee of a home care provider, however designated, who has the authority to establish or control business policy.

Provide the name, title, address, phone number, and email address for all managerial officials. Indicate whether the individual will have direct contact with home care clients. You do not need to list owners who are already listed above. Attach an additional sheet if necessary.

Managerial official in charge of day-to-day operations (144A.472, Subd. 1 (11))

Legal Name: _____________________________________ Title: ________________________________
Permanent Address (PO Box is not acceptable): _____________________________________________
City/State/Zip: _______________________________________________________________________
Telephone: ________________________ Email Address: _____________________________________
Will this individual provide direct contact? ☐ Yes ☐ No
Type: ☐ Administrator ☐ Director ☐ Officer ☐ Trustee ☐ Other or Employee

Additional managerial officials

Legal Name: _____________________________________ Title: ________________________________
Permanent Address (PO Box is not acceptable): _____________________________________________
City/State/Zip: _______________________________________________________________________
Telephone: ________________________ Email Address: _____________________________________
Will this individual provide direct contact? ☐ Yes ☐ No
Type: ☐ Administrator ☐ Director ☐ Officer ☐ Trustee ☐ Other or Employee

Legal Name: _____________________________________ Title: ________________________________
Permanent Address (PO Box is not acceptable): _____________________________________________
City/State/Zip: _______________________________________________________________________
Telephone: ________________________ Email Address: _____________________________________
Will this individual provide direct contact? ☐ Yes ☐ No
Type: ☐ Administrator ☐ Director ☐ Officer ☐ Trustee ☐ Other or Employee

Legal Name: _____________________________________ Title: ________________________________
Permanent Address (PO Box is not acceptable): _____________________________________________
City/State/Zip: _______________________________________________________________________
Telephone: ________________________ Email Address: _____________________________________
Will this individual provide direct contact? ☐ Yes ☐ No
Type: ☐ Administrator ☐ Director ☐ Officer ☐ Trustee ☐ Other or Employee
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Type:  ☐ Administrator  ☐ Director  ☐ Officer  ☐ Trustee  ☐ Other or Employee

Legal Name: ____________________________________ Title: ____________________________________

Permanent Address (PO Box is not acceptable): _____________________________________________

City/State/Zip: _______________________________________________________________________

Telephone: ________________________ Email Address: _____________________________________

Will this individual provide direct contact? ☐ Yes  ☐ No

Type:  ☐ Administrator  ☐ Director  ☐ Officer  ☐ Trustee  ☐ Other or Employee

Management Companies
Will there be another legal entity providing management services for this home care provider? If so, complete the following information:

Legal Name: ____________________________________ Title: ____________________________________

Permanent Address (PO Box is not acceptable): _____________________________________________

City/State/Zip: _______________________________________________________________________

Telephone: ________________________ Email Address: _____________________________________

Submit a copy of the management agreement between the applicant and the entity providing management services.

Background Studies
All owners, managerial officials and the named RN or other licensed health professional on home care license applications must complete and pass background studies, as required by 144A.476, prior to MDH issuing a temporary license or a change of ownership license. Background studies are conducted by the Department of Human Services (DHS). Information about initiating background studies will be provided to applicants when MDH confirms receipt of the application.

After MDH issues a temporary license or change of ownership license, providers must complete background studies for all individuals seeking employment, paid or volunteer, as required by 144.057. DHS will provide more information at that time.

Questions about background studies?
Contact DHS Background Studies (https://mn.gov/dhs/general-public/background-studies/providers/) or 651-431-6620.

Workers’ Compensation Insurance
State law requires that the commissioner of health withhold the license for the operation of a home care provider until the applicant presents acceptable evidence of compliance with workers’ compensation requirements. **If the applicant has employees it must have active workers’ compensation insurance and the applicant must be listed as the insured entity.** An application for workers’ compensation insurance is not acceptable as evidence of coverage. You will not be issued a license to operate as a home care provider unless acceptable evidence of compliance with 176.181 and 144.057.
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176.182 is presented with this application or you meet an exception from coverage. Applicants can find information on the Department of Labor website:

Workers' Compensation – Businesses

Check the type of evidence of coverage that is included with this application.

☐ Certificate of Workers’ Compensation Insurance Coverage
This document is supplied by an authorized workers’ compensation carrier pursuant to Minnesota Statute 60A.06, Subd. 1(5b). The insurance must be in effect prior to the issuance of a license.

☐ Self-Insured Workers’ Compensation (Including Attachment “A”)
This type of coverage is generally held by large organizations. The certificate is issued from the commissioner of commerce permitting an organization to self-insure pursuant to Minnesota Statute 79A and Minnesota Rules Chapter 2780. Questions regarding self-insurance should be directed to:

Minnesota Department of Commerce

☐ Self-Insured as a Government Entity
Written confirmation from your third party 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 Minnesota Statute 176.181, Subd. 2. The reinsurance certificate must be renewed annually on a calendar year basis.

☐ I do not have employees
This option is only applicable if the home care provider does not have employees. "Employee" is defined in Minnesota Statute 176.011, subd. 9.

Fees
A fee must accompany all applications. An application without a fee is incomplete. Fees are nonrefundable. If payment is rejected due to insufficient funds a $30.00 fee will apply. Make check payable to “Minnesota Department of Health”.

Fee
Change of Ownership Comprehensive License Application – $4,200

Managerial Official Verification
Read the following statements, initial each, if true, and sign below.

I certify that I have read and understand the following Minnesota Statutes:

_____ Home Care Statutes (https://www.health.state.mn.us/facilities/regulation/homecare/laws/index.html)
_____ Housing with Services Establishment (https://www.revisor.mn.gov/statutes/cite/144d) (if applicable)
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______ Assisted Living Services (https://www.revisor.mn.gov/statutes/cite/144g) (if applicable)
______ Reporting of Maltreatment of Minors (https://www.revisor.mn.gov/statutes/cite/626.556)
______ Reporting of Maltreatment of Vulnerable Adults (https://www.revisor.mn.gov/statutes/cite/626.557)
______ Electronic Monitoring in Certain Facilities (https://www.revisor.mn.gov/statutes/cite/144.6502) (if applicable)

_____ I understand that pursuant to Minnesota Statute 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets Minnesota Statute sections 144A.43 through 144A.484 requirements for home care licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a temporary license or license. I understand that information submitted to the commissioner in this licensing application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys’ offices, police, local or county public health offices.

_____ I understand that in accordance with Minnesota Statute 144.051 Data Relating to Licensed and Registered Persons, all data submitted on this application shall be classified as public information upon issuance of a temporary license or license. All data submitted are considered private until a temporary license or license is issued.

I declare that, as the managerial official in charge of day-to-day operations of this business, I have examined this application and all attachments, and checked the above boxes indicating my review and understanding Minnesota Statutes and requirements related to home care. To the best of my knowledge and belief, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required.

Name (print or type):  ____________________________________ Date: _________________________
Signature:  _____________________________________________ Title:  ________________________

Application Checklist

Applicants must complete this checklist and include it with their application, along with the fee and attachments, including all policies and procedures outlined below. Label each attachment (in the upper right corner) with the number or letter as indicated below.

Fees

☐ Include a check or money order payable to “Minnesota Department of Health”. Starter or counter checks are not accepted. Fees are non-refundable.
  o Change of ownership comprehensive license application fee - $4,200

Workers’ Compensation Insurance

☐ Attachment #1 – Include evidence of workers’ compensation insurance coverage.
Policies and Procedures

Attach the following agency-specific policies and procedures (144A.472). See information on the website:

☐ Attachment #2 – Requirements for reporting of maltreatment of minors (626.556) and reporting of maltreatment of vulnerable adults (626.557).

☐ Attachment #3 – Requirements for instructors, training content and competency evaluations (144A.4795, subd. 7).

☐ Attachment #4 – Training, orientation and competency evaluations of home care staff (144A.4795; 144A.4796).

☐ Attachment #5 – Complaint and investigation process (144A.4791, subd. 11).

☐ Attachment #6 – Service plan implementation and revisions (144A.4791, subd. 9).

☐ Attachment #7 – Home care client bill of rights (144A.44 and 144A.4791, subd. 1).

☐ Attachment #8 – Tuberculosis prevention: control plan and risk assessment (144A.4798, subd. 1).

☐ Attachment #9 – Comprehensive assessment, monitoring and reassessment (144A.4791, subd. 8).

☐ Attachment #10 – Supervision of unlicensed personnel performing delegated home care tasks (144A.4797).

Other Documents

☐ Attachment #11 – If you have liability insurance, include evidence of this coverage.

☐ Attachment #12 – Federal tax identification number (FEIN) documentation (IRS form SS-4)

☐ Attachment #13 – Bill of sale or transfer of ownership documents (for CHOWs, when available)

☐ Attachments A-E – (as applicable) from Ownership section

☐ Check this box if you are also submitting a housing with services application. Do not attach your HWS application here.

☐ Submit a copy of the management agreement between the applicant and the entity providing management services (if applicable).