Change of Information
TEMPORARY LICENSED AND LICENSED HOME CARE PROVIDERS

Minnesota home care statute requires licensed home care providers and registered home management providers to notify the Minnesota Department of Health (MDH) **within ten days** when there is a change on the license or registration. Use this form to notify MDH.

Minnesota Statute 144A.472, Subd. 6, https://www.revisor.mn.gov/statutes/cite/144A.472

**Note:** If you are a Medicare-certified Home Health Agency (HHA), you must complete additional information. Contact Licensing and Certification at 651-201-4101 or health.fpc-web@state.mn.us or visit Federal Certification Process for Home Health Agencies (https://www.health.state.mn.us/facilities/regulation/hhamedicare/) for more information.

Current Information on Record with MDH

*Licensee’s Legal Name:__________________________________________________________
*Licensee’s Doing Business As (DBA) Name:__________________________________________
*Health Facility ID (HFID – 5 digit #):_______________________________________________
*Agent:_______________________________________________________________________
*Email:________________________________________________________________________
*Mailing Address:________________________________________________________________
*City, State, & Zip:_______________________________________________________________
*Phone:__________________________  *Medicare-certified HHA:  ☐ Yes  ☐ No
*Effective Date of Changes: ________ / _______ / __________

*Information is required to process changes of information.

Change of Company 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’ 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 Contact Information

☐ Change of Physical Address  ☐ Change of Mailing Address  ☐ Both

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HCALP-F4040
04/29/2019
Previous Address: ______________________________________
______________________________________
______________________________________

New Address: ______________________________________
______________________________________
______________________________________

New Phone #: ______________________________________

New Fax #: ______________________________________

New Email Address: ______________________________________

Workers’ Compensation

☐ Agency has hired employees and now has workers’ compensation insurance.
☐ Workers’ compensation insurance is carried by a management company or an affiliated organization.

Provide the following information.

Insurer: ______________________________________  Insured: _______________________________
Policy #: _______________________________ Effective date: ___________ End date: _____________

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 home care provider. A new agent cannot authorize adding his/her own name to the license.

Previous Agent Name: ______________________________________

New Agent Name: ______________________________________

New Agent’s Email: ______________________________________

Change of Housing with Services

List changes to housing with service locations below. If you are terminating services to clients you must comply with the following statutes.

Home care services:
Minnesota Statutes 144A.44 (https://www.revisor.mn.gov/statutes/cite/144A.44)
Minnesota Statutes 144A.4791, Subd. 10 (https://www.revisor.mn.gov/statutes/cite/144A.4791)
Minnesota Statutes 144A.4794, Subd. 4 (https://www.revisor.mn.gov/statutes/cite/144A.4794)

Assisted living services:
Minnesota Statutes 144A.441 (https://www.revisor.mn.gov/statutes/cite/144A.441)
Minnesota Statutes 144A.442 (https://www.revisor.mn.gov/statutes/cite/144A.442)
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Added Location(s): __________________________ HFID(s): ________

Added Location(s): __________________________ HFID(s): ________

Dropped Location(s): __________________________ HFID(s): ________

Dropped Location(s): __________________________ HFID(s): ________

NOTE: If you are closing a license do not use this form; use the Closure Form (HCALP-F4045).

Change of Office Locations

If you have changed office locations, list below:

Added Location(s): __________________________ HFID(s): ________

Dropped Location(s): __________________________ HFID(s): ________

*Authorizing official on record: __________________________

*Signature of authorizing official: __________________________

*The person authorizing changes to the license 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.homecare@state.mn.us

Questions?
Call 651-201-5273