Application for Registration as a Provider of Home Management Services

Overview
This application is for use by individuals or organizations that provide at least two of the following services: housekeeping, meal preparation and shopping to a person who is unable to perform these activities due to illness, disability or physical condition. The registration must be renewed annually.

Statute
144A.482 Registration of Home Management Providers
   https://www.revisor.mn.gov/statutes/cite/144A.482

Instructions
Please answer all questions completely and accurately to avoid unnecessary delay. All renewal registrations must be filed 30 days prior to the expiration date of the current registration certificate.

Submission
Send the completed application and fee to:
   Home Care and Assisted Living Program
   Minnesota Department of Health
   Health Regulation Division
   P.O. Box 3879
   St. Paul, Minnesota  55101-3879

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

Applicant Information
Assumed Name / “Doing Business As” Name (DBA): ________________________________
Physical Address: ________________________________________________________________
City: ___________________________ State: ________ Zip: ____________________________
APPLICATION FOR HOME MANAGEMENT REGISTRATION

County: _______________________________________________________________________
Telephone: ______________________ Fax: ________________________________________
Mailing Address: ______________________________________________________________
City: _____________________________ State:_________ Zip:_____________________
Website (if applicable): __________________________________________________________
Counties where services are provided: ____________________________________________
Note: 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.

Agent
Agent Name: ___________________________________________________________________
("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 management provider.)
Agent Email: ___________________________________________________________________

Ownership Information
Legal Name: ____________________________________________________________________
Federal Tax FEIN # ____________________ State Tax ID #______________________________

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

Owners and Managerial Officials
In the space below, provide the full legal name, title, address, phone number, and email
address for all officers, directors, partners, owners and managerial officials of the applicant
listed above. Include the percent of ownership or interest. Use additional pages if necessary.

Legal Name: ________________________________ Title: ______________________________
Permanent Address (PO Box is not acceptable): ______________________________________
City/State/Zip: _________________________________________________________________
APPLICATION FOR HOME MANAGEMENT REGISTRATION

Telephone: _______________________ Email Address: ________________________________
Owner/Member: % of ownership: ____________________

______________________________________________________________________________

Legal Name: ________________________________ Title: ______________________________
Permanent Address (PO Box is not acceptable): _______________________________________
City/State/Zip:  _________________________________________________________________
Telephone:  _______________________ Email Address:  ________________________________
Owner/Member: % of ownership: _________________

______________________________________________________________________________

Legal Name: ________________________________ Title: ______________________________
Permanent Address (PO Box is not acceptable): _______________________________________
City/State/Zip:  _________________________________________________________________
Telephone:  _______________________ Email Address:  ________________________________
Owner/Member: % of ownership: _________________

Home Management Services Offered

Check which services will be provided by the registrant:

☐ Housekeeping
☐ Meal Preparation
☐ Shopping

Workers’ Compensation Insurance

State law requires that the commissioner of health withhold the registration for the operation of a home management business 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 registration to operate as a home management provider unless acceptable evidence of compliance with sections 176.181 and 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 registration.

☐ 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
https://mn.gov/commerce/industries/insurance/licensing/self-insurance/

☐ 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.

If you do not plan to hire employees for your home management agency as of now, please confirm in writing by submitting a definitive signed letter. This letter must include your address and state that you are not planning to hire employees. If the situation changes and you hire employees, you agree to contact MDH.

Registration Fee
Annual Registration Fee:

- Individuals – $20.00
- Organizations – $50.00

A fee of $30.00 will be charged for any payment rejected due to insufficient funds.

Managerial Official Verification
The undersigned hereby registers to provide home management services subject to the requirements of Minnesota Statutes, sections 144A.44 and 144A.482. 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 144A.44 and 144A.482
  (https://www.health.state.mn.us/facilities/regulation/homecare/laws/index.html)
- 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)

- I understand that the home care bill of rights as in provided in Minnesota Statute, section 144A.44 applies to clients receiving home management services and I agree to comply with those provisions.
APPLICATION FOR HOME MANAGEMENT REGISTRATION

_____ I understand the commissioner may suspend or revoke the certificate of registration or assess fines for violation of the home care bill of rights.

_____ I understand that any individual who provides home management services under Minnesota Statute, section 144A.482 will, within 120 days of beginning to provide services, attend 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.

_____ 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 the registration. All data submitted are considered private until the registration is issued.

_____ I understand that pursuant to Minnesota Statute 13.04 Rights of Subjects of Data, the commissioner will use information provided in this application to determine if the applicant meets the requirements for home management registration. 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 registration. I understand that information submitted to the commissioner in this 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.

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

Applicant signature ______________________________________________________________

Name (please print or type)  _______________________________________________________

Title ________________________________________ Date  _____________________________

Minnesota Department of Health
Home Care and Assisted Living Program
Health Regulation Division
PO Box 3879
St. Paul, MN 55101-3879
651-201-5273
health.homecare@state.mn.us
Home Care and Assisted Living Program
https://www.health.state.mn.us/facilities/regulation/homecare/index.html