DEPARTMENT OF HEALTH

Application for Change of Ownership
COMPREHENSIVE HOME CARE

General Instructions

This application is for individuals and organizations applying for a comprehensive 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/).

Licensure Requirements

Under Minnesota law, a home care provider is defined as an individual, organization, association, corporation, unit of government, or other entity that is regularly engaged in delivering at least one home care service directly in a client's home for a fee (Minn. Stat. § 144A.43, Subd. 4). To maintain a Basic or Comprehensive Home Care license through the Minnesota Department of Health (MDH), providers must meet this definition by delivering qualifying home care services—as described in Minn. Stat. § 144A.471, Subdivisions 6 and 7—to at least one client, for a fee, during each 12-month license period.

If you have questions about whether your services align with MDH home care licensing requirements, we encourage you to contact us at Health.homecare@state.mn.us or 651-201-4200, before submitting an application.

Submitting the Application and Attachments

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.

Applicants must upload the application and required attachments to the MDH application portal: Facility and Provider Licensing System (https://hrdlicensing.web.health.state.mn.us/#).

If you are also submitting an Integrated License Home and Community-Based Services (HCBS) Designation, you have the option to submit that application and relevant supporting documents at the same time as the comprehensive home care license. Please see the Integrated License application for additional information. Alternatively, you can submit the HCBS application at a later date.

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

Attachment Checklist

Applicants must upload all applicable attachments outlined below with an application, in the MDH application portal.

- ☐ Evidence of workers' compensation insurance coverage, if applicable.
- ☐ Evidence of liability insurance, if applicable.
- ☐ Federal tax identification number (FEIN) documentation (IRS form 147-C).
- ☐ From ownership section, Attachments A-E, as applicable based on ownership type and labeled in top right corner with letter shown in ownership section.
- ☐ Bill of sale or transfer of ownership documents (when available).
- ☐ Copy of the management agreement between the applicant and the entity providing management services, if applicable.
- ☐ Explanation of why the license was revoked, if applicable.
- ☐ Explanation of how this home care provider, if granted, will manage business differently than the license that was denied, if applicable.

Acknowledgment of Receipt of Application and Attachments

MDH will acknowledge receipt of the application in the MDH application portal. Incomplete or inaccurate applications may be rejected and will be sent back to the applicant (144A.472).

Fees

Once MDH determines it has all required application information, signatures, and attachments, MDH will contact the applicant to request payment of the application fee, in the MDH application portal.

Change of Ownership Comprehensive Home Care License = $4,200.

Review Process

As part of the review process, additional information may be requested. If additional information is needed, MDH will contact you to request the additional information. Please answer all questions completely and accurately to avoid unnecessary delays. If your application is not filled out properly, required attachments are not submitted, or other issues prevent your application from being deemed complete, MDH will not ask for payment.

Finally, a thorough verification of the application will take place. The application is deemed complete when all documentation and background studies have been submitted and fully verified. MDH will notify and issue the appropriate home care license to successful applicants.

Questions?

Contact Health.homecare@state.mn.us or 651-201-4200.

Current Licensee Information

Name of existing licensee _____

Existing licensee's Health Facility ID (HFID) _____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 _____

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.

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_____

Office Hours

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

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)

☐ 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 Minnesota Licenses and/or Enrollment

Please mark either the Yes, No, or Pending column with an "X" for each license type/enrollment listed. If yes, provide the license # or other ID.

License/Enrollment	Yes	No	Pending	License # or other ID
Family adult foster care				
Corporate adult foster care				
Adult day care				
245D home and community-based services				
Personal care assistance provider				
Assisted living facility				
Assisted living facility with dementia care				
Other Minnesota home care license(s)				
Other				

Does applicant hold home health-related licenses from other states?

☐ Yes (If yes, complete the information below. Add more pages if necessary)

☐ No

State	License type	License #

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 temporary license is granted.

☐ Yes ☐ No

Other Office Locations

If you have additional office locations, list them here.

Address	Telephone
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

Do you intend to provide both sleeping accommodations and home care services to clients?

☐ Yes

☐ No

If you answered "Yes", please note that a Temporary Comprehensive Home Care License is **not appropriate** for the services you intend to provide.

Under Minn. Stat. § 144A.471, Subd. 1a, any provider offering both sleeping accommodations and home care services is required to be licensed as an Assisted Living Facility.

Instead, you must submit an application for a Provisional Assisted Living License, which can be found here:

Provisional Assisted Living Licensure Information and Application.

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.**

Enter #	Comprehensive Home Care Services
	Advanced practice nurse services.
	Registered nurse services.
	Licensed practical nurse services.
	Physical therapy services.
	Occupational therapy services.
	Speech-language pathologist services.
	Respiratory therapy services.
	Social worker services.
	Dietician or nutritionist services.
	Medication management service†.
	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:

†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 Consumers about Home Care (https://www.health.state.mn.us/facilities/regulation/homecare/consumers/faq.html)

Enter #	Basic Home Care Services
	Assistance with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing

Enter #	Basic Home Care Services
	Standby assistance to assist a client with an assistive task by providing cues, oversight, and minimal physical assistance
	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.

Enter #	Home Management Services
	Shopping.
	Housekeeping/other household chores.
	Meal preparation.

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?_____

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 https//mblsportal.sos.state.mn.us/Business/Search. 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 #_____

See Minnesota Department of Revenue (https//www.revenue.state.mn.us/minnesota-tax-id-requirements) to determine if you need a state tax ID.

Parent Company

Is the applicant a ***subsidiary*** of another organization?

☐ Yes (If yes, provide the information requested below) ☐ No

Parent Organization Name _____

Parent Organization Federal Tax ID _____

Parent Organization Address _____

City/State/Zip _____

Ownership Type

Select the ownership type that applies to this application.

☐ Sole Proprietorship
☐ For-Profit Corporation
☐ Nonprofit Corporation
☐ For-Profit Limited Liability Company
☐ Nonprofit Limited Liability Company
☐ Partnership
☐ State
☐ County
☐ City
☐ Tribal
☐ Church
☐ 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 for each document.

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 DISCTRICT 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. **Attach additional copies of this page if more 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))

Legal Name _____ Title _____

Permanent Address (PO Box is not acceptable) _____

City/State/Zip _____

Telephone _____ Email Address _____

Owner/Member % of ownership _____

Will this individual provide direct contact? ☐ Yes ☐ No

Legal Name _____ Title _____

Permanent Address (PO Box is not acceptable) _____

City/State/Zip _____

Telephone _____ Email Address _____

Owner/Member % of ownership _____

Will this individual provide direct contact? ☐ Yes ☐ No

Legal Name _____ Title _____

Permanent Address (PO Box is not acceptable) _____

City/State/Zip _____

Telephone _____ Email Address _____

Owner/Member % of ownership _____

Will this individual provide direct contact? ☐ Yes ☐ No

Legal Name _____ Title _____

Permanent Address (PO Box is not acceptable) _____

City/State/Zip _____

Telephone _____ Email Address _____

Owner/Member % of ownership _____

Will this individual provide direct contact? ☐ Yes ☐ No

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. **Attach additional copies of this page if more space is needed.**

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 ☐ Board Member ☐ 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 ☐ Officer ☐ Board Member

☐ Director ☐ 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 ☐ Officer ☐ Board Member

☐ Director ☐ 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 ☐ Officer ☐ Board Member

☐ Director ☐ 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 ☐ Officer ☐ Board Member

☐ Director ☐ Trustee ☐ Other or Employee

Management Companies

Will there be another legal entity providing management services for this home care provider?

☐ Yes (If yes, complete the following information) ☐ No

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 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 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/) 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 176.182 is presented with this application or you meet an exception from coverage. Applicants can find more information on the Department of Labor website: Workers' Compensation – Businesses (https//www.dli.mn.gov/business/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 Workers' Compensation (https://mn.gov/commerce/licensing/list/insurance/workers-compensation.jsp).

☐ **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 currently. If I hire employees, I will obtain workers' compensation insurance and notify MDH:** This option is only applicable if the home care provider does not have employees. "Employee" is defined in Minnesota Statute 176.011, subd. 9.

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)

_____ Reporting of Maltreatment of Minors (https//www.revisor.mn.gov/statutes/cite/260E)

_____ Reporting of Maltreatment of Vulnerable Adults (https//www.revisor.mn.gov/statutes/cite/626.557)

_____ I verify that the applicant has the following policies and procedures in place so that if a license is issued, the applicant will implement the policies and procedures and keep them current.

_____1. Requirements in chapter 260E, reporting of maltreatment of minors, and section 626.557, reporting of maltreatment of vulnerable adults.

_____2. Conducting and handling background studies on employees.

_____3. Orientation, training, and competency evaluations of home care staff, and a process for evaluating staff performance.

_____4. Handling complaints from clients, family members, or client representatives regarding staff or services provided by staff.

_____5. Conducting initial evaluation of clients' needs and the providers' ability to provide those services.

_____6. Conducting initial and ongoing client evaluations and assessments and how changes in a client's condition are identified, managed, and communicated to staff and other health care providers as appropriate.

_____7. Orientation to and implementation of the home care client bill of rights.

_____8. Infection control practices.

_____9. Reminders for medications, treatments, or exercises, if provided.

_____10. Conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards.

_____11. Conducting initial and ongoing assessments of the client's needs by a registered nurse or appropriate licensed health professional, including how changes in the client's conditions are identified, managed, and communicated to staff and other health care providers, as appropriate.

_____12. Ensuring that nurses and licensed health professionals have current and valid licenses to practice.

_____13. Medication and treatment management.

_____14. Delegation of home care tasks by registered nurses or licensed health professionals.

_____15. Supervision of registered nurses and licensed health professionals.

_____16. Supervision of unlicensed personnel performing delegated home care tasks.

_____ 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 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 license. All data submitted are considered private until a 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 _____

Minnesota Department of Health
Health Regulation Division
Licensing, Registration, and Certification
PO Box 3879
St. Paul, MN 55101-3879
651-201-4200
health.homecare@state.mn.us
Home Care https//www.health.state.mn.us/

09/16/2025

To obtain this information in a different format, call: 651-201-4200.