DEPARTMENT OF HEALTH

For MDH Use Only

Check #_____
Fee Deposit #_____
Deposit Date_____
Initials_____
SFM Date_____

Application for a Medicaid Certified Psychiatric Residential Treatment Facility (PRTF) and License as a Supervised Living Facility (SLF)

In accordance with Minnesota Statute §13.41, **ALL DATA SUBMITTED ON THIS APPLICATION SHALL BE CLASSIFIED PUBLIC INFORMATION.**

Answer all questions completely and accurately to avoid unnecessary delay.

Minnesota Department of Health
Health Regulation Division
PO Box 64900
St. Paul, MN 55164-0900

The undersigned hereby makes application to operate a Supervised Living Facility subject to the provisions of Minnesota Statutes Section 144.50-144.58, and the rules adopted thereunder and a Psychiatric Residential Treatment Facility subject to the provisions CFR Part 483, Subpart G.

Type of Application (check all that apply)

☐Initial License/Certification ☐License Renewal
☐Annual Federal Attestation ☐Change of Ownership*

*If a change of ownership application, proposed effective date:_____

A. Identification

1. Please correct name and address if incorrect:
    a. Name_____
    b. Street_____
    c. City/Zip_____
2. Telephone number_____Fax number _____
3. Name of county in which facility is located_____
4. Name of administrator_____
5. Administrator's email address_____

B. Ownership

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

   Ownership Code_____

GOVERNMENTAL NONFEDERAL	NONGOVERNMENTAL NONPROFIT	NONGOVERNMENTAL FOR PROFIT	OTHER
11. State 12. County 13. City 14. City-County 15. Hospital District or Authority	20. Church-related 21. Nonprofit Corporation 22. Other Nonprofit Ownership	23. Individual 24. Partnership 25. Corporation 26. Group 28. Limited Liability Company 29. Business Trust	27. Tribal

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

   _____

   Federal ID #_____State Tax ID #_____

3. If a corporation, give the date and place of incorporation_____

4. President/Chairperson_____

C. Licensed Beds (A bed must be licensed if it is available for use by residents)

Insert the licensed bed capacity for determination of license fee.

Supervised Living Facility: Class B (**all PRTF residents are classified as not capable of self-preservation**):

_____

D. Personnel

1. Name and title of person in charge in the absence of the administrator

   _____

2. Give the name of the person in charge of each category:

   a. Nursing Service_____

   b. Dietary Service_____

   c. Medical Records_____

E. Program License Information

Department of Human Services program license currently held:

☐ Program Rule 2960 License – PRTF Variance

F. Other Licenses/Registrations

What other licenses/registrations issued by the State of Minnesota does the owner or legal entity hold? (Please list license/registration name and number): _____

_____

G. SLF Waiver Application to Serve Individuals 21 Years of Age or Younger

This SLF application is a request to waive Minnesota Rule 4665.0100 Definitions Subpart 10 to read:

"Supervised Living Facility" means a facility in which there is provided supervision, lodging, meals and in accordance with provisions of rules of the Department of Human Services, counseling and developmental habilitative or rehabilitative services to five or more persons who are developmentally disabled, chemically dependent, mentally ill, or physically disabled.

H. Commission for Accreditation

Attach the accreditation decision letter from the Accrediting Organization, including the effective date, the expiration date of the accreditation, and the date of the last site visit by the Accrediting Organization.

Check the appropriate Accrediting Organization:

☐ Joint Commission on Accreditation of Healthcare Organizations

☐ Commission on Accreditation of Rehabilitation Facilities

☐ Council on Accreditation of Services for Families and Children

I. Verification

The law requires that an application on behalf of a corporation, association or governmental unit shall be made by any two officers thereof or by its managing agents. **This requires two (2) signatures.** All other applications require one (1) signature.

The Applicant(s) state that the information contained on all parts of this application is complete and accurate.

_____	_____
Signature	Signature
_____	_____
Name	Name
_____	_____
Date	Date
_____	_____
Title or Position	Title or Position

J. License Fees

Supervised Living Facility	$183.00 base fee plus $91.00 per bed

Make checks payable to "Minnesota Department of Health"

NOTE: If you have questions concerning this license application, please email MDH at health.fpc-licensing@state.mn.us.

K. Ownership Information Sheet

Legal Entity (same as Item B.2. on Page 2)

Name of Facility_____City_____

Zip Code_____County_____Date _____

This form must be completed by all psychiatric residential treatment facilities/supervised living facilities licensed/certified by the Minnesota State Department of Health. This requirement is applicable to facilities of all categories of ownership - nonprofit corporation, city, county, district, state, proprietary, church, etc.

The requirement stems from Minnesota Rule 4665.0400, subp. 2 of the Department of Health Supervised Living Facilities Rules.

Please provide the following information:

1. Full disclosure of each person having interest of ten (10) percent or more.
2. In case of corporate ownership*, the name and address of each officer and director.
3. If the home is organized as a partnership, the name and address of each partner.
4. If the home is operated by a lessee, the persons or business entities having an interest in the lessee organization and an executed copy of the lease agreement furnished.
5. If the home is operated by the holder of a franchise, disclosure of the franchise holder with an executed copy of the franchise agreement.

Name of Officers, Directors and Owners	Title (President, Director, Partner, Stockholder, etc.)	Address (Street, City, Zip)	% of Ownership (if proprietary, for profit)

*A licensee that is a corporation should submit with this application a copy of the Articles of Incorporation or governing body bylaws to the Department of Health. Please note that any amendments to either the Articles of Incorporation or the governing body bylaws are to be submitted to this department as they occur.

L. Evidence of Compliance with Workers' Compensation Coverage Provisions

State law requires that the Commissioner of Health shall withhold the license for the operation of a health care provider until the applicant presents acceptable evidence of compliance with workers' compensation coverage provisions.

One of the following documents must accompany this application. Please check which document is attached.

1. ___ **Certificate of Insurance** supplied by an authorized Workers' Compensation carrier pursuant to Minn. Statute 60A.06, Subd. 1(5b). The Certificate should include the name of the licensee, the name of the corporation legally responsible for the licensee, or the name that the licensee is doing business as. The Certificate of Insurance must be in effect prior to the issuance of an initial license or have an effective date on or after the effective date of a renewal license.

2. ___ **"Certificate of Exemption"** from the Commissioner of Commerce permitting an organization to self-insure pursuant to Minn. Statute 79A and Minn. Rules Chapter 2780. The Certificate of Exemption is available to privately owned or publicly held companies and groups. The Certificate of Exemption must be renewed every five years. Questions regarding the Certificate of Exemption should be directed to the Minnesota Department of Commerce at 651-296-4026. **For multiple providers merged under one group, please include Attachment A with the Certificate of Exemption.**

3. ___ Written confirmation from your Third Part 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 Minn. Statute 176.81, Subd. 2. The Reinsurance Certificate must be renewed annually on a calendar year basis.

You cannot be issued a license and may not operate as a health care provider unless acceptable evidence of compliance with workers' compensation coverage provisions is provided.

Minnesota Department of Health
Heath Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4106
www.health.state.mn.us

12/17- FPC928 PRTF-SLF

To obtain this information in a different format, call: 651-201-4101.

Federal Attestation Statement for PRTF

Facility Name: _____

Address: _____

_____

Phone Number: _____

State Provider Identification Number (Renewals Only): _____

Facility Characteristics

Bed Size: _____

Number of individuals on the date of this application currently served within the PRTF who are provided service based on their eligibility for the Medicaid Inpatient Psychiatric Services for Individuals Under age 21 Benefit (Psych under 21): _____

Number of individuals on the date of this application, if any, whose Medicaid Inpatient Psychiatric Services Under 21 Benefit is paid for by any state other than the state of the PRTF identified in this attestation letter: _____

List all states from which the PRTF has ever received Medicaid payment for the provision of Psych Under 21 Services: _____

_____ (Initial) I certify this facility currently meets all the requirements of Part 483, Subpart G governing the use of restraint and seclusion.

_____ (Initial) I certify this facility currently meets all the requirements of Appendix Z – Emergency Preparedness that apply to PRTFs.

_____ (Initial) I acknowledge the right of the State Agency (or its agents) and, if necessary, CMS to conduct an on-site survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged against the facility, or to investigate serious occurrences.

_____ (Initial) I understand a new Attestation of Compliance Statement needs to be submitted annually and in the event a new facility director is appointed.

FEDERAL ATTESTATION STATEMENT FOR PRTF

Signature _____
(Facility Director)

Title _____

Date _____

For MDH Use - Initial Applications Only:

Effective date of MDH Medicaid Certification

Approval _____

Minnesota Department of Health
Heath Regulation Division
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St. Paul, Minnesota 55164-0900
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5/18- PRTF –Attestation only

To obtain this information in a different format, call: 651-201-4106.