



Registration for Supplemental Nursing Services Agency

In accordance with Minnesota Statutes, Section 13.41, **ALL DATA SUBMITTED ON THIS REGISTRATION FORM SHALL BE CLASSIFIED PUBLIC INFORMATION UPON ISSUANCE OF A REGISTRATION CERTIFICATE.**

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

**Minnesota Department of Health
Health Regulation Division
Licensing and Certification Program
PO Box 64900
St. Paul, MN 55164-0900**

The undersigned hereby registers to operate a Supplemental Nursing Services Agency subject to Minnesota Statutes, Chapters 144.057, 144A.70 - 74.

A. Identification

Each separate location of the business of a supplemental nursing services agency shall have a separate registration.

1. Agency Name _____
2. Agency Street Address _____
(P.O. Box address without a street address is unacceptable.)
3. Agency City/State/Zip _____
4. Telephone Number _____
5. Hours of Operation _____ Email Address _____
6. After Hours Number _____
7. Fax Number _____
8. Name of county in which the agency is located _____
9. Name of county/counties in which the agency provides services _____

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	20. Church-related	23. Individual	27. Tribal
12. County	21. Nonprofit Corporation	24. Partnership	
13. City	22. Other Nonprofit Ownership	25. Corporation	
14. City-County		26. Group	
15. Hospital District or Authority		28. Limited Liability Company	
		29. Business Trust	
		30. Housing and Redevelopment Authority	

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

3. Federal ID # _____ State Tax ID # _____

4. If a corporation, give the date and place of incorporation _____
Attach a Certificate of Authority to do business in Minnesota if incorporated in another state.

5. If a corporation, attach copies of articles of incorporation and current by-laws.

6. President _____

7. Agent(s) _____
(Individual(s) authorized to transact business with the Department of Health and upon whom all notices and orders shall be served. Include address if different from service address. Please attach another sheet of paper if necessary.)

Address _____ City, State, Zip _____

C. Management Agent (if different from owner)

Name _____

Street Address _____ City, State, Zip _____

D. Officers and Members of Governing Body

Attach names and addresses of officers and members of governing body, or check here if not applicable.

Not Applicable

E. Employee Licensing, Training and Continuing Education

I verify in accordance with MN Statute §144A.72 that all employees meet the minimum licensing, training, and continuing education standards for the position in which the employee will be working.

Authorized Signature _____ Title _____

F. Renewal Applications Only

Have you provided supplemental nursing services in the past 12 month to a health care facility?
(Renewals only)

Yes No

Provide the last date of service, name of health care facility and service _____

G. Specific Information

1. What other licenses does the owner hold? Please list.

2. When did this agency begin offering supplemental nursing services? _____

MM/DD/YYYY

REGISTRATION FOR SUPPLEMENTAL NURSING SERVICES AGENCY

3. What supplemental nursing services will be provided or procured in which type of health care facility?

Health care facility means a hospital, boarding care home, outpatient surgical center, nursing home, home care agency, a housing with services establishment; or a board and lodging providing supportive or health supervision.

Indicate approximate total number of employees per each category.

Supplemental Nursing Services:

Supplied to what type of health care facility:

(Circle all appropriate)

_____ Registered Nurses	Hospitals, Nursing Homes, Home Care, Other _____
_____ Licensed Practical Nurses	Hospitals, Nursing Homes, Home Care, Other _____
_____ Nursing Assistants	Hospitals, Nursing Homes, Home Care, Other _____
_____ Nurse Aides	Hospitals, Nursing Homes, Home Care, Other _____
_____ Orderlies	Hospitals, Nursing Homes, Home Care, Other _____

Other services provided by this agency at this location _____

H. Verification/Registration Fee

Annual Registration Fee: \$2,035.00. **Each separate location of the business of a supplemental nursing services agency shall file a separate registration form and submit a \$2,035.00 fee.**

To the best of my knowledge, I certify that the information provided on this form is accurate and complete. Enclosed is the \$2,035.00 annual registration fee made payable to "Minnesota Department of Health."

Signature of Authorized Representative

Name (please print or type)

Title

Date

NOTE: If you have questions concerning this registration form, please call 651-201-4101.

The following must be received before your application is considered to be complete:

- Agency Record: Policy & Procedure - Submit with this application a policy and procedure that describes how the SNSA's records will be immediately available at all times to the Commissioner of Health and that all records will be retained for five calendar years.
- Certificate of Authority to do business in Minnesota if incorporated in another state.
- 1. Articles of Incorporation or Articles of Organization.
2. Current by-laws or operating agreement.
3. Names and addresses of officers and members of governing body, managers, members, officers.
4. A brief description of the organization structure of the agency, including a table of organization and relationship to any existing parent entity (if applicable).
- Evidence of medical malpractice insurance (professional liability insurance is acceptable).
- Evidence of employee dishonesty bond in the amount of \$10,000.00.
- Evidence of current workers' compensation coverage as required by Minnesota Statutes, Sections 176.181 and 176.182.
- Name and address of the bank, savings bank, or savings association in which the SNSA will deposit all the SNSA's employees' income tax withholdings. If you believe you are not responsible for employee income tax withholding, you must provide the name and address of each employee for whom income taxes are not being withheld.
- Attestation Statement regarding the registration and operation of a Supplemental Nursing Services Agency.
- Completed background studies for all controlling persons. This is required only on initial registrations and/or change of ownership or management. The Minnesota Department of Health will notify the Department of Human Services to initiate the background study once the application has been reviewed.

REGISTRATION FOR SUPPLEMENTAL NURSING SERVICES AGENCY

SUPPLEMENTAL NURSING SERVICE AGENCY CONTROLLING PERSON INFORMATION SHEET

Legal Entity _____ HFID # _____ Phone _____

Name of Provider _____ Address _____

City _____ State _____ Zip Code _____

Date Completed _____ Administrator _____ Email Address _____

INITIAL AND CHANGE OF OWNERSHIP APPLICANTS:

Please note that you must submit a background study using NETStudy through the Minnesota Department of Human Services for all controlling persons before a registration certificate may be issued. A controlling person is defined as an officer, program administrator, or director whose responsibilities include the direction of the management or policies of a supplemental nursing services agency. Controlling person also means an individual who, directly or indirectly, beneficially owns an interest in a corporation, partnership, or other business association that is a controlling person. Information regarding NETStudy may either be obtained from the Minnesota Department of Health website at Background Studies for New Owners (<https://www.health.state.mn.us/facilities/regulation/docs/bgs.pdf>) or by calling 651-201-4101.

ALL APPLICANTS:

Please provide the names, titles and addresses of all controlling persons and their percent of ownership.

Name of Controlling Persons	Title (President, Director, Partner, Stockholder, etc.)	Address (Street, City, Zip)	Percent of Ownership if Proprietary (For Profit)	For MDH Use Only Date BGS Received

REGISTRATION FOR SUPPLEMENTAL NURSING SERVICES AGENCY

Name of Controlling Persons	Title (President, Director, Partner, Stockholder, etc.)	Address (Street, City, Zip)	Percent of Ownership if Proprietary (For Profit)	For MDH Use Only Date BGS Received

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.

Attestation Statement Regarding the Registration and Operation of a Supplemental Nursing Services Agency

(Read this statement carefully before signing)

Based on my personal knowledge and belief, I attest that the response on this statement regarding compliance with MS 144A 70-74 related to the registration and operation of a Supplemental Nursing Services Agency are true and correct.

(Type or print name of agency) _____, a SNSA registered with the Minnesota Department of Health, declares that each temporary employee provided to health care facilities is an employee of the SNSA and is not an independent contractor.

(Type or print name of agency) _____, a SNSA registered with the Minnesota Department of Health carries workers compensation insurance on its employees.

(Type or print name of agency) _____, a SNSA registered with the Minnesota Department of Health withholds required income tax on employee wages and makes periodic payment of those withheld funds to the state and federal government.

(Type or print name of agency) _____, a SNSA registered with the Minnesota Department of Health has a bond to cover employee theft and dishonesty of at least \$10,000.

(Type or print name of agency) _____, a SNSA registered with the Minnesota Department of Health retains all records for five calendar years. All records of the SNSA must be immediately available to the Minnesota Department of Health.

(Type or print name of agency) _____, a SNSA registered with the Minnesota Department of Health has separately registered each separate location of the business as required under MS 144A.71.

I understand that the Minnesota Department of Health may conduct an onsite visit at any time to examine records to validate that the statements made above are true and correct.

Name _____
(Typed or Printed)

Signature _____
(Authorized Representative)

Title _____ Date _____

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4101
health.SNSA.email.box@state.mn.us

8/27/19 FPC931 SNSA

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