DEPARTMENT OF HEALTH

For MDH Use Only

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

2021 Registration Form for Boarding and Lodging Establishments or Lodging Establishments Providing Special Services

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. All renewal registrations shall be submitted prior to the expiration date of the current registration certificate with:

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

The undersigned hereby registers to operate a Boarding and Lodging Establishment Providing Special Services (BLSS) subject to Minnesota Statutes, Section 157.17.

Type of Application (check one)

☐Initial License ☐Registration Renewal ☐Change of Ownership*

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

A. Identification

1. Business/Establishment Name_____

   Establishment Street Address_____

   Establishment City/State/Zip_____

2. Telephone Number:_____

   After Hours Number:_____

   Fax Number:_____

   Email Address:_____

3. Name of county in which facility is located _____

B. Ownership

1. Fill in the code which corresponds to the type of entity legally responsible for operating the BLSS establishment.

   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_____
   Attach a Certificate of Authority to do business in Minnesota if incorporated in another state.

4. President _____

5. Owner_____

C. Other Licenses

1. What other licenses does the owner or legal entity hold?
   Answer each question and provide the license number for each license that applies:

   a. Board & Lodging or Lodging Establishment ☐Yes ☐No license # _____
   (Please attach a copy of this license. MDH will not be able to issue your registration without a copy of your 2021 license.)

   b. Corporate Adult Foster Care ☐Yes ☐No License #_____

   c. Home Care ☐Yes ☐No License #_____

   d. Adult Foster Care ☐Yes ☐No License #_____

   e. Housing with Services ☐Yes ☐No License #_____

   f. Boarding Care Home ☐Yes ☐No License #_____

   g. Nursing Home ☐Yes ☐No License #_____

   h. Hospital ☐Yes ☐No License #_____

   i. Hospice ☐Yes ☐No License #_____

   j. DHS License under MN Statute 245A ☐Yes ☐No License #_____

   k. Other_____ License #_____

   l. Other_____ License #_____

D. Services

1. What **supportive services** will be provided by the BLSS? Also list number of residents that receive these services:

   a. Providing social and recreational opportunities: ☐Yes ☐No # of Residents: _____

   b. Assisting with Transportation: ☐Yes ☐No # of Residents: _____

   c. Arranging for meeting and appointments: ☐Yes ☐No # of Residents: _____

   d. Arranging for medical or social services: ☐Yes ☐No # of Residents: _____

   e. Reminding residents to take medications that are self-administered:
   ☐Yes ☐No # of Residents: _____

   f. Providing storage for medications if requested: ☐Yes ☐No # of Residents: _____

2. What **health supervision services** will be provided by the BLSS? Also list number of residents that receive these services:

   a. Assistance in preparation and administration of medications other than injectables: ☐Yes ☐No # of Residents: _____

   b. Providing therapeutic diets: ☐Yes ☐No # of Residents: _____

   c. Taking vital signs: ☐Yes ☐No # of Residents: _____

   d. Providing assistance with dressing, grooming or bathing: ☐Yes ☐No # of Residents: _____

   e. Providing assistance with walking devices: ☐Yes ☐No # of Residents: _____

3. Please provide the names and license number of the licensed nurse responsible for monitoring the health supervision of residents.

   Name: _____ License #_____

   Number of hours licensing nurse services is provide each week by the above nurse:_____

E. Resident Capacity on May 1, 2020

1. Total number of licensed beds for all residents in the establishment?_____
2. Total number of licensed beds for residents receiving special services?_____
3. Current total number of occupied beds for residents receiving special services?_____
4. Current number of residents receiving special services who are age 55 or older?_____

F. Employee Information

1. Do you have a system in place for performing criminal background checks for all individuals who have direct contact with residents in this establishment that are registered to provide supportive or health supervision services under MN Statute 157.17?

   ☐Yes ☐No

G. Verification

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

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

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

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

10/20- BLSSRENEWREG

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