DEPARTMENT OF HEALTH

For MDH Use Only

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

2021 Application for a License to Operate a Hospital

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. The application shall be returned to the address noted below no later than **December 31, 2020**.

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

The undersigned hereby makes application to operate a hospital and/or related institution subject to the provision of Minnesota Statutes Section 144.50-144.58, and the rules adopted thereunder.

Type of Application (check one)

☐Initial License ☐License Renewal ☐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 patients or residents)

Insert the licensed bed capacity for each category for determination of license fee. A "**hospital**" means an institution primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

A "**psychiatric hospital**" means an entire institution which is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons. A psychiatric wing or building of a general hospital would not be considered a psychiatric hospital.

Specialized Hospital (Mental) means a state-operated institution for the diagnosis and treatment of mentally ill persons.

Hospital_____ Bassinets_____ **Total Beds and Bassinets:**_____

Psychiatric Hospital:_____ Specialized Hospital (Mental):_____

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. Accreditation Status

Minnesota Statute 144.55 subdivision 4 provides as follows: "Any hospital surveyed and accredited under the standards of the hospital accreditation program of an approved accrediting organization that submits to the commissioner within a reasonable time copies of (a) **its currently valid accreditation certificate and accreditation letter, together with accompanying recommendations and comments and** (b) **any further recommendations, progress reports and correspondence directly related to the accreditation** is presumed to comply with the application requirements of subdivision 1 and the standards requirements of subdivision 3 and no further routine inspections or accreditation information shall be required by the commissioner to determine compliance . . .". (emphases supplied)

Accredited: ☐Yes ☐No

If accredited, attach the documents required by subdivision 4 above. Failure to submit the required information with this license application will result in the loss of the presumption of compliance provided in the law.

F. Affiliation and Management Agreement Information

1. Is this hospital chain affiliated?

   ☐Yes ☐No

   If yes, list the name, address of corporation and employer identification number.

   Name_____ Address_____

   City/St/Zip_____ EIN #_____

2. Is this hospital operated by a management company, or leased in whole or part by another organization?

   ☐Yes ☐No

   If yes, list the name, address of organization and employer identification number.

   Name_____ Address_____

   City/St/Zip_____ EIN #_____

G. Provider-based Locations under the Hospital's License and Medicare Provider Number

Please provide the names and address of all components that are billed on the hospital's Medicare provider number and that operate under the hospital's license.

In addition, please provide:

- A short description of the services provided (i.e. physical therapy, speech therapy, occupational therapy, ambulatory surgery, outpatient medical services)
- The Medicare provider number (this number should be the same as the hospital's Medicare provider number)
- Established Date (date facility began billing for provider-based services under hospital's provider number)
- Sprinkler Status (see below for a description of options)
  Sprinkler Status Options:
  1 – Totally sprinklered: All required areas are sprinklered
  2 – Partially sprinklered: Some but not all required areas sprinklered
  3 – Sprinklers: None
  4 – Sprinklers are not required, but the location is sprinklered

***ATTACH ADDITIONAL SHEETS OF PAPER IF NECESSARY**

Hospital Name____
Hospital Provider Number______________________________________

Name__________________________
Address_________________________
City/Zip_________________________
Phone__________________________
Services Provided____________________
\# of Beds_________________________
Medicare Provider #___________________
Established Date_____________________
Sprinkler Status_____________________

Name__________________________
Address_________________________
City/Zip_________________________
Phone__________________________
Services Provided____________________
\# of Beds_________________________
Medicare Provider #___________________
Established Date_____________________
Sprinkler Status_____________________

Name__________________________
Address_________________________
City/Zip_________________________
Phone__________________________
Services Provided____________________
\# of Beds_________________________
Medicare Provider #___________________
Established Date_____________________
Sprinkler Status_____________________

Name__________________________
Address_________________________
City/Zip_________________________
Phone__________________________
Services Provided____________________
\# of Beds_________________________
Medicare Provider #___________________
Established Date_____________________
Sprinkler Status_____________________

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

License Fees

Accredited Hospital	$7,055.00
Non-Accredited Hospital	$4,680.00 base fee plus $234.00 per bed including bassinets
All Hospitals	$600.00 base fee plus $16.00 per bed including bassinets for Adverse Health Care Events Reporting
	$1,000.00 base fee plus $12.00 per bed including bassinets for Statewide Trauma System

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

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
651-201-4101
www.health.state.mn.us

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