



For MDH Use Only

Check # \_\_\_\_\_

Fee Deposit # \_\_\_\_\_

Deposit Date \_\_\_\_\_

Initials \_\_\_\_\_

SFM Date \_\_\_\_\_

# 2021 Application for a License to Operate a Supervised Living Facility

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 Supervised Living Facility subject to the provisions 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	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	

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 determination of license fee.

Supervised Living Facility: Class A: \_\_\_\_\_ Class B: \_\_\_\_\_

## 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 Licensure Information

Type of Department of Human Services license(s) currently held:

Rule 32 (Detox)     Rule 34 (DD)     Rule 35 (CD)     Rule 36 (MI)     Rule 80 (PH)

## F. Building Classification

Capability of residents for self-preservation in case of emergency

1. Number of residents physically and mentally capable of self-preservation / \_\_\_/\_\_\_/\_\_\_/

2. Number of residents not mentally or physically capable of self-preservation / \_\_\_/\_\_\_/\_\_\_/

## 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

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title or Position

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title or Position

## 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](mailto:health.fpc-licensing@state.mn.us).**

## 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 supervised living facilities licensed 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.

## 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  
Health Regulation Division  
P.O. Box 64900  
St. Paul, Minnesota 55164-0900  
651-201-4101  
[www.health.state.mn.us](http://www.health.state.mn.us)

10/20- FPC928 SLF

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