

# Application for a License to Operate a Nursing Home

## RENEWAL LICENSE

In accordance with [Minnesota Statutes, section 13.41 \(https://www.revisor.mn.gov/statutes/cite/13.41\)](https://www.revisor.mn.gov/statutes/cite/13.41), all data submitted on this license application shall be classified public information upon issuance of a license.

The undersigned hereby makes application for license to operate a nursing home subject to the provision of [Minnesota Statutes, section 144A \(https://www.revisor.mn.gov/statutes/cite/144A\)](https://www.revisor.mn.gov/statutes/cite/144A), [Minnesota Statutes, chapter 4658 \(https://www.revisor.mn.gov/rules/4658/\)](https://www.revisor.mn.gov/rules/4658/) and the rules adopted thereunder.

## Application and Review Process

Answer all questions completely and accurately to avoid unnecessary delay. Mail application, fee payment and required supporting documents at least 60 days before the requested date for licensure ([Minnesota Rules, chapter 4658.0025, subpart 1 \(https://www.revisor.mn.gov/rules/4658.0025/#rule.4658.0025.1\)](https://www.revisor.mn.gov/rules/4658.0025/#rule.4658.0025.1)). Refer to the last page for Minnesota Department of Health (MDH) mailing address.

The application is deemed complete when all documentation, inspections and background studies have been correctly completed and verified. MDH will contact you to request additional information, if needed.

## Facility Identification

Facility Name (Doing Business As): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ County: \_\_\_\_\_

Legal property description: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Fax number (if applicable): \_\_\_\_\_

Health Facility Identification (HFID) number (if applicable): \_\_\_\_\_

Do you plan to be Medicare certified?  Yes  No  Already Certified

## Agent

- [Minnesota Statutes, section 144A.03, subd. 2 \(https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.2\)](https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.2)

The **agent** is the person(s) “who shall be responsible for dealing with the commissioner of health on all matters” and “whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of all the controlling persons of the facility.”

Provide the agent’s legal name and contact information. MDH will use the mailing and/or email address below to send correspondence(s) to the facility.

APPLICATION FOR A LICENSE TO OPERATE A NURSING HOME - RENEWAL

Full legal name: \_\_\_\_\_  
 Mailing address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone number: \_\_\_\_\_  
 Email address: \_\_\_\_\_

## Ownership

- [Minnesota Statutes, section 144A.03 \(https://www.revisor.mn.gov/statutes/cite/144A.03\)](https://www.revisor.mn.gov/statutes/cite/144A.03)
- [Minnesota Rules, chapter 4658.0025, subd. 14E \(https://www.revisor.mn.gov/rules/4658.0025/#rule.4658.0025.14\)](https://www.revisor.mn.gov/rules/4658.0025, subd. 14E)

Fill in the code that corresponds to the type of entity legally responsible for operating this facility: \_\_\_\_\_

Governmental Non-Federal	Governmental Federal	Non-Governmental Nonprofit	Non-Governmental For-profit	Other
11. State 12. County 13. City 14. City-County 15. Hospital District or Authority	18. Veterans Administration	20. Church-related 21. Nonprofit Corporation 22. Other Nonprofit Ownership 34. Nonprofit Limited Liability Company 36. Nonprofit Corporation	23. Individual 24. Partnership 26. Group 29. Business Trust 33. For-profit Limited Liability Company 35. For-profit Corporation	27. Tribal 31. Other (list): _____ 32. Sole Proprietorship

Provide the legal entity name that is responsible for the operation of this facility, as it appears on file with the [Office of the Minnesota Secretary of State \(https://mbisportal.sos.state.mn.us/Business/Search\)](https://mbisportal.sos.state.mn.us/Business/Search):

- Legal entity name: \_\_\_\_\_

Federal Employer Identification Number (FEIN): \_\_\_\_\_

MN State Tax ID number: \_\_\_\_\_

President/Owner Representative Name: \_\_\_\_\_

- Direct telephone number: \_\_\_\_\_
- Direct email address: \_\_\_\_\_

## Bed Capacity

- [Minnesota Statutes, section 144A.03, subd. 1b\(5\)](https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.1)  
(<https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.1>)
- [Minnesota Rules, chapter 4658.0025, subp. 14\(D\)](https://www.revisor.mn.gov/rules/4658.0025/#rule.4658.0025.14)  
(<https://www.revisor.mn.gov/rules/4658.0025/#rule.4658.0025.14>)
- [Minnesota Statutes, section 144A.07, subd. 4b](https://www.revisor.mn.gov/statutes/cite/144A.071#stat.144A.071.4b)  
(<https://www.revisor.mn.gov/statutes/cite/144A.071#stat.144A.071.4b>)

Active licensed bed capacity: \_\_\_\_\_

Current number of beds on layaway: \_\_\_\_\_

(Beds may remain on layaway for up to 10 years from the date the beds were initially placed on layaway status.)

## Owners, Controlling Persons and Managerial Officials

- [Minnesota Statutes, section 144A.01](https://www.revisor.mn.gov/statutes/cite/144A.01) (<https://www.revisor.mn.gov/statutes/cite/144A.01>)
- [Minnesota Statutes, section 144A.03, subd. 1\(b\)\(3\) and 1\(b\)\(12\)](https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.1)  
(<https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.1>)

Complete the table in [Appendix A: Owners, Controlling Persons and Managerial Officials](#) with the name, contact information, and ownership information of each owner, controlling person, and managerial official.

Refer to the definitions below to determine individuals and legal entities that must be disclosed.

A **controlling person** means “an owner and the following individuals and entities, if applicable: (1) each officer of the organization, including the chief executive officer and chief financial officer; (2) the nursing home administrator; (3) any managerial official;” and “any entity or natural person who has any direct or indirect ownership interest in: (1) any corporation, partnership or other business association which is a controlling person; (2) the land or structure on which a nursing home is located; (3) the structure in which a nursing home is located; (4) any entity with at least a five percent mortgage, contract for deed, deed of trust, or other security interest in the land or structure comprising the nursing home; or (5) any lease or sublease of the land, structure, or facilities comprising a nursing home.”

**Direct ownership interest** “means an individual or legal entity with the possession of at least five percent equity in capital, stock, or profits of the licensee, or who is a member of a limited liability company of the licensee.”

**Indirect ownership interest** “means an individual or legal entity with a direct ownership interest in an entity that has a direct or indirect ownership interest of at least five percent in an entity that is a licensee.”

**Managerial official** “means an individual who has the decision-making authority related to the operation of the nursing home and responsibility for either: (1) the ongoing management of the nursing home; or (2) the direction of policies, services, or employees of the nursing home.”

## Disclosure of Managerial Employees

- [Minnesota Statutes, section 144A.03 , subd. 1\(b\)\(3\)](https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.1)  
(<https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.1>)
- [Minnesota Rules, chapter 4658.0025, subp. 16](https://www.revisor.mn.gov/rules/4658.0025/#rule.4658.0025.16)  
(<https://www.revisor.mn.gov/rules/4658.0025/#rule.4658.0025.16>)

## Nursing Home Administrator

Full legal name: \_\_\_\_\_

Direct telephone number: \_\_\_\_\_

Direct email address: \_\_\_\_\_

Start date: \_\_\_\_\_ License number: \_\_\_\_\_

Status:  Permanent  Acting (temporary and unlicensed)  Interim

## Assistance Administrator (if applicable)

Full legal name: \_\_\_\_\_

Director telephone number: \_\_\_\_\_

Direct email address: \_\_\_\_\_

Start date: \_\_\_\_\_ License number: \_\_\_\_\_

## Medical Director

Full legal name: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Director telephone number: \_\_\_\_\_

Direct email address: \_\_\_\_\_

Start date: \_\_\_\_\_ License number: \_\_\_\_\_

## Director of Nursing

Full legal name: \_\_\_\_\_

Director telephone number: \_\_\_\_\_

Direct email address: \_\_\_\_\_

Start date: \_\_\_\_\_ License number: \_\_\_\_\_

## Ownership of Nursing Home Building

- [Minnesota Statutes, section 144A.01, subdivision 4\(b\)\(2\) and 4\(b\)\(3\)](https://www.revisor.mn.gov/statutes/cite/144A.01#stat.144A.01.4)  
(<https://www.revisor.mn.gov/statutes/cite/144A.01#stat.144A.01.4>)

Complete the information in this section and use [Appendix A: Owners, Controlling Persons and Managerial Officials](#) to disclose any legal entity(s) and individual owner(s) having a 5% or greater interest in the building or real property.

### Building Ownership

Name of contact person: \_\_\_\_\_

Title of contact person: \_\_\_\_\_

Business address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ County: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Email address: \_\_\_\_\_

Legal Entity Type of Building Ownership (i.e., Corporation, LLC): \_\_\_\_\_

Is the licensee applicant the owner of the physical building? If no, provide the lease information below.

Yes

No

### Lease Information

Fill in the information below for the lessee and sub-lessee of the building where the nursing is located (if applicable).

#### License applicant:

Is the lessee

Is the sub-lessee

Lessee full legal name: \_\_\_\_\_

Lessee business address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ County: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Email address: \_\_\_\_\_

**Sub-lessee:**

Sub-lessee full legal name: \_\_\_\_\_

Sub-lessee business address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ County: \_\_\_\_\_

Sub-lessee contact person: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Email address: \_\_\_\_\_

**Related Organization**

- [Minnesota Statutes, section 256R.02, subd. 43](https://www.revisor.mn.gov/statutes/cite/256R.02#stat.256R.02.43)  
(<https://www.revisor.mn.gov/statutes/cite/256R.02#stat.256R.02.43>)

**Related organization** means “(a) a person that furnishes goods or services to a nursing facility and that is a close relative of a nursing facility, an affiliate of a nursing facility, a close relative of an affiliate of a nursing facility, or an affiliate of a close relative of affiliate of a nursing facility. As used in this subdivision, paragraph (b) to (e) apply.

(b) “Affiliate” means a person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with another person.

(c) “Person” means an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, or a government or political subdivision.

(d) “Close relative of an affiliate of a nursing facility” means an individual whose relationship by blood, marriage, or adoption to an individual who is an affiliate of a nursing facility is no more remote than first cousin.

(e) “Control” including the terms “controlling,” “controlled by,” and “under common control with” means the possession, direct or indirect, of the power to direct or cause the direction of the management, operations, or policies of a person, whether through the ownership of voting securities, by contract, or otherwise.”

Is the owner of the nursing home building or property a related organization to the licensee of the nursing home?

Yes

No

If **yes**, explain the relationship: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Eligibility and Qualification

- [Minnesota Statutes, section 144A.03 \(https://www.revisor.mn.gov/statutes/cite/144A.03\)](https://www.revisor.mn.gov/statutes/cite/144A.03)

Complete the following questions 1 to 8 below. For any **yes** responses, complete and submit [Appendix B: Eligibility and Qualifications](#) **per individual**.

1. Within the last 10 years, preceding submission of the license application, have the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s) been convicted of a crime or found civilly liable for a federal or state felony-related offense that was detrimental to the best interests of the facility and its residents? This includes:
  - Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.
  - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.
  - Any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct.
  - Any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act.

Yes - Submit [Appendix B: Eligibility and Qualifications](#) for each owner/controlling person/managerial official/nursing home administrator.

No
2. Within the last 10 years, preceding submission of the license application, have the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s) been convicted of any misdemeanor under federal or state law relating to:
  - The delivery of an item or service under Medicaid or a state health care program or the abuse or neglect of a patient in connection with the delivery of a health care item or service.
  - Theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

Yes - Submit [Appendix B: Eligibility and Qualifications](#) for each owner/controlling person/managerial official/nursing home administrator.

No

3. Within the last 10 years, preceding submission of the license application, have the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s) been convicted of any felony or misdemeanor under federal or state law relating to:
- The interference with or obstruction or any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or 1001.201.
  - The unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
- Yes - Submit [Appendix B: Eligibility and Qualifications](#) for each owner/controlling person/managerial official/nursing home administrator.
- No
4. Has the license applicant, any direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s) ever had:
- Any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of the license while a formal disciplinary proceeding was pending before a state licensing authority.
  - Any revocation or suspension of accreditation.
  - Any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Yes - Submit [Appendix B: Eligibility and Qualifications](#) for each owner/controlling person/managerial official/nursing home administrator.
- No
5. Has the license applicant, any direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s); currently, or in the past ever had their license or federal certification for a long-term care, community-based, or health care facility or agency:
- Denied, suspended, restricted, conditioned, refused, not renewed, or revoked under a private or state-controlled receivership?
  - Are these same actions listed above pending under the laws of any state or federal authority?
- Yes, or pending - Submit [Appendix B: Eligibility and Qualifications](#) for each owner/controlling person/managerial official/nursing home administrator.
- No
6. In the preceding three years, have the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s) has a record of defaulting in the payment of money collected for others, including the discharged debts through bankruptcy proceedings?
- Yes - Submit [Appendix B: Eligibility and Qualifications](#) for each owner/controlling person/managerial official/nursing home administrator.
- No

7. In the preceding three years has there been any unsatisfied judgments against the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s)?
- Yes - Submit [Appendix B: Eligibility and Qualifications](#) for each owner/controlling person/managerial official/nursing home administrator.
- No
8. In the preceding three years, are there any liens against the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s) or their property?
- Yes - Submit [Appendix B: Eligibility and Qualifications](#) for each owner/controlling person/managerial official/nursing home administrator.
- No

## Affiliations

- [Minnesota Statutes, section 144.A01 \(https://www.revisor.mn.gov/statutes/cite/144A.01\)](https://www.revisor.mn.gov/statutes/cite/144A.01)

**Affiliated** means currently or has held a position defined as an Owner, Controlling Person or Managerial Official.

Has the license applicant, direct/indirect owner(s), controlling person(s), managerial official(s), or nursing home administrator been affiliated in the past five years with a long-term care, community-based, or health care facility or agency in Minnesota or in any other state?

- No
- Yes

If **yes**, complete and submit the [Appendix C: Affiliations](#).

## Chain Organizations

- [Minnesota Statutes, section 144A.03, subd. 1\(b\)\(18\) \(https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.1\)](https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.1)
- [42 CFR 421.404 \(https://www.ecfr.gov/current/title-42/section-421.404\)](https://www.ecfr.gov/current/title-42/section-421.404)
- [42 CFR 400.202 \(https://www.ecfr.gov/current/title-42/section-400.202\)](https://www.ecfr.gov/current/title-42/section-400.202)
- [Medicare Enrollment Application; CMS-885A, section 5\(C\) Chain Home Offices Only \(https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855a.pdf\)](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855a.pdf)

A **chain organization** means an “entity that provides centralized management and administrative services to the providers or suppliers under common ownership and common control, such as centralized accounting, purchasing, personnel services, management direction and control, and other similar services.”

**Common control** “exists when an individual, a group of individuals, or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of the group of suppliers or eligible providers.”

**Eligible provider** “means a hospital, skilled nursing facility, or critical access hospital that meets the definition of a provider under § 400.202 of this chapter.”

**Complete the information below for chain organizations.**

Is the license applicant under the control of a chain organization?

No

Yes

If yes, provide the following: \_\_\_\_\_

Full legal name (or entity name): \_\_\_\_\_

Name of contact person: \_\_\_\_\_

Title: \_\_\_\_\_

Business address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Email address: \_\_\_\_\_

## Management Agreement

- [Minnesota Statutes, section 144A.01, subd. 15](https://www.revisor.mn.gov/statutes/cite/144A.01#stat.144A.01.15)  
(<https://www.revisor.mn.gov/statutes/cite/144A.01#stat.144A.01.15>)
- [Minnesota Statutes, section 144A.03, subd. 1\(b\)\(10\)](https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.1)  
(<https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.1>)

**Management Agreement** means a written, executed agreement between a licensee and a manager regarding the provision of certain services of behalf of the licensee.

**Manager** means an individual or legal entity designated by the licensee through a management agreement to act on behalf of the licensee in the on-site management of the nursing home.

1. Is the operation of the nursing home under a management agreement?

No

Yes

APPLICATION FOR A LICENSE TO OPERATE A NURSING HOME - RENEWAL

If **yes**, provide the following:

Legal entity type of ownership (i.e., Corporation, LLC): \_\_\_\_\_

Doing Business As (DBA): \_\_\_\_\_

Company name as registered with the MN Secretary of State: \_\_\_\_\_

Federal Tax Identification Number (FEIN): \_\_\_\_\_

Name of Contact Person: \_\_\_\_\_

Title: \_\_\_\_\_

Business address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Email address: \_\_\_\_\_

2. Is the manager a related organization to the license application?

No

Yes

If **yes**, please explain the relationship: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 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.

- Certificate of Insurance** supplied by an authorized Workers' Compensation carrier pursuant to [Minnesota Statutes, section 60A.06, subd. 1\(5b\)](https://www.revisor.mn.gov/statutes/cite/60A.06) (<https://www.revisor.mn.gov/statutes/cite/60A.06>). 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 Liability 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 renewal license.
- Self-insured workers' compensation (including its Attachment "A")**. This type of coverage is generally held by large organizations. The certificate is issued from the commissioner of commerce permitting an organization to self-insure pursuant to [Minnesota Statutes, section 79A](https://www.revisor.mn.gov/statutes/cite/79A) (<https://www.revisor.mn.gov/statutes/cite/79A>) and [Minnesota Rules, chapter 2780](https://www.revisor.mn.gov/rules/2780/) (<https://www.revisor.mn.gov/rules/2780/>). Questions regarding self-insurance should be directed to the Minnesota Department of Commerce.
- Written confirmation from your Third-Party 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 [Minnesota Statutes, section 176.181, subd. 2](https://www.revisor.mn.gov/statutes/cite/176.181, subd. 2) (<https://www.revisor.mn.gov/statutes/cite/176.181#stat.176.181.2>). The Reinsurance Certificate must be renewed annually on a calendar year basis.

## Background Studies

- [Minnesota Statutes, section 144.057, subd. 1\(7\)](https://www.revisor.mn.gov/statutes/cite/144.057, subd. 1(7)) (<https://www.revisor.mn.gov/statutes/cite/144A.03#stat.144A.03.1>)

All license applicants; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s) must "undergo a background study under chapter 245C, regardless of the licensure status of the license applicant, owner, managerial official, or controlling individual." Prior to MDH issuing the nursing home license. Background studies must be completed and cleared by the department of Human Services (DHS).

If individuals are licensed from a health-related licensing board (HLB) who has also undergone a background check under [Minnesota Statutes, section 214.075](https://www.revisor.mn.gov/statutes/cite/214.075), shall not have a background study completed by the commissioner of human services (a NETStudy 2.0 background study).

DHS will provide the onboarding process to the background study. Any questions about the background study or NETStudy 2.0 can be directed to DHS [Background studies](https://mn.gov/dhs/general-public/background-studies/) (<https://mn.gov/dhs/general-public/background-studies/>), email: [dhs.netstudy2@state.mn.us](mailto:dhs.netstudy2@state.mn.us).

**Please note: The legal name must match NETStudy 2.0, legal documents and the nursing home initial application.**

## Fees

- Minnesota Statutes, section 144.122, clause (d) (<https://www.revisor.mn.gov/statutes/cite/144.122>)

Applications must be accompanied by the appropriate nonrefundable fee based on the following fee schedule.

Type	Fees
Base Fee	\$183.00
License Fee per Active Bed	\$105.00
Funding of Advisory Council Education per Bed	\$ 5.00

For example:

- Base Fee + (License Fee per Bed + Funding of Advisory Council Education fee per Bed x number of active beds) = licensing fee payment due.
- \$183 + (\$110 Combined Fees x Number of Beds) = licensing fee payment due.

## Affirmation

I certify that the information provided on this form is accurate and complete.

In accordance with [Minnesota Statutes, section 144.52](https://www.revisor.mn.gov/statutes/cite/144.52) (<https://www.revisor.mn.gov/statutes/cite/144.52>), the law requires that an application on behalf of a corporation or association or other governmental unit shall be made by any two officers thereof or by its managing agents. **This requires two (2) signatures (the signature of the owner of the licensee or an authorized agent of the licensee).**

Signature of Authorized Representative: \_\_\_\_\_

Name (print or type): \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_

Name (print or type): \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**Keep a copy of the application and attachments for your records.**

If you have questions concerning this license application, please email [Health.HRD-FedLCR@state.mn.us](mailto:Health.HRD-FedLCR@state.mn.us) or call 651-201-4200.

Minnesota Department of Health  
Health Regulation Division  
Federal Licensing, Certification and Registration section  
P.O. Box 64900  
St. Paul, MN 55164-0900

06/11/2025

*To obtain this information in a different format, call: 201-4200.*

## Attachment Checklist

- Application form and license fee made payable to the **Minnesota Department of Health**.
- [Appendix A: Owners, Controlling Persons and Managerial Officials](#).
- [Appendix B: Eligibility and Qualifications](#) (if applicable).
- [Appendix C: Affiliations](#) (if applicable).
- Evidence of compliance with workers' compensation coverage provisions.
- Certificate of Assumed Name with the Office of the Minnesota Secretary of State (SOS) (if changed).
- Certificate of authority to do business in Minnesota, if registered in another state ([Minnesota Statutes 144A.03, subd. 1\(18\)\(c\)](#) and [Minnesota Statutes, section 303.03](#)).
- Lease and sublease agreement (if applicable).
- Management agreement between the management company and licensee applicant (if applicable).
- An organizational chart identifying the facility's internal management structure and the ownership relationships as it relates to the licensee. The organizational chart should reflect all direct and indirect legal entities and individual owners with a five percent or greater interest in the licensee.
- An organizational chart relating to the structure and land on which the nursing home is located. The organizational chart should reflect all direct and indirect legal entities holding 5 percent or greater interest in the property.

[Minnesota Statutes, section 144A.03, subd. 1\(18\)](#) states that "any other relevant information which the commissioner of health by rule or otherwise may determine is necessary to properly evaluate an application for license."

## Appendix A: Owners, Controlling Persons and Managerial Officials

Examples of common titles include:

- Indirect owner, direct owner, building owner.
- Company Management: CEO, COO, CFO, VP of Operations, Regional Operations Director, President (include management company or chain organization, if applicable).
- All members of the board of directors including the chair/president and the treasurer.
- Facility Management: Administrator, Assistant Administrator, Executive Director, Director of Nursing or Clinical Services, Medical Director.
- The holder of the mortgage, contract for deed, deed of trust, or other security interest in the land or structure comprising a nursing home.
- Government: city council, county board.

This is not an all-inclusive list. See the section above titled [Owners, Controlling Persons, and Managerial Officials](#) above for definitions of terms.

For the **Type** column, check all that apply.

Full Name of Individual / Legal Entity	Title	Mailing Address	Telephone number	Email Address	Type	Direct / Indirect Ownership	Ownership Percentage
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		

APPLICATION FOR A LICENSE TO OPERATE A NURSING HOME - RENEWAL

Full Name of Individual / Legal Entity	Title	Mailing Address	Telephone number	Email Address	Type	Direct / Indirect Ownership	Ownership Percentage
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		
					<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial		

## Appendix B: Eligibility and Qualifications

Submit the following document with your application if additional eligibility and qualifying questions need to be answered when submitting the Nursing Home Initial License Application.

**Complete one copy of this form for each owner/controlling person/managerial official/nursing home administrator that had a yes response in the [Eligibility and Qualification section](#) of the application form.**

Name of Individual: \_\_\_\_\_

Title: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City and State: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Email address: \_\_\_\_\_

1. Within the last 10 years, preceding submission of the license application, have the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s) been convicted of a crime or found civilly liable for a federal or state felony-related offense that was detrimental to the best interests of the facility and its residents? This includes:
  - Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.
  - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.
  - Any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct.
  - Any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act.

Yes

No

If **yes**, complete and submit the required information below, including who owned the facility at the time of the conviction/findings and copies of relevant court records.

Title of position at the health care facility: \_\_\_\_\_

Type of conviction: \_\_\_\_\_

Date of conviction/findings: \_\_\_\_\_

2. Within the last 10 years, preceding submission of the license application, have the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s) been convicted of any misdemeanor under federal or state law relating to:

- The delivery of an item or service under Medicaid or a state health care program or the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

- Yes
- No

If **yes**, complete and submit the required information below, including all ownership, facility information, and copies of relevant court records.

Title of position at the health care program: \_\_\_\_\_

Type of conviction: \_\_\_\_\_

Date of conviction: \_\_\_\_\_

3. Within the last 10 years, preceding submission of the license application, have the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s) been convicted of any felony or misdemeanor under federal or state law relating to:
- The interference with or obstruction or any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or 1001.201.
  - The unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

- Yes
- No

If **yes**, complete and submit the required information below, including all ownership, facility information, and copies of relevant court records.

Title of position at the health care program: \_\_\_\_\_

Type of conviction: \_\_\_\_\_

Date of conviction: \_\_\_\_\_

4. Has the license applicant, any direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s) ever had:
- Any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of the license while a formal disciplinary proceeding was pending before a state licensing authority.
  - Any revocation or suspension of accreditation.
  - Any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program or any debarment from participation in any federal executive branch procurement or non-procurement program.

- Yes

No

If **yes** or pending, complete and submit the required information below for each health care program such actions apply to and copies of the federal/state disposition of the action. Submit additional sheets if needed.

Title of position at health care program: \_\_\_\_\_

Percent (%) of ownership (if applicable): \_\_\_\_\_

Name of health care program: \_\_\_\_\_

Program Address: \_\_\_\_\_

City and State: \_\_\_\_\_

Type of adverse action: \_\_\_\_\_

Effective date of adverse action: \_\_\_\_\_

5. Has the license applicant, any direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s); currently, or in the past ever had their license or federal certification for a long-term care, community-based, or health care facility or agency:

- Denied, suspended, restricted, conditioned, refused, not renewed, or revoked under a private or state-controlled receivership?
- Are these same actions listed above pending under the laws of any state or federal authority?

Yes

No

If **yes** or pending, complete and submit the required information below for each health care program such actions apply to and copies of the federal/state disposition of the action. Submit additional sheets if needed.

Title of position at health care program: \_\_\_\_\_

Percent (%) of ownership (if applicable): \_\_\_\_\_

Name of health care program: \_\_\_\_\_

Program Address: \_\_\_\_\_

City and State: \_\_\_\_\_

Type of adverse action: \_\_\_\_\_

Effective date of adverse action: \_\_\_\_\_

6. In the preceding three years, have the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s) has a record of defaulting in the payment of money collected for others, including the discharged debts through bankruptcy proceedings?

Yes

No

APPLICATION FOR A LICENSE TO OPERATE A NURSING HOME - RENEWAL

If **yes**, complete and submit the required information below and provide names of all parties, dates, court, and disposition of each action.

Name of all parties: \_\_\_\_\_

Dates: \_\_\_\_\_

Name of the court: \_\_\_\_\_

Disposition of each action: \_\_\_\_\_

7. In the preceding three years has there been any unsatisfied judgments against the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s)?

Yes

No

If **yes**, complete and submit the required information below and provide names of all parties, dates, court, addresses of creditor(s), amount(s), and the reasons for non-payment. Submit additional sheets if needed.

Name of all parties: \_\_\_\_\_

Date(s) of judgments: \_\_\_\_\_

Name of the court: \_\_\_\_\_

Name of creditor(s): \_\_\_\_\_

Address of creditor(s): \_\_\_\_\_

Amount: \_\_\_\_\_

Reasons: \_\_\_\_\_

8. In the preceding three years, are there any liens against the license applicant; direct/indirect owner(s); controlling person(s); managerial official(s); or nursing home administrator(s) or their property?

Yes

No

If **yes**, complete and submit the required information below and provide names of all parties, dates, court, addresses of creditor(s), amount(s), and the reasons for non-payment. Submit additional sheets if needed.

Name of all parties: \_\_\_\_\_

Date(s) of liens: \_\_\_\_\_

Name of the court: \_\_\_\_\_

Name of creditor(s): \_\_\_\_\_

Address of creditor(s): \_\_\_\_\_

Amount: \_\_\_\_\_

Reasons: \_\_\_\_\_

## Affirmation

I certify that the information provided on this form is accurate and complete.

Legal name (print or type): \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix C: Affiliations

Submit the following document with the application form. Complete additional copies of this form if needed.

Provide all affiliations for each direct/indirect owner(s), controlling person(s), managerial official(s), or nursing home administrator affiliated in the past five years with a long-term care, community-based, or health care facility or agency in Minnesota or in any other state.

- For **Title**, list position titles (e.g., building owner, CEO, administrator, etc.).
- For **Health Care Facility Name**, list the Doing Business As (DBA) name.
- Examples of **Type of Facility** include but are not limited to nursing home, hospice, home care, assisted living, or any long-term care, community-based, health care facility or agency in Minnesota or in any other state.
- For **Type**, check all that apply.

Full Name of Individual / Legal Entity with affiliation	Title	Health Care Facility Name	City and State	Dates of Affiliation	Type of Facility	Type
						<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial
						<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial
						<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial
						<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial
						<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial
						<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial
						<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial
						<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial

APPLICATION FOR A LICENSE TO OPERATE A NURSING HOME - RENEWAL

Full Name of Individual / Legal Entity with affiliation	Title	Health Care Facility Name	City and State	Dates of Affiliation	Type of Facility	Type
						<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial
						<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial
						<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial
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						<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial
						<input type="checkbox"/> Owner <input type="checkbox"/> Controlling <input type="checkbox"/> Managerial