Registration Form for Housing with Services Establishment with Assisted Living Designation and Uniform Consumer Information Guide

In accordance with Minnesota Statutes §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. A complete application includes this Registration Form, the Addendum to HWS Registration Form and a copy of your Uniform Consumer Information Guide (UCIG). A UCIG does not need to be submitted for a housing with services registered under 144D.025 serving homeless. A $155.00 fee must be submitted for an initial application for each address. A fee is not required for a change of ownership application. If you have questions concerning this registration form, please email Health.HWS@state.mn.us.

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 Housing with Services (HWS) Establishment subject to Minnesota Statutes, Chapter 144D.

A. Type of Application (check one)

☐ Initial Registration ☐ Change of Ownership; Proposed effective date _____

B. 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 establishment is located_____

4. Will this establishment provide service to the entire address identified under Section B.1?
   ☐Yes ☐No; If no, please list the unit(s) and/or apartment numbers:_____

C. Ownership

1. Please fill in the code that corresponds to the type of entity legally responsible for operating the HWS 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 legal entity responsible for the operation of HWS establishment.

   _____

   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. _____

   President_____

4. 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 than establishment address. Please attach another sheet of paper if necessary.)

   Address_____City, State, Zip_____

   Email Address _____Phone _____

D. Management Agent (if different than owner)

Name_____Telephone Number_____

Street Address_____City, State, Zip_____

E. Owners, Officers and Members of Governing Body

On the Ownership Information Sheet, provide/attach names and addresses of owners, officers and members of governing body on the ownership information sheet or check here if not applicable.

☐ Not Applicable

F. Housing Manager

The Housing Manager is the person primarily responsible for oversight and management of a *HWS establishment, as designated by the owner of the housing with services establishment:

Name_____

Email Address_____Direct Phone_____

Employment Start Date_____

Section F does not apply to a HWS registered under 144D.025 serving the homeless.

G. Registration Status

Please answer Yes or No to each question below.

1. **Required Registration.** Will this HWS establishment provide sleeping accommodations to one or more adult residents, of which at least 80 percent of the adult residents are 55 years or older?

   ☐ Yes ☐ No

2. **Optional Registration.** Will this HWS establishment provide sleeping accommodations to one or more adult residents, except that **fewer than 80%** of the adult residents are 55 years of age or older?

   ☐ Yes ☐ No

3. **Optional Registration.** Will this HWS establishment provide sleeping accommodations to one or more adult residents who meet the State's definition of long-term homelessness?

   ☐ Yes ☐ No

   If "yes" to question 3, answer question 4.

4. Will 100% of sleeping accommodations at this HWS establishment be provided to residents who meet the State's definition of long-term homelessness?

   ☐ Yes ☐ No

H. Resident Capacity

1. Maximum Resident Capacity by Building at the address identified in Section B.1:

   Building #1 Capacity_____

   Building #2 Capacity_____
2. Number of Residents on May 1st of this year_____

I. Other Licenses

Please answer each question Yes or No.

What other licenses does the owner and/or legal entity hold? Please provide the license number for each license that applies:

1.	Family Adult Foster Care	☐ Yes ☐ No	License #_____
2.	Corporate Adult Foster Care	☐ Yes ☐ No	License #_____
3.	Home Care	☐ Yes ☐ No	License #_____
4.	Board & Lodging Establishment	☐ Yes ☐ No	License #_____
5.	Boarding Care Home	☐ Yes ☐ No	License #_____
6.	Nursing Home	☐ Yes ☐ No	License #_____
7.	Hospital	☐ Yes ☐ No	License #_____
8.	Hospice	☐ Yes ☐ No	License #_____
9.	Other_____	☐ Yes ☐ No	License #_____
10.	Other_____	☐ Yes ☐ No	License #_____

J. Services

What services will be offered or provided at the HWS establishment? Check all that apply:

1. **Two or more regularly scheduled supportive services:**
   - a. Arranging for medical services for the resident ☐ Yes ☐ No
   - b. Arranging for health-related services for the resident ☐ Yes ☐ No
   - c. Arranging for social services for the resident ☐ Yes ☐ No
   - d. Transportation for medical or social services appointments ☐ Yes ☐ No
   - e. Handling or assisting with personal funds of residents ☐ Yes ☐ No
   - f. Helping with personal laundry for the resident ☐ Yes ☐ No
2. **One or more health-related services:**
   - a. Professional nursing services ☐ Yes ☐ No

b. Administration of medications ☐ Yes ☐ No

c. Performing routine delegated medical or nursing or assigned therapy procedures assisting with body positioning or transfers of clients who are not ambulatory, feeding of clients who, because of their condition, are at risk of choking ☐ Yes ☐ No

d. Assistance with bowel and bladder control, devices and training programs ☐ Yes ☐ No

e. Assistance with therapeutic or passive range of motion exercises ☐ Yes ☐ No

f. Providing skin care, including full or partial bathing and foot soaks ☐ Yes ☐ No

g. During episodes of serious disease or acute illness, services performed for a client to assist nutritional needs, and to assist with the client's mobility including movement, change of location, and positioning and bathing, oral hygiene, dressing, hair care, toileting, bedding changes, basic housekeeping, and meal preparation ☐ Yes ☐ No

h. Preparing modified diets, such as diabetic or low sodium diets ☐ Yes ☐ No

i. Reminding clients to take regularly scheduled medications or perform exercises ☐ Yes ☐ No

j. Household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease ☐ Yes ☐ No

k. Household chores when the client's care requires the prevention of exposure to infectious disease or containment of infectious disease ☐ Yes ☐ No

l. Assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the client is ambulatory, and if the client has no serious acute illness or infectious disease ☐ Yes ☐ No

m. The central storage of medications ☐ Yes ☐ No

3. **Any health related service must be offered or provided by a licensed, comprehensive home care provider. Health related services are offered or provided by:**

Company Name_____

Address_____

Telephone Number_____ License #_____

Website_____

If a HWS establishment has one or more arranged home care providers, the establishment shall have that arranged home care provider deliver the following information in writing to a prospective resident, prior to the date on which the prospective resident executes a contract with the establishment or the prospective resident's move-in date, whichever is earlier:

1. the name, mailing address, and telephone number of the arranged home care provider;
2. the name and mailing address of at least one natural person who is authorized to accept service of process on behalf of the entity described in clause (1);
3. a description of the process through which a home care service agreement or service plan between a resident and the arranged home care provider, if any, may be modified, amended, or terminated;
4. the arranged home care provider's billing and payment procedures and requirements; and any limits to the services available from the arranged provider.

PLEASE ATTACH A COPY OF THE ABOVE INFORMATION.

K. Base Rate

1. Does the HWS establishment's base rate (rent) paid by the resident include the cost of supportive services that will be offered or provided as indicated in I1 above?
   ☐ Yes ☐ No
2. Does the HWS establishment's base rate (rent) paid by the resident include the cost of health related services that will be offered or provided as indicated in I2 above?
   ☐ Yes ☐ No
3. Does the HWS establishment's base rate (rent) paid by the resident include the cost of other services in addition to the supportive and health related services offered or provided as indicated in I1 and I2 above?
   ☐ Yes ☐ No
4. Please indicate other services by checking the appropriate box or entering below:
   Meals ☐ Yes ☐ No
   Housekeeping ☐ Yes ☐ No
   Security ☐ Yes ☐ No
   Other_____

L. Written Contract

1. A copy of the contract and individually executed contracts is available at the registered establishment for on-site inspection by the commissioner upon request at any time. I verify that this HWS establishment has entered into a signed, written contract, according to the requirements in Minnesota Statutes 144D.04, with each resident or resident representative and the contract includes:

   a. the name, street address, and mailing address of the establishment;
   b. the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;
   c. the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;
   d. the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;
   e. a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;
   f. the term of the contract;
   g. a description of the services to be provided to the resident in the base rate to be paid by resident; including a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate;
   h. a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;
   i. a description of the process through which the contract may be modified, amended, or terminated;
   j. a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;
   k. the resident's designated representative, if any;
   l. the establishment's referral procedures if the contract is terminated;
   m. requirements of residency used by the establishment to determine who may reside or continue to reside in the housing with services establishment;

n. billing and payment procedures and requirements;
o. a statement regarding the ability of residents to receive services from service providers with whom the establishment does not have an arrangement;
p. a statement regarding the availability of public funds for payment for residence or services in the establishment;
q. a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

☐ Yes ☐ No

2. For a resident receiving one or more health-related services from the establishment's arranged home care provider, I verify that this HWS establishment has included the following statement in the contract:

a. regarding the ability of a resident to furnish and decorate the resident's unit within the terms of the lease;
b. regarding the resident's right to access food at any time;
c. regarding a resident's right to choose the resident's visitors and times of visits;
d. regarding the resident's right to choose a roommate if sharing a unit; and
e. notifying the resident of the resident's right to have and use a lockable door to the resident's unit. The landlord shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible.

☐ Yes ☐ No

M. Alzheimer's or Related Disorder Disclosure Verification

Does this HWS establishment:

1. Advertise, market or otherwise promote the establishment as providing specialized care for Alzheimer's disease or related disorder?
   ☐ Yes ☐ No
2. Secure, segregate, or provide a special program or special unit for residents with a diagnosis of probable Alzheimer's disease or a related disorder?
   ☐ Yes ☐ No

***If yes to either of the above you must answer questions 3 and 4.**

3. I verify that this HWS establishment has provided to each resident or authorized resident representative and the Office of Ombudsman for Long-Term Care, written disclosure of a special program or special care unit containing the requirements in MN Statute 325F.72, Subd. 2 as stated below before entering into an agreement to provide care:
   a. a statement of the overall philosophy and how it reflects the special needs of residents with Alzheimer's disease or other dementias;
   b. the criteria for determining who may reside in the special care unit;
   c. the process used for assessment and establishment of the service plan or agreement, including how the plan is responsive to changes in the resident's condition;
   d. staffing credentials, job descriptions, and staff duties and availability, including any training specific to dementia;
   e. physical environment as well as design and security features that specifically address the needs of residents with Alzheimer's disease or other dementias;
   f. frequency and type of programs and activities for residents of the special care unit;
   g. involvement of families in resident care and availability of family support programs;
   h. fee schedules for additional services to the residents of the special care unit; and

i. a statement that residents will be given a written notice 30 days prior to changes in the fee schedule.
☐ Yes ☐ No

4. Duty to Update
I verify substantial changes to disclosures are reported to each resident or authorized resident representative and the Office of the Ombudsman for Long-Term Care.
☐ Yes ☐ No

N. Assisted Living

Verification Statement for HWS establishments regarding the use of the phrase "Assisted Living" pursuant to Minnesota Statute Section 144G.02. Subdivision 1:

1. This HWS establishment intends to use the phrase "assisted living" orally or in writing to advertise, market or otherwise describe, offer or promote itself:
☐ Yes ☐ No

If yes, you must answer questions 2-9.

Does this HWS establishment that uses the phrase "Assisted Living" provide or make available the following through a licensed home care provider:

2. Assistance with self-administration of medication; or medication administration:
☐ Yes ☐ No
3. Assistance with at least **three** of the following seven activities of daily living:
   a. Bathing ☐ Yes ☐ No
   b. Dressing ☐ Yes ☐ No
   c. Grooming ☐ Yes ☐ No
   d. Eating ☐ Yes ☐ No
   e. Transferring ☐ Yes ☐ No
   f. Continence Care ☐ Yes ☐ No
   g. Toileting ☐ Yes ☐ No
4. Assessments of the physical and cognitive needs by a registered nurse:
☐ Yes ☐ No
5. Have and maintain a system for delegation of health care activities to unlicensed assistive health care personnel by a registered nurse, including supervision and evaluation of the delegated activities:
☐ Yes ☐ No
6. Staff access to an on-call registered nurse 24 hours per day, seven days per week:
☐ Yes ☐ No
7. Does this HWS establishment offer or provide to have the arranged home care provider:
   a. Conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a service agreement or service plan prior to the date on which a prospective resident executes a contract with a housing with services establishment or the date which a prospective resident moves in, whichever is earlier:
   ☐ Yes ☐ No
   b. Have and maintain a system to check on each assisted living client at least daily:
   ☐ Yes ☐ No
   c. Provide a means for assisted living clients to request assistance for health and safety needs 24 hours per day, seven days a week, from the establishment or a person or entity with which the establishment has made

arrangements:
☐ Yes ☐ No

d. Offers to provide or make available the following supportive services: (i) two meals per day; (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the client, reasonable assistance with arranging transportation to medical and social services appointments, and the name of or other identifying information about the person or persons responsible for providing this assistance; (v) upon the request of the client, reasonable assistance with accessing community resources and social services available in the community, and the name of or other identifying information about the person or persons responsible for providing this assistance; and (vi) periodic opportunities for socialization:
☐ Yes ☐ No

e. Have a person or persons available 24 hours per day, seven days per week, who is responsible for responding to the requests of assisted living clients for assistance with health or safety needs, who shall be: awake, located in the same building, or on a contiguous campus with the HWS establishment in order to respond within a reasonable amount of time; capable of communicating with assisted living clients; capable of recognizing the need for assistance; capable of providing either the assistance required or summoning the appropriate assistance; and capable of following directions:
☐ Yes ☐ No

8. If total maximum resident capacity entered on Section H.1 is 12 or fewer, please answer the following:
Does this HWS establishment have:

a. a person available 24 hours a day, seven days per week who shall be awake:
☐ Yes ☐ No

If no to 8a, does this HWS establishment follow the exemption from awake staff requirements by having:

b. the person or persons available and responsible for responding to requests for assistance are physically present within the HWS establishment in which the assisted living clients reside:
☐ Yes ☐ No

c. a system in place that is compatible with the health, safety, and welfare of the establishment's assisted living clients:
☐ Yes ☐ No

d. a contract that includes a statement disclosing the establishment's qualification for, and intention to rely upon, this exemption from awake staff:
☐ Yes ☐ No

e. if answered No to question **8a**, please attach a statement describing how the HWS meets the conditions of the awake staff requirement.

f. does the HWS establishment make this statement available to actual and prospective assisted living clients:
☐ Yes ☐ No

9. Does the HWS establishment inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a HWS establishment or the date on which a prospective resident moves in, whichever is earlier:
☐ Yes ☐ N

O. Dementia Care Training for establishments with a special program or special care unit for residents with probable Alzheimer's disease and/or Assisted Living Services

1. I verify that all HWS non direct-care* employees (including maintenance, housekeeping, food service and other staff) completed (or will complete) at least two hours of training on topics related to persons with dementia (see topics specified below) for each 12 months of employment start date and thereafter.
   ☐ Yes ☐ No
2. I verify that all HWS non direct-care employees (including maintenance, housekeeping, food service and other staff) hired January 1, 2016 or later*, completed (or will complete) at least four hours of initial training on the areas specified below within 160 working hours of the employment start date.
   - An explanation of Alzheimer's disease and related disorders;
   - Assistance with activities of daily living;
   - Problem solving with challenging behaviors; and
   - Communication skills.

   ☐ Yes ☐ No
3. I verify that this HWS Establishment allows for the required training as part of employee and staff duties.
   ☐ Yes ☐ No
4. I verify that the training dates and the topics covered are or will be documented in writing and recorded in the employee's personnel file.
   ☐ Yes ☐ No
5. I verify that this HWS Establishment provides to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training and the basic topics covered.
   ☐ Yes ☐ No
6. I understand that the commissioner may review training records as part of this application, as well as any time during the year to verify compliance with this requirement.
   ☐ Yes ☐ No

**Direct-care staff under Minnesota Statute 144D.01 Subd. 3a. means staff and employees who provide home care services listed in section 144A.471, subdivisions 6 and 7.*

** New employees may satisfy the initial dementia training requirement by producing written proof of previously completed required training within the past 18 months.*

P. Housing Manager Training Requirements

Continuing Education

1. I verify that the housing manager identified in Section F has completed (or will complete) at least 30 hours of continuing education every two years from the employment start date in topics relevant to the operations of the HWS establishment and the needs of its tenants.

   Continuing education earned to maintain a professional license, such as nursing home administrator license, nursing license, social worker license and real estate license can be used to complete this requirement.

   ☐ Yes ☐ No

2. I understand that the commissioner may review training records as part of this application, as well as any time during the year to verify compliance with this requirement.

   ☐ Yes ☐ No

For the housing manager identified in Section F of a HWS establishment with **special program or special care unit for residents with Alzheimer's disease or other dementias** and/or who advertise, market or otherwise promote the establishment as providing services for persons with Alzheimer's disease or other dementias under Minnesota Statute 325F.72:

3. I verify that the housing manager identified in Section F has completed (or will complete) at least <u>two</u> hours of training on topics related to persons with dementia for each 12 months of employment thereafter.

   ☐ Yes ☐ No

4. I verify that the housing manager identified in Section F (if hired January 1, 2016 or later), has completed (or will complete) at least <u>eight</u> hours of initial training on the areas specified below within 160 working hours of the employment start date.

   New managers may satisfy the initial <u>eight</u>-hour dementia training requirement by producing written proof of previously completed required training within the past 18 months.

   - an explanation of Alzheimer's disease and related disorders;
   - assistance with activities of daily living;
   - problem solving with challenging behaviors; and
   - communication skills.

   ☐ Yes ☐ No

5. I verify that the HWS establishment maintains records for at least three years demonstrating that the housing manager (identified in Section F) has attended educational programs as required by Minnesota Section 144D.10.

   ☐ Yes ☐ No

For the housing manager identified in Section F of a HWS establishment that provides **assisted living** under Minnesota Chapter 144G, but **DOES NOT** have a special program or special care unit for residents with a diagnosis of probable Alzheimer's disease or related disorders:

6. I verify that the housing manager identified in Section F has completed (or will complete) at least <u>two</u> hours of training on topics related to persons with dementia for each 12 months of employment thereafter.

☐ Yes ☐ No

7. I verify that the housing manager identified in Section F (if hired January 1, 2016 or later), has completed (or will complete) at least four hours of initial training on the areas specified below within 160 working hours of the employment start date.

   New managers may satisfy the initial four hour dementia training requirement by producing written proof of previously completed required training within the past 18 months.

   - an explanation of Alzheimer's disease and related disorders;
   - assistance with activities of daily living;
   - problem solving with challenging behaviors; and
   - communication skills.

   ☐ Yes ☐ No

8. I verify that the HWS establishment maintains records for at least three years demonstrating that the housing manager (identified in Section F) has attended educational programs as required by Minnesota Section 144D.10.
   ☐ Yes ☐ No

Q. Emergency Planning

In accordance with 144D. 11, I verify that this HWS establishment meets the following emergency planning requirements:

1. Has a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in- place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency.
   ☐ Yes ☐ No
2. Posts an emergency disaster plan prominently.
   ☐ Yes ☐ No
3. Provides building emergency exit diagrams to all tenants upon signing a lease.
   ☐ Yes ☐ No
4. Posts emergency exit diagrams on each floor.
   ☐ Yes ☐ No
5. Has a written policy and procedure regarding missing tenants.
   ☐ Yes ☐ No
6. Provides emergency and disaster training to all staff during the initial staff orientation and annually thereafter and makes emergency and disaster training available to all tenants annually. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.
   ☐ Yes ☐ No
7. Conducts and documents a fire drill or other emergency drill at least every six months. To the extent possible, drills must be coordinated with local fire departments or other community emergency resources.
   ☐ Yes ☐ No

The Minnesota Department of Public Safety, Office of the State Fire Marshal recommends that each HWS contact their local fire chief/fire code official to review their emergency plan.

R. Certification/Registration Fee

To the best of my knowledge, I certify that the information provided on this form is accurate and complete. Enclosed is the $155 annual registration fee made payable to "***Minnesota Department of Health***."

A form on behalf of a corporation, association or governmental unit shall be signed by at least two authorized representatives, one of which shall be an office

_____	_____
Signature of Authorized Representative	Signature of Authorized Representative
_____	_____
Name (please print or type)	Name (please print or type)
_____	_____
Title	Title
_____	_____
Date	Date

Ownership Information Sheet

Name of Provider_____

City_____ State_____ Zip Code_____

County_____ Date Completed_____

Please provide the names, titles and addresses of all owners, officers and/or members of the governing body and the percent of ownership if proprietary.

Name of Owners, Officers, and Members of the Governing Body	Title (President, Director, Partner, Stockholder, etc.)	Address (Street, City, Zip)	Percent of Ownership (if proprietary)

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

11/18/19 – HWS Registration Form

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