Application for a License to Operate a Psychiatric Residential Treatment Facility

In accordance with Minnesota Statute §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.** This application is a request to waive Minnesota Rule 4665.0100, Subp. 10 (https://www.revisor.mn.gov/rules/4665.0100/).

Answer all questions completely and accurately to avoid unnecessary delay. Mail the completed application, fee payment, and applicable supporting documents to MDH (see last page for mailing address). Renewal license applications should be submitted 30 days prior to the expiration date of the current license.

Incomplete applications will be communicated to the provider via email.

The undersigned hereby makes application to operate a Psychiatric Residential Treatment Facility (PRTF) subject to the provisions of, Minnesota Statutes, Section 144.50 - 144.55 (https://www.revisor.mn.gov/statutes/cite/144.50), Chapter 4655 and the rules adopted thereunder.

Application Type

Check one option (see Appendix A for documents to attach)

☐ Initial License
☐ Change of Ownership. Proposed effective date:
☐ License Renewal

Facility Identification

Facility Name (doing business as):

Address:

City/State/Zip:

☐ Check here if mailing address is the same as above.

Complete if different:

Health Facility Identification (HFID) number:

Telephone Number:

Fax Number:

☐ Check here if new telephone or fax number.

Name of county in which the PRTF is located:

Agent/Administrator's Name:

- Direct Email Address:
- Direct Phone Number:

Name of person responsible for completing this application:

Email to receive correspondences from MDH:

☐ Check here if email is the same as the Agent/Administrator

Personnel

Name and title of person in charge in the absence of the administrator:

Give the name of the person in charge of each category:

- Nursing Service:
- Dietary Service:
- Medical Records:

Ownership

Fill in the code that corresponds to the type of entity legally responsible for operating the facility.

Ownership Code

Governmental Non-Federal	Governmental Non-Profit	Non-Governmental For-Profit	Other
11. State 12. County 13. City 14. City – County 15. Hospital district of 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 30. Housing and Redevelopment Employment	27. Tribal

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://mblsportal.sos.state.mn.us/Business/Search):

Federal EIN #:

State Tax ID #:

President/Owner Representative:

- Address:
- City/State/Zip:

Licensed Beds

All PRTF residents are classified as not capable of self-preservation, Class B.

Minnesota Statutes, Section 144.50, Subd. 6. (https://www.revisor.mn.gov/statutes/cite/144.50#stat.144.50.6)

- Number of Class B beds:

Building Classification

Provide information regarding the capability of residents for self-preservation in the case of an emergency. Minnesota Rules 4665.0500 (https://www.revisor.mn.gov/rules/4665.0500/)

- Current number of residents physically and mentally capable of self-preservation:
- Current number of residents not physically and mentally capable of self-preservation:

Program Licensure Information

Check box if you meet Variance.

☐ Variance to Minnesota Rules, Chapter 2960 for Children's Psychiatric Residential Treatment Facilities (PRTF)

Enter program information for this location, as it appears on file with the Minnesota Department of Human Services, DHS Licensing Information Lookup (https://licensinglookup.dhs.state.mn.us/).

Program Name:

- License Number: _____
- Capacity: _____

Program Name: _____

- License Number: _____
- Capacity: _____

Commission for Accreditation

Attach the accreditation approval letter from the Accrediting Organization, which includes the doing business name, address, accreditation effective and expiration dates as a PRTF, and most recent site visit date.

Check the appropriate Accrediting Organization.

☐ Joint Commission on Accreditation of Healthcare Organizations

☐ Commission on Accreditation of Rehabilitation Facilities

☐ Council on Accreditation of Services for Families and Children

Ownership Information Sheet

Provide the legal names, titles and addresses of all officers, directors, owners, and managerial employees, and the percent of ownership if applicable.

Name	Title (President, Director, Partner, Stockholder, Etc.)	Address (Street, City, State, Zip Code)	Percentage Of Ownership (If For Profit)

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 Minn. Statute 60A.06, Subd. 1(5b) (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 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 Minn. Stat. 79A (https://www.revisor.mn.gov/statutes/cite/79A) and Minn. 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 Minn. Statute 176.181, Subd. 2 (https://www.revisor.mn.gov/statutes/cite/176.181). 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.

Fees

All applications must be accompanied by the appropriate nonrefundable fee based on the following fee schedule set by Minnesota Statute 144.122, clause (d) (https://www.revisor.mn.gov/statutes/cite/144.122).

Licensing fees includes the following:

Type	Fees
Base Fee	$238.00
License Fee per Bed	$118.00

For example: Base Fee + License Fee per Bed = licensing fee payment due.

For example: $238 + $118 License Fee x Number of Beds) = licensing fee payment due.

Affirmation and License Fee

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

☐ I have enclosed the appropriate evidence of compliance with Workers' Compensation Coverage Provisions.

☐ Enclosed is the renewal licensee fee made payable to the **Minnesota Department of Health**.

In accordance with MN Statute 144.52 Application (https://www.revisor.mn.gov/statutes/cite/144.52), 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.

Signature of Authorized Representative: _____

Name (print or type): _____

Title: _____

Date: _____

Signature of Authorized Representative: _____

Name (print or type): _____

Title: _____

Date: _____

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

Mailing Address:
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

07/21/2025

To obtain this information in a different format, call: 651-201-4200.

Federal Attestation Statement for Psychiatric Residential Treatment Facility

Attestation must include the following information.

Facility Name (doing business as): _____

Address: _____

City/State/Zip: _____

☐ Check here if mailing address is the same as above.

Complete if different: _____

Health Facility Identification (HFID) number: _____

Telephone number: _____

Bed capacity: _____

As of the date of this attestation:

- Number of individuals currently served within the PRTF who are provided service based on their eligibility for the Medicaid Inpatient Psychiatric Services for Individuals Under age 21 Benefit (Psych under 21): _____
- Number of individuals, if any, whose Medicaid Inpatient Psychiatric Services Under 21 Benefit is paid for by any State other than the State of the PRTF identified in this attestation letter: _____
- List all states from which the PRTF has ever received Medicaid payment for the provision of Psych under 21 services: _____

  _____

Affirmation

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

☐ I certify that the facility currently meets all the requirements of Part 483, Subpart G governing the use of restraint and seclusion.

☐ I acknowledge the right of the State Agency (or its agents) and, if necessary, CMS to conduct an on-site survey at any time to validate the facility's compliance with requirements of the rule, to investigate complaints lodged against the facility, or to investigate serious occurrences.

☐ I will submit a new attestation of compliance annually by July 21st of each fiscal year and in the event of a new facility director is appointed.

Signature of Administrator: _____

Name (print or type): _____

Title: _____

Date: _____

Appendix A: Application Type

Submit the following documents based on the application type.

Initial License

Required documents for an initial license include:

- Evidence of Workers' Compensation: See the Example Form: Certificate of Liability (https://www.health.state.mn.us/facilities/regulation/docs/exampleinsurance.pdf) for an example of how to fill out this form.
- Transfer Agreement:
  - Metro Counties: Community-Wide Transfer Agreement between Hospitals and Related Health Facilities in the Minnesota Seven-County Metropolitan Area (https://www.health.state.mn.us/facilities/regulation/docs/fpc2756a.pdf)
  - Non-Metro Counties: Transfer Agreement between a Hospital and a Related Health Facility in Minnesota (https://www.health.state.mn.us/facilities/regulation/docs/fpc2756b.pdf)
- Organizational chart demonstrating relationship of owners to licensee.
- Federal Attestation Statement for PRTF
- Accrediting Organization Approval Letter

Renewal

Required documents for license renewal include:

- Evidence of Workers' Compensation: See the Example Form: Certificate of Liability (https://www.health.state.mn.us/facilities/regulation/docs/exampleinsurance.pdf) for an example of how to fill out this form.
- Federal Attestation Statement for PRTF
- Accrediting Organization Approval Letter

Change of Ownership

Required documents for change of ownership include:

- Evidence of Workers' Compensation: See the Example Form: Certificate of Liability (https://www.health.state.mn.us/facilities/regulation/docs/exampleinsurance.pdf) for an example of how to fill out this form.
- Transfer Agreement:
  - Metro Counties: Community-Wide Transfer Agreement between Hospitals and Related Health Facilities in the Minnesota Seven-County Metropolitan Area (https://www.health.state.mn.us/facilities/regulation/docs/fpc2756a.pdf)
  - Non-Metro Counties: Transfer Agreement between a Hospital and a Related Health Facility in Minnesota (https://www.health.state.mn.us/facilities/regulation/docs/fpc2756b.pdf)

- Organizational charts demonstrating relationship of owners to licensee, both pre-sale and post-sale.
- Federal Attestation Statement for PRTF
- Accrediting Organization Approval Letter
- Bill of Sale