Reset Form

CORPORATE Adult Foster Care (AFC), Community Residential Setting (CRS), Family Adult Day Services (FADS), AFC/CRS Alternate Overnight Supervision Technology

Family Systems License Application

Minnesota Department of Human Services, Licensing Division
Office of Inspector General

Date of Application: _____
(Please type or print using black or blue ink)

1. License type: (check all that apply)

☐ **Corporate Adult Foster Care (AFC)** – the program is not operated in your home
☐ **Community Residential Setting (CRS)** – the program is not operated in your home and all individuals served by the program receive services under a disability waiver
☐ **FADS** (county variance required)
☐ **AFC/CRS Alternate Overnight Supervision Technology**

Check One: ☐ New ☐ Renewal ☐ Update ☐ Change of Premise

Program name and location: Enter the name and physical location of your program. A street address is required; a PO Box may be added if required for mail delivery. The name, address, and telephone number of your program will be public information listed on DHS' online Licensing Information Look Up.

PROGRAM NAME		
STREET ADDRESS (and PO BOX if required for mail delivery)		TELEPHONE NUMBER
CITY	COUNTY	ZIP

2. License history:

Are you currently or have you ever been licensed? ☐ Yes (complete below) ☐ No

Type of License (check all that apply) ☐ Community Residential Setting ☐ Family Child Care ☐ Child Foster Care ☐ Adult Foster Care ☐ FADS ☐ Other:_____

License Number	County/ Agency/ State	Effective Dates of License

Have you ever had a DHS license denied or revoked? ☐ Yes ☐ No
If yes, list the date of denial or revocation and license type or the license number

Date of License Denial or Revocation	License Type for Denied License or License #

Do you currently hold at least one other corporate adult foster care or community residential setting license issued by DHS? ☐ Yes ☐ No
If yes, provide your DHS License Holder Entity ID Number:_____

Do you currently hold a 245D Home & Community Based Services (HCBS) License? ☐ Yes ☐ No

If yes, provide your 245D HCBS License Number: _____

Are you renewing your corporate license? ☐ Yes ☐ No
If you answered YES, enter either of the following:

MN Tax ID Number if you are a non-individual license holder	Social Security Number if you are an individual license holder

If you currently hold a Corporate AFC or CRS license issued by DHS and provided your DHS License Holder Entity ID number and your relevant tax identification number above, SKIP Sections 3, 4, 5, 6 and 13. This information is already on file with DHS. If you do not currently hold a corporate AFC or CRS license, answer ALL of the remaining questions.

3. License holder and tax identification information: The license holder is the business entity that is responsible for the license. The Minnesota Human Services Licensing Act makes a distinction between "individual" and "nonindividual" license holders.

An individual license holder is generally a **sole owner** or **sole proprietorship** where the business is owned and run by one or more person(s). The license holder is not a corporation, partnership, voluntary association, or other organization or government entity, and there is no legal distinction between the owner and the business. **If you are applying as an individual license holder, you must list your full legal name as the license holder.**

A nonindividual license holder means that you have **created a business organization** such as a corporation in order to make a legal distinction between the owner(s) and the business. **If you are applying as a nonindividual license holder, you must list the business name as it appears on your tax forms or as it is listed with the Secretary of State's business registration.**

Both individual and nonindividual license holders are required to provide tax identification (ID) information including Federal Employer ID Number (FEIN), and/or Minnesota Tax ID Number, if you have either. Individual applicants and license holders must also provide their Social Security Number (SSN). Tax ID information is not public; however, DHS is required to provide the tax ID and the SSN of each license holder to the Minnesota Department of Revenue.

Under the Minnesota Government Data Practices Act, we must advise you that:

i. This information may be used to deny the issuance of a license, or to revoke a license, if you owe the Minnesota Department of Revenue delinquent taxes, penalties, or interest.

ii. DHS will only provide the tax identification information to the Minnesota Department of Revenue. However, under the Federal Exchange of Information Act, the Department of Revenue is allowed to supply this information to the Internal Revenue Service.

Complete one of the following sections:

☐ **Non-individual license holder**	☐ **Individual license holder**
You must provide **the full name** of your business as it appears on your tax forms or as registered with the Secretary of State. Business name or name of Government Entity: _____ _____ *Print full business name– do not abbreviate* Federal Employer ID: _____	You must provide **your full legal name** as it appears on your driver's license or state-issued identification card. Legal name: _____ *Print name* DOB (MM/DD/YYYY):_____ Legal name of individual co-license holder (if applicable): _____ *Print name* DOB (MM/DD/YYYY): _____ Social Security #: _____

4. License holder address: This is the primary business address of the license holder; P.O. Box may be added if required for mail delivery.

STREET ADDRESS (and PO Box if required for mail delivery)			
CITY	COUNTY	STATE	ZIP
TELEPHONE NUMBER	FAX NUMBER		

Address for Second "individual" Co-Applicant (if applicable)

STREET ADDRESS of SECOND "INDIVIDUAL" CO-APPLICANT (and PO Box if required for mail delivery)			
CITY	COUNTY	STATE	ZIP
TELEPHONE NUMBER	FAX NUMBER		

5. Controlling individual(s) information: "Controlling individual" is defined in Minnesota Statutes, section 245A.02, subdivision 5a, and includes both organizations and individuals. All individual license holders and applicants are also the controlling individuals. Nonindividual applicants must identify all of the officers, owners, and managerial officials of the organization as controlling individuals.

- An **owner** of an organization is an individual who has 5% or more direct or indirect ownership interest in a corporation, partnership, or other business association issued a license under Chapter 245A.
- A **managerial official** is an individual who has decision-making authority related to the operation of the program, and the responsibility for the ongoing management of or direction of the policies, services, or employees of the program.

Nonindividual applicants only – please complete the information below:

FULL LEGAL NAME, DO NOT ABBREVIATE			
STREET ADDRESS (and PO Box if required for mail delivery)			
CITY	STATE	ZIP	TELEPHONE NUMBER
TYPE OF CONTROLLING INDIVIDUAL (check all applicable boxes) ☐ OWNER, ___% of ownership if 5% or more ☐ OFFICER ☐ MANAGERIAL OFFICIAL			

FULL LEGAL NAME, DO NOT ABBREVIATE			
STREET ADDRESS (and PO Box if required for mail delivery)			
CITY	STATE	ZIP	TELEPHONE NUMBER
TYPE OF CONTROLLING INDIVIDUAL (check all applicable boxes) ☐ OWNER, ___% of ownership if 5% or more ☐ OFFICER ☐ MANAGERIAL OFFICIAL			

FULL LEGAL NAME, DO NOT ABBREVIATE			
STREET ADDRESS (and PO Box if required for mail delivery)			
CITY	STATE	ZIP	TELEPHONE NUMBER
TYPE OF CONTROLLING INDIVIDUAL (check all applicable boxes) ☐ OWNER, ___% of ownership if 5% or more ☐ OFFICER ☐ MANAGERIAL OFFICIAL			

FULL LEGAL NAME, DO NOT ABBREVIATE			
STREET ADDRESS (and PO Box if required for mail delivery)			
CITY	STATE	ZIP	TELEPHONE NUMBER
TYPE OF CONTROLLING INDIVIDUAL (check all applicable boxes) ☐ OWNER, ___% of ownership if 5% or more ☐ OFFICER ☐ MANAGERIAL OFFICIAL			

IF YOU HAVE MORE CONTROLLING INDIVIDUALS, ATTACH A SEPARATE SHEET OF PAPER WITH THE ADDITIONAL NAMES.

6. Authorized Agent information: You must designate one controlling individual to act as the authorized agent. The agent is authorized to accept service on behalf of all of the controlling individuals or individual license holders of the program. Service on the agent is service on all of the controlling individuals or license holders of the program. It is the responsibility of the authorized agent to ensure that any mail received from DHS is distributed as needed and a response provided within stated timelines when required.

Who is the authorized agent for your program?
(required only for new applicants who do not have a license holder entity ID number)

NAME	EMAIL

7. Dwelling Information (check all that apply)

☐ Owned ☐ Rented

☐ Single Family Home ☐ Duplex/Twin home ☐ Apartment/Condo ☐ Townhome ☐ Mobile Home ☐ Other

☐ Basement ☐ First Floor ☐ Second Floor ☐ Above Second Floor

☐ Attached Garage ☐ Wood Burning Stove/Fireplace

8. Individuals living in the program: Live-in staff if applicable. Do not include individuals receiving licensed services.

☐ Check this box if not applicable

Name (Last, First, MI)	Relationship	Gender	Birth Date
Name (Last, First, MI)	Relationship	Gender	Birth Date

9. References: Required at initial licensure for AFC and FADS programs only, not required if adding a FADS license to an existing AFC license.

☐ Check this box if not applicable

Name (Last, First, MI)		
Street Address	Telephone Number	
City	State	Zip Code

Name (Last, First, MI)		
Street Address	Telephone Number	
City	State	Zip Code

Name (Last, First, MI)		
Street Address	Telephone Number	
City	State	Zip Code

10. Population Served - AFC and CRS applicants must complete this section

☐ Check this box if not applicable

Licensed Capacity (indicate number of individuals served by your program):	
Population Served (check all that apply)	
☐ Persons with a developmental disability	☐ Persons with chemical dependency
☐ Persons with a physical disability	☐ Persons with a mental illness
☐ Persons with a brain injury	☐ Elderly
Gender Served	
☐ Male ☐ Female ☐ Either	

11. FADS applicants only must complete this section

☐ Check this box if not applicable

Licensed Capacity (indicate number of individuals served by your program):	
Daily Hours of Operation:	
Monday _____	Friday _____
Tuesday _____	Saturday _____
Wednesday _____	Sunday _____
Thursday _____	

12. AFC/CRS Alternate Overnight Supervision Technology applicants only must complete this section:

☐ Check this box if not applicable
(Submit documentation of items required on the Alternate Overnight Supervision Technology Checklist)

Response Alternative ☐ 1 (one) ☐ 2 (two)	
Name of county where program is located	Telephone Number

13. Municipality: Required at initial licensing and for change of premise. Not required for FADS stand-alone programs.

☐ Check this box if not applicable (FADS only)

Applicants for a residential program license issued by the Department of Human Services under Minnesota Statutes, Chapter 245A, the Human Services Licensing Act, are responsible for contacting the municipality where the program will be located to ask about local ordinance requirements. The license applicant is responsible for taking all necessary actions as directed by the municipality to comply with local ordinance requirements. Please document the following regarding your contact with the local municipality.	
Name of Municipality	Date of Contact
Name of Official	Telephone Number

14. Workers compensation insurance verification: You must complete and submit the *Certificate of Compliance Minnesota Workers' Compensation Law* MN LIC 04 form with your license application. Under section 176.182 DHS is prohibited from issuing a license until the applicant presents evidence of compliance with the worker's compensation insurance requirement.

Minnesota workers' compensation law requires all employers to purchase workers' compensation insurance or become self-insured. For information on workers' compensation insurance requirements go to the Minnesota Department of Labor and Industry website at: https://www.dli.mn.gov/workers.workers-compensation-workers.

15. Applicant acknowledgement of public funding reimbursement for licensed services:

DHS license holders who elect to receive *any* public funding reimbursement (including Medical Assistance) for licensed services, must acknowledge that they will comply with funding requirements, that compliance with those requirements may be monitored by DHS Licensing, and that they know the consequences for noncompliance with those requirements (Minnesota Statutes, section 245A.04, subdivision 1).

☒ **I do elect** to receive public funding reimbursement for the licensed services and will comply with all requirements.

☐ **I do not elect** to receive public funding reimbursement for the licensed services.

16. **Collocated settings:** Any service setting developed after January 1, 2023 must comply with the following collocated setting policy:

- When a single provider leases or owns more than one service setting located on the same or adjoining property (e.g. collocated), the lead agency can only authorize services in one of the settings.

Risks of non-compliance. Community residential service (CRS) license holders must attest to compliance with the collocated setting policy for each licensed setting by completing the Collocated Setting Provider Assurance Statement as a condition of Minnesota Health Care Programs (MHCP) enrollment to provide Community Residential Services (CRS). License holders are subject to monetary recovery, Minnesota Rules, part 9505 program sanctions, or civil or criminal action when the license holder fails to comply with terms of the MHCP provider agreement, including compliance with:

- Any fully executed addendum and assurance statements required by DHS; and
- Federal and state statutes and rules relating to the delivery of services to individuals and to the submission of claims for such services.

License holders can use the DSD contact form to submit questions regarding collocated setting policy.

Applicants must complete the Application Agreement, Acknowledgement and Verification Form on the following page.

Applicant Agreement, Acknowledgement and Verification Form

At initial application only: The authorized agent must review and approve the license application by signing below. **The signature must be made in the presence of a notary public.** An original notarized copy of the Applicant Agreement, Acknowledgement and Verification Form is required.

For license renewals, updates, change of premise: Notarization is not required. The authorized agent must review and approve the license application and must sign and date the application.

By signing below, I agree that the information that I have provided on this application form is true, accurate and complete. If the Commissioner of Human Services grants me a license, I agree to comply with the requirements in Minnesota Statutes, chapter 245A and all applicable laws and rules, at all times during the terms of the license. I acknowledge that the Commissioner's representative has the right to request any documentation required by Minnesota Rules or Laws and to inspect the facility/service at any time during the hours that services are provided. I acknowledge that the documentation and inspection required by statutes and rules is necessary for the Commissioner to determine whether I am complying with Minnesota Rules and Laws. I understand that the Commissioner may fine, suspend, revoke or make conditional, or deny a license if an applicant or a license holder fails to comply fully with the applicable laws or rules, or knowingly withholds relevant information from or gives false or misleading information to the Commissioner in connection with an application for a license or during an investigation.

Authorized Agent:

I, _____ (*print full legal name*) state that I am the authorized agent for the license holder identified above. I understand that, by signing below, I am responsible for dealing with the commissioner of human services on all matters provided for in Minnesota Statutes, chapter 245A. I also understand that service of all notices and orders affecting any license held by the License Holder identified above may be made on me, in accordance with Minnesota Statutes, section 245A.04, subdivision 1.

State of Minnesota, County of _____

Signed or attested before me on

(Date) _____

Signature of notarial official

_____

_____
Signature
(sign in front of notary public at initial application)

_____
Signature
(license renewal, update or change of premise)

_____
Date
(license renewal, update or change of premise only)