For MDH Use Only

Check #_____
Fee Deposit #_____
Deposit Date_____
Initials_____
SFM Date_____

2018 Application for a License to Operate a Prescribed Pediatric Extended Care (PPEC) Center

In accordance with Minnesota Statute §13.41, **ALL DATA SUBMITTED ON THIS APPLICATION SHALL BE CLASSIFIED PUBLIC INFORMATION.**

Answer all questions completely and accurately to avoid unnecessary delay.

Minnesota Department of Health
Health Regulation Division
PO Box 64900
St. Paul, MN 55164-0900

The undersigned hereby makes application to operate a Prescribed Pediatric Extended Care center subject to the provisions Minnesota Statutes Section 144H.01-144H.20.

Type of Application (check one)

☐Initial License ☐License Renewal ☐Change of Ownership*

*If a change of ownership application, proposed effective date:_____

A. Identification

Is this center operated on the same grounds as a child care center licensed under Minnesota Rules, chapter 9503?

☐ Yes ☐ No

1. Current name and address:
   a. Name_____
   b. Street_____
   c. City/Zip_____
2. Telephone number_____Fax number_____
3. Name of county in which center is located_____
4. Name of administrator_____
5. Administrator's email address_____

B. Ownership

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

   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 corporation, association, governmental unit, person or partners legally responsible for the operation of this center.

   _____

   Federal ID #_____State Tax ID #_____

3. If a corporation, give the date and place of incorporation_____

4. President/Chairperson_____

5. 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 the Center address.

   Address _____City _____State _____Zip _____

6. Name of the licensed and American Board of Pediatrics Certified Medical Director _____

   _____License Number _____

   Please check: ☐ Employee ☐ Contractor ☐ Volunteer

7. Name of the licensed Director of Nursing (Registered Nurse) _____

   _____License Number _____

C. Services Offered

Basic Services: The law requires a PPEC center to provide basic services defined as:
(1) the development, implementation, and monitoring of a comprehensive protocol of care that is developed in conjunction with the parent or guardian of a medically complex or technologically dependent child and that specifies the medical, nursing, psychosocial, and developmental therapies required by the medically complex or technologically dependent child; and
(2) the caregiver training needs of the child's parent or guardian.

Supportive Services or Contracted Services: Please insert a "1" if the PPEC service will be provided directly by employees of the licensee and a "2" if the services will be provided by contracting with another provider for service. If services will be provided both directly and by contract, please insert a "3".

_____Occupational Therapy

_____Physical Therapy

_____Speech-Language Therapy

_____Respiratory Therapy

_____Social Work

_____Developmental

_____Psychological

_____Other (please list below)

_____

_____

D. Employee Information

1. Do you have a system to ensure that each individual who has direct contact with patients including the licensee, managerial officials, supervisors, direct care givers and volunteers does not have a conviction, criminal history, or substantiated maltreatment that would interfere with the safety or wellbeing of the patients?

   ☐ Yes ☐ No

2. Does every individual who provides direct care, supervision of direct care or management services, including the licensee, have extensive, documented education and skills training in providing care to infants and toddlers, provide employment references documenting skill in the care of infants and toddlers, provide employment references documenting skill in the care of infants and children, and hold a current certification in cardiopulmonary resuscitation?

   ☐ Yes ☐ No

E. Verification

The law requires that an application on behalf of a corporation, association or governmental unit shall be made by any two officers thereof or by its managing agents. **This requires two (2) signatures.** All other applications require one (1) signature.

The Applicant(s) state that the information contained on all parts of this application is complete and accurate.

Signature	Signature
Name	Name
Date	Date
Title or Position	Title or Position

F. License Fee

NOTE: All applications must be accompanied by the appropriate fee based on the following fee schedule.

Type	License Fee
A. Initial Application	$3,820.00
B. Renewal Application (submit 30 days prior to license expiration date)	$1,800.00
C. Change of Ownership	$4,200.00
D. Late Fee (renewals only)	$25.00

Make checks payable to "Minnesota Department of Health."

NOTE: If you have questions concerning this license application, please email MDH at health.fpc-licensing@state.mn.us.

Ownership Information Sheet for Prescribed Pediatric Extended Care Centers

Legal Entity (same as Item B.2. on Page 2)_____ HFID# _____

Facility Name_____

Address_____

City_____State_____Zip Code_____Phone_____

Date Completed_____Administrator_____Email Address_____

Please provide the names, titles and addresses of all officers, directors, owners and managerial employees, the percent of ownership if proprietary and check if the individual provides direct contact to home care or hospice clients on the next page.

Name of Officers, Directors, Owners, and Managerial Employees	Title (President, Director, Partner, Stockholder, etc.)	Address (Street, City, Zip)	Percent of Ownership (if proprietary)	Check if Individual Provides Direct Contact	For MDH Use Only Initial and CHOWS Date BGS Rec'd

Ownership Information

HFID #_____

Name of Officers, Directors, Owners, and Managerial Employees	Title (President, Director, Partner, Stockholder, etc.)	Address (Street, City, Zip)	Percent of Ownership (if proprietary)	Check if Individual Provides Direct Contact	For MDH Use Only Initial and CHOWS Date BGS Rec'd

G. Evidence of Compliance with Workers' Compensation Coverage Provisions

State law requires that the Commissioner of Health shall withhold the license for the operation of a health care provider until the applicant presents acceptable evidence of compliance with workers' compensation coverage provisions.

One of the following documents must accompany this application. Please check which document is attached.

1. ___ **Certificate of Insurance** supplied by an authorized Workers' Compensation carrier pursuant to Minn. Statute 60A.06, Subd. 1(5b). The Certificate should include the name of the licensee, the name of the corporation legally responsible for the licensee, or the name that the licensee is doing business as. The Certificate of Insurance must be in effect prior to the issuance of an initial license or have an effective date on or after the effective date of a renewal license.

2. ___ **"Certificate of Exemption"** from the Commissioner of Commerce permitting an organization to self-insure pursuant to Minn. Statute 79A and Minn. Rules Chapter 2780. The Certificate of Exemption is available to privately owned or publicly held companies and groups. The Certificate of Exemption must be renewed every five years. Questions regarding the Certificate of Exemption should be directed to the Minnesota Department of Commerce at 651-296-4026. **For multiple providers merged under one group, please include Attachment A with the Certificate of Exemption.**

3. ___ Written confirmation from your Third Part Administrator or evidence of coverage from the Workers' Compensation Reinsurance Association (WCRA) allowing you to **self-insure as a Government Entity/Political Subdivision** pursuant to Minn. Statute 176.81, Subd. 2. The Reinsurance Certificate must be renewed annually on a calendar year basis.

You cannot be issued a license and may not operate as a health care provider unless acceptable evidence of compliance with workers' compensation coverage provisions is provided.

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

12/17- FPC928 PPEC

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