Notice of Completed Closure

ASSISTED LIVING PROVIDERS

Instructions

- This form will (1) notify the commissioner, in writing, that the licensee completed the closure and (2) verify to the commissioner that the licensee complied with the coordinated move requirements in Minn. Stat. 144G.55 (www.revisor.mn.gov/statutes/cite/144G.55).
- Utilize information provided by the resident or resident's representatives, case manager or family members to complete this form.
- This form must be submitted within 14 calendar days of all residents having left the facility.
- Send this form to health.assistedliving@state.mn.us
- For more information about requirements of closures and this form see:
  - Minn. Stat. 144G.55 (https://www.revisor.mn.gov/statutes/cite/144G.55)
  - Minn. Stat. 144G.57 (https://www.revisor.mn.gov/statutes/cite/144G.57)
  - Minn. Rule 4659.0130 Subp. 7 (https://www.revisor.mn.gov/rules/4659.0130/#rule.4659.0130.7)

Provider License Information

Licensee's Doing Business As (DBA) Name: _____

Licensee's Legal Name: _____

Health Facility ID (HFID – 5 digit #): _____

Date of Assisted Living Closure: _____

Number of Residents Moved: _____

Content of Form to Include:

- Each resident's name
- Date each resident moved out of the facility
- Each resident's new place of residence
- Current contact information of resident, including new address and phone number
- Each resident's new care provider
- Verify that the facility complied with the coordinated move requirements in Minn. Stat. 144G.55 including:
  - The facility consulted and cooperated with the resident, legal representative, designated representative, case manager (if applicable), relevant health professionals, and any other persons of the resident's choosing to make arrangements to move the resident, including consideration of the resident's goals.
  - The facility prepared a relocation plan to prepare for the move of each resident to the new location or service provider.
  - Verification that the location where the resident moved meets their social, emotional, and health needs *(Minn. Stat. 144G.57, Subd. 4; Minn. Stat. 144G.55, Subd. 1(a) (1-2))*

Resident Roster

Resident Name	Date Resident Moved	Name of New Facility	Address & Phone # of New Facility	Name of New Care Provider	I Attest the Licensee Consulted and & Cooperated with the Resident with their Move	I Attest the Licensee Prepared a Relocation Plan to Prepare for the Move	I Attest the Licensee ensured the Location the Resident Moved to meets their Social, Emotional, & Health Needs

Verification

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

Title: ☐ Owner ☐ Authorized Agent

Owner or Authorized Agent Printed Name: _____

Owner or Authorized Agent Signature: _____

Date: _____

Return Completed Form to:

health.assistedliving@state.mn.us

Minnesota Department of Health
Health Regulation Division
Assisted Living Licensure
P.O. Box 3879
St. Paul, MN 55101-3879
651-201-4200
www.health.state.mn.us/facilities/regulation/assistedliving/

06/17/2022

To obtain this information in a different format call 651-201-5273.