

Closure of a Campus Building

ASSISTED LIVING PROVIDERS

Use this form if you will be closing one or more (but not all) buildings within a licensed assisted living campus.

If you would like to close your facility completely, you will need to follow the instructions found on the [Closure Form for Assisted Living Providers](#)

(www.health.state.mn.us/facilities/regulation/assistedliving/docs/surveyforms/f4045.pdf).

Completed forms should be sent to health.assistedliving@state.mn.us.

Current Information on Record with MDH

Information marked with an asterisk () is required to process changes of information.*

*Licensee’s Legal Name: _____

*Licensee’s Doing Business As (DBA) Name: _____

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

*Mailing Address: _____

*City, State, & Zip: _____

*Phone: _____

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The building identification information should match what was submitted on the Building Information form (PDF) submitted as part of the application.

Before completing this form, read the following statute to understand the requirements for transferring: [Minn. Stat. § 144G.56 \(www.revisor.mn.gov/statutes/cite/144G.56\)](http://www.revisor.mn.gov/statutes/cite/144G.56)

Building identification information (ex. Building A or Building B): _____

Building Address: _____

City, State, & Zip: _____

Proposed Effective date of building closure: _____

Number of residents in building: _____

Enter the names of providers with whom you plan to coordinate the transfer of care: _____

If the address of the building being closed is currently listed as the street address for the facility, please provide the updated facility address: _____

Information Regarding Transfer Notice to Residents

Minn. Stat. § 144G.56, Subd. 3 requires that you notify your residents at least 30 calendar days in advance. The written notice must contain:

- Effective date of transfer
- Proposed transfer location
- Contact information of a person employed by the facility with whom the resident may discuss the notice of transfer
- Contact information for the ombudsman for long-term care
- A statement that the resident may refuse the proposed transfer and may discuss any consequences of a refusal with staff of the facility

This notice must be sent to:

- The residents
- The residents' designated representatives
- The residents' legal representatives

Signature

Authorizing Official on Record: _____

Signature of Authorizing Official: _____

*The person authorizing changes to the license must be an owner, managerial official, board member, or agent who is *currently listed* in the MDH database for MDH to accept changes requested on this form.

Date: ____ / ____ / ____

Return this Completed Document to:

health.assistedliving@state.mn.us

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

6/30/2022

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