

# Pre-Survey Checklist

## STATE EVALUATION: ASSISTED LIVING PROVIDERS (144G)

### Provider Information

Provider: HFID:  
License Type:  
Issued: Expired: Capacity:  
Facility Address:  
Business Address (if different):  
Phone:  
County #: District #:  
Agent: Email:  
CNS/RN: Email:  
LALD: Email:

LALD listed as Director of Record on BELTSS?

Date notification to MDH of providing services (within 2 days of start of services):

Website address/reviewed:

Comments:

Advertising/social media reviewed:

Comments:

### Survey Information

Team Member(s):

Projected entrance date:

Survey project #:

Complaint #:

ACO #:

Follow up #1:

Follow up #2:

## Previous Surveys

Date of previous survey:

Correction orders issued:

Date(s) of follow up survey(s):

Status of correction orders upon follow up:

Complaint investigations:

Results:

## Ombudsman Notification

Email Ombudsman for Long Term Care

Contact:

Date:

Comments:

Email Ombudsman for Mental Health and Developmental Disabilities

Contact:

Date:

Comments:

Minnesota Department of Health  
Health Regulation Division  
PO Box 3879  
St. Paul, MN 55101-3879  
651-201-4200  
[health.assistedliving@state.mn.us](mailto:health.assistedliving@state.mn.us)  
[www.health.state.mn.us](http://www.health.state.mn.us)

12/21/2022

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