

WORKSHEET for DHS License Holder Updates

As a current DHS license holder, you are required to provide additional information to the commissioner upon request. Once you log on to the DHS License Holder Information Update System with the User ID and password sent to you, you must complete your updates at that time. You will not be able to “save and exit” once you log on and begin the update process, so please have the information with you and be prepared to complete the update as soon as you log-on. Use this worksheet to organize the information you must provide to DHS. More information about the required updates for current license holders is available at www.dhs.state.mn.us/licenseupdate.

Tax Identification Information:

7-digit MN TAX ID Follow format: 7777777 or enter all zeros (0000000) if you do not have one	SSN (required ONLY if you are an individual license holder) Follow format: 999-99-9999	9-digit FEDERAL EMPLOYER ID NUMBER Follow format: 99-9999999 or enter all zeros (00-0000000) if you don't have one

Controlling Individual Who Is The Authorized Agent:

FULL LEGAL NAME OF AUTHORIZED AGENT (name must be identical to the name as it appears on the DHS background study notice)		DHS Background Study Number
ADDRESS (STREET ADDRESS REQUIRED, A PO BOX IS NOT ACCEPTABLE)		TITLE/POSITION:
CITY	COUNTY	
STATE	ZIP	E-MAIL ADDRESS:
TELEPHONE NUMBER		FAX NUMBER (optional)
TYPE OF CONTROLLING INDIVIDUAL (check all applicable boxes) <input type="checkbox"/> OWNER, ___% of ownership if 5% or more <input type="checkbox"/> OFFICER <input type="checkbox"/> MANAGERIAL OFFICIAL		
This person MUST Sign the Affidavit of Authorized Agent form in front of a notary public and you must be prepared to scan it and submit it electronically as an attachment as part of your online update.		

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Additional Controlling Individual(s), if any:

FULL LEGAL NAME OF CONTROLLING INDIVIDUAL (name must be identical to the name as it appears on the DHS background study notice)	DHS Background Study Number
POSITION/TITLE:	
TYPE OF CONTROLLING INDIVIDUAL (check all applicable boxes)	
<input type="checkbox"/> OWNER, ___% of ownership if 5% or more <input type="checkbox"/> OFFICER <input type="checkbox"/> MANAGERIAL OFFICIAL	

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

COMPLIANCE OFFICER, only if You Receive Medical Assistance Funding For Your Services

FULL LEGAL NAME OF COMPLIANCE OFFICER			
ADDRESS (STREET ADDRESS REQUIRED, A PO BOX IS NOT ACCEPTABLE)			TITLE/POSITION:
CITY	COUNTY	STATE	ZIP
TELEPHONE NUMBER		FAX NUMBER (optional)	