Illinois Department on Aging

COMMUNITY CARE PROGRAM
PROVIDER CERTIFICATION
APPLICATION FOR

IN-HOME SERVICE PSA 11

INSTRUCTIONS: Please print or type (no pencil). Write "N/A" if question is not applicable.

Applicant:

PART A. PROPOSED SERVICE AREA

1. **Put a check mark (☑) in all counties your agency is applying to serve in PSA 11:**

- ☐ Alexander County
- ☐ Franklin County
- ☐ Gallatin County
- ☐ Hardin County
- ☐ Jackson County
- ☐ Johnson County
- ☐ Massac County
- ☐ Perry County
- ☐ Pope County
- ☐ Pulaski County
- ☐ Saline County
- ☐ Union County
- ☐ Williamson County

IF the geographic area is **smaller** than a county, identify municipalities or relevant portions of County(ies), Township(s) and/or Sub-area(s)/Zip Code(s):

_____

_____

_____

ATTACH A MAP OF THE PROPOSED AREA.

2. If the geographic area is smaller than a county, you must meet one of the following exceptions:

☐ a. Serving limited or non-English speaking clients
Identify language group(s) served: _____
_____

☐ b. Unit of local government
Provide details: _____
_____

☐ c. Benevolent, charitable, social or religious organization providing services under organization charter to a specific population or in an area smaller than a county, township or sub-area.
Provide details: _____
_____

PART B. APPLICANT INFORMATION

1. **LEGAL NAME OF AGENCY** _____

_____

2. **ADDRESS OF ADMINISTRATIVE OFFICE**

Street: _____

City: _____ State: _____ Zip Code: _____

Telephone: ( ) _____ Ext. _____ Fax: ( ) _____

3. **CONTACT PERSON AT ADMINISTRATIVE OFFICE**

Name: _____ Title: _____

E-Mail: _____

4. **BUSINESS HOURS OF ADMINISTRATIVE OFFICE:** _____ **a.m.** to _____ **p.m.**

Complete questions 5–11 for each local office in the PSA for which you are applying. Attach additional sheets as necessary.

5. **ADDRESS OF LOCAL OFFICE** (if **different** from Administrative Office)

Street: _____

City: _____ State: _____ Zip Code: _____

Telephone: ( ) _____ Ext. _____ Fax: ( ) _____

6. **LOCAL OFFICE CONTACT PERSON**

Name: _____ Title: _____

E-Mail: _____

7. **BUSINESS HOURS OF LOCAL OFFICE:** _____ **a.m.** to _____ **p.m.**

8. **SERVICE HOURS OF LOCAL OFFICE:** _____ **a.m.** to _____ **p.m.**

9. **DAYS OF OPERATION OF LOCAL OFFICE:**

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

10. **DAYS / DATES WHEN SERVICE WILL NOT BE PROVIDED:** _____

_____

_____

_____

11. **Number of Supervisors** _____ **Number of Homecare Aides** _____

PART C. SERVICE INFORMATION

Check (X) Yes or No for questions 1 – 12

1. I have read and understand **all** applicable Community Care Program rules set forth in 89 Illinois Administrative Code Part 240. ❑ **Yes** ❑ **No**

2. I have read and understand the definition of In-Home Service as stated in Section 240.210 of the CCP rules. ❑ **Yes** ❑ **No**

3. I have read and understand that I must provide the specific service components of In-Home Service as stated in Section 240.210(a) of the CCP rules, when required by the Plan of Care, including:

   a. teaching/performing of meal planning and preparation; routine housekeeping skills/tasks; shopping skills/tasks; and home maintenance and repairs; ❑ **Yes** ❑ **No**

   b. performing/assisting with essential shopping/errands and handling the participant's money, performing as specifically required by the plan of care and monitored by the homecare supervisor; ❑ **Yes** ❑ **No**

   c. assisting with self-administered medication which shall be limited to: reminding the participant to take his/her medications, reading instructions for utilization, uncapping medicine containers, and providing the proper liquid and utensil with which to take medications; ❑ **Yes** ❑ **No**

   d. assisting with following a written special diet plan and reinforcement of diet maintenance; ❑ **Yes** ❑ **No**

   e. observing participant's functioning and condition and reporting to the supervisor as defined by the plan of care; ❑ **Yes** ❑ **No**

   f. performing/assisting with personal tasks that are not medical in nature as defined by the plan of care; and ❑ **Yes** ❑ **No**

   g. escort/transportation to medical facilities, or for essential errands/shopping, or for essential participant business with or on behalf of the participant as defined by the plan of care. ❑ **Yes** ❑ **No**

4. I will comply with all aspects of the Plan of Care specified in CCP rule Section 240.730. ❑ **Yes** ❑ **No**

5. I will comply with all Administrative Requirements for Certification specified in CCP rule Section 240.1505. ❑ **Yes** ❑ **No**

6. I have read and understand that my agency must establish and comply with all written policies and procedures specified in CCP rule Section 240.1510. ❑ **Yes** ❑ **No**

7. I will be accountable for all Provider Responsibilities as specified in CCP rule Section 240.1520,

   a. I have read and understand that my agency must accept all CCP participant referrals except under the conditions specified in CCP rule Section 240.1520 (f). ❑ **Yes** ❑ **No**

   b. I have read and understand that my agency shall not deviate from a CCP participant's plan of care without specific direction from the Department or the Care Coordination Unit except under the conditions specified in CCP rule Section 240.1520 (g). ❑ **Yes** ❑ **No**

   c. I have read and understand that my agency must advise the CCU of any changes in the participant's physical, mental or environmental needs when the changes would affect the participant's eligibility or service level or would require a change in the plan of care, as specified in CCP rule Section 240.1520 (h). ❑ **Yes** ❑ **No**

   d. I have read and understand that my agency must respond to all participant requests within 15 calendar days from the date of the request, as specified in CCP rule Section 240.1520 (i). ❑ **Yes** ❑ **No**

   e. I have read and understand that my agency must bill the Department electronically as specified in CCP rule Section 240.1520 (j). ❑ **Yes** ❑ **No**

   f. I have read and understand that my agency must bill a CCP participant for any incurred expense for care in compliance with CCP rule Section 240.1520 (k). ❑ **Yes** ❑ **No**

8. I have read and understand as stated in CCP rule Section 240.1525 (a) that In-Home service providers must maintain a physical facility in each planning and service area and must have all of the following:

   a. designated locked storage space for participant records; ❑ **Yes** ❑ **No**

   b. accessibility of records for all participants served in the PSA when required by Department review staff or designees; ❑ **Yes** ❑ **No**

   c. a primary business telephone listed under the name of the business locally that allows for reliable, dependable and accessible communication; ❑ **Yes** ❑ **No**

   d. internet, facsimile and email access; and ❑ **Yes** ❑ **No**

   e. sufficient office space, office equipment and office support to fulfill the requirements of the contract. ❑ **Yes** ❑ **No**

9. I have read and understand as stated in Section 240.1525 (b), that the annual audit report required by the Department must include an independent Certified Public Accountant's opinion concerning the provider's compliance with financial Reporting requirements. ❑ **Yes** ❑ **No**

10. I have read and understand as stated in Section 240.1525 (c) that management staff of the in-home service provider shall be required to complete in-home service management training prior to the award of a CCP in-home service provider agreement from the Department. ❑ **Yes** ❑ **No**

11. I have read and understand the staffing requirements required for in-home service provision as stated in CCP rule Section 240.1530, including the following:

a. I have read and understand as stated in Section 240.1530 (c), that supervisors must maintain a maximum 15 minute response time when homecare aides they supervise are serving in a participant's home; ❑ **Yes** ❑ **No**

b. I have read and understand as stated in Section 240.1530 (d), that in-home service providers shall not sub-contract for management, supervisory or in-home staff; ❑ **Yes** ❑ **No**

c. I have read and understand as stated in Section 240.1530 (e), that in-home service providers shall make one hour service segments available when needed to meet applicant/participant needs; ❑ **Yes** ❑ **No**

d. I have read and understand as stated in Section 240.1530 (f), that in-home service providers must have an Electronic Visit Verification system as set forth by Department standards. "Part E, Electronic Visit Verification (EVV) Certification" form, must be submitted before an agreement can be executed; ❑ **Yes** ❑ **No**

e. I have read and understand as stated in Section 240.1530 (g), that in-home service providers shall make extended evening weekday service and weekend service available to CCP participants as required by the plan of care and that a supervisor must be on-call and available whenever service is being provided; ❑ **Yes** ❑ **No**

f. I have read and understand, as stated in Section 240.1530 (i), the restriction imposed on the hiring of family caregivers. ❑ **Yes** ❑ **No**

12. I have read and understand the required In-Home staff positions, qualifications, training and responsibilities as stated in Section 240.1535. ❑ **Yes** ❑ **No**

PART D. TRANSPORTATION

1. How will transportation be provided to CCP participants when required by the Plan of Care?

❑ Participant transportation is only provided in a vehicle(s) owned or leased by this agency.

❑ Participant transportation is provided directly by the homecare aide.

❑ Participant transportation will be provided by a subcontractor. "Part F., Request for Approval to Subcontract" form, must be submitted before an agreement can be executed.

❑ Participant transportation is provided through public transportation.

❑ Arrangements have not yet been made for the provision of participant transportation.

PART E. ELECTRONIC VISIT VERIFICATION (EVV) CERTIFICATION

Complete one (1) form for each In-Home Service Specific Application/PSA

Agency's Name _____

EVV Contact Person at Administrative Office_____ Title_____

Contact Person's 10-digit Tel. Number_____ E-mail Address_____

1. Advise the type of EVV system being used or for which a contract has been entered. Select all that apply.
   - ❑ Cell Phone
   - ❑ IVR / Telephone
   - ❑ Tablet based solution
   - ❑ Fixed Visit Verification
   - ❑ Other, please list _____
   - ❑ Other, please list _____

2. EVV Provider Company (1)_____ System Type_____

   EVV Provider Company (2) _____ System Type_____

3. Can the CCP participant or authorized designee electronically verify that services were delivered in accordance with their Plan of Care through your agency's EVV system? ❑ Yes ❑ No

4. If yes to Question #3, please specify how the electronic participant verification is completed and verified?

   _____

   _____

I certify that the information provided herein is true and complete to the best of my knowledge. I also certify that this provider agency will cooperate with the Department in verifying this information and that it authorizes any third party with information relevant to EVV certification to release such information to the Department upon request. Failure to comply with the Department's EVV requirements or submission of false information shall result in denial of certification.

_____ _____

Signature of Authorized Representative and Title Date

_____

Name and Title (Type or Print Legibly)

PART F. ILLINOIS DEPARTMENT ON AGING REQUEST FOR APPROVAL TO SUBCONTRACT

MAKE COPIES AS NEEDED

A. REQUESTING AGENCY

Name: _____

SITE ADDRESS

Street: _____

City: _____ State: _____ Zip Code: _____

CONTACT PERSON

Name: _____

Title: _____

Telephone: ( ) _____ Fax: ( ) _____

B. SUBCONTRACTOR

Name: _____

ADDRESS

Street: _____

City: _____ State: _____ Zip Code: _____

Authorized Subcontractor Representative

Name: _____

Title: _____

Telephone: ( ) _____ Fax: ( ) _____

C. PURPOSE OF SUBCONTRACT

_____

_____

_____ _____

Signature (Authorized Representative/Requesting Agency) **Date**

_____

Type or Print Name/Title (Authorized Representative/Requesting Agency)

PART G. APPLICANT SIGNATURE PAGE

By my **notarized** signature below,

I certify that information in this In-Home Service Provider Certification Application is true, accurate, and complete to the best of my knowledge as of the time of signing; that the agency is fiscally sound; that the service proposed herein complies with all Rules of the Community Care Program and will be available on an equal basis in a nondiscriminatory manner without reprisal or retaliation to all eligible participants regardless of age; ancestry; citizenship; color; creed or religion; familial status; gender, sex or sexual orientation; genetic information; marital status; military status or unfavorable discharge from military service; national origin or race; order of protection status; parental status; physical or mental disability; political beliefs; or any other protected classification under applicable civil rights laws; that the agency is in compliance with all applicable Federal, State, and local laws, regulations, and ordinances; and that the agency will cooperate with Department officials in verifying information and hereby authorizes any third party with relevant information bearing on the certification decision to release such information to the Department upon request.

I understand that knowingly providing false information or omitting information may result in denial of certification, decertification or debarment as a service provider under the Community Care Program, termination of any provider agreement and/or other enforcement under federal and state law.

I also agree to update this information as necessary so that it remains true, accurate, and complete while this application is being processed.

_____ _____

Signature of Authorized Representation Date

_____

Name/Title **(Type or Print)**

NOTARY CERTIFICATE

STATE OF _____)
) SS:
COUNTY OF _____)

Subscribed and sworn to before me this _____ day of _____, 20_____.

_____ _____

Signature of Notary Public Printed or typed name of Notary Public

_____ _____

County of residence Date commission expires

Return original and 2 copies of form to: **REMEMBER TO KEEP A COPY FOR YOUR RECORDS**

Illinois Department on Aging
ATTN: Office of Service Development and Procurement
One Natural Resources Way, #100
Springfield, IL 62702-1271

This application is authorized as outlined by the Illinois Act on the Aging. Disclosure of this information is REQUIRED. Failure to provide information could result in denial of certification as a service provider under the Community Care Program.
The Illinois Department on Aging does not discriminate in admission to programs or treatment of employment in government-funded programs, services, or activities in compliance with applicable civil rights laws, policies, and procedures. If you feel you have been discriminated against, you have a right to file a complaint with the Illinois Department on Aging. For information, call the Senior HelpLine: 1-800-252-8966 (Voice); 1-888-206-1327 (TTY).