State of Illinois
Illinois Department on Aging

Community Care Program

LEGAL ENTITY APPLICATION FOR PROVIDER CERTIFICATION

INSTRUCTIONS:
PLEASE PRINT OR TYPE (NO PENCIL). WRITE "N/A" IF QUESTION IS NOT APPLICABLE.

PART A: APPLICANT INFORMATION

1. LEGAL NAME OF APPLICANT AGENCY →			
a. D/B/A (if applicable) →			
b. Commonly used name (if different from Line 1a.) →			
c. Web site address of applicant agency →			
ATTACHMENT: Organization chart			
2. ADMINISTRATIVE OFFICE			
a. Address →	Street:		
→	City:		
→	State:	Zip Code:	
b. Business Hours/Days of Week →			
c. Contact Person at Administrative Office →	Name:		
→	Title:		
→	Phone: ( )		Ext:
→	Fax: ( )		
→	E-mail:		
3. APPLICANT'S AUTHORIZED REPRESENTATIVE			
Name:			
Title:			
Phone: ( )	Ext.		
Fax: ( )			
E-mail:			

PART B: ORGANIZATIONAL INFORMATION

1. LEGAL STRUCTURE – MARK THE TYPE OF LEGAL STRUCTURE OF THE APPLICANT AGENCY.	
❑ Individual/Sole Proprietorship	❑ Not-for-Profit Corporation
❑ Partnership	❑ Unit of State Government
❑ Corporation	❑ Unit of Local Government
❑ Limited Liability Company	❑ Other (specify) _____
ATTACHMENT: Legal Structure Documentation	
2. DIRECTORS, OFFICERS, OWNERS	
List the directors, officers or owners of the applicant agency. Attach page, if needed.	
Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:
3. AUTHORIZED REPRESENTATIVES OF THE APPLICANT AGENCY	
List ALL individuals who have been designated as an Authorized Representative of the applicant agency. Attach page, if needed.	
Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:

PART C: FINANCIAL INFORMATION

1. FISCAL YEAR OF APPLICANT AGENCY: →	Month/Date through Month/Date
2. ILLINOIS DEPARTMENT OF HUMAN RIGHTS (IDHR) NUMBER: →	IDHR #:
3. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN) OR SOCIAL SECURITY NUMBER (individuals or sole proprietorships only) →	FEIN #: **OR**
	Soc. Sec. #:
4. W-9 REQUEST FOR TAXPAYER ID NUMBER AND CERTIFICATION →	a. Attach a completed W-9 for your agency. A form download is available at www.irs.gov/pub/irs-pdf/fw9.pdf

REQUIRED FINANCIAL ATTACHMENTS:

- W-9 form
- Audited financial report with a balance sheet, income statement, statement of cash flow, and all applicable notes for last complete fiscal year.
- Agency business plan.
- Bank reference for each account maintained by your agency.
- Budget narrative which discusses plans to monitor/analyze the budget and to cover potential cash flow problems and year-end deficits.

5. INSURANCE

Indicate below the applicant agency insurance coverage:

a. General liability ($1,000,000 per occurrence, $3,000,000 in the aggregate) ❑ **Yes** ❑ **No**

b. Motor vehicle liability, uninsured motorist and medical payments ❑ **Yes** ❑ **No**

c. Volunteer protection ❑ **Yes** ❑ **No**

d. Worker's compensation ❑ **Yes** ❑ **No**

e. Other: _____

ATTACHMENT: Insurance Certificate

PART D: COMPUTER CAPABILITIES

1. COMPUTER SPECIFICATIONS

Does your agency's computer system meet the minimum specifications for Department Internet billing applications? (refer to instructions) ❑ **Yes** ❑ **No**

PART E: BUSINESS PRACTICE HISTORY

1. PAST BUSINESS PRACTICES

Mark all applicable items relevant to the service for which certification is sought regarding past business practices by the applicant agency and its affiliates (including the managers, directors or owners) for the 10-year period preceding the date of this application.

- ❑ denial, suspension, revocation or termination for cause of a license or contract, or any other enforcement action, such as court civil or criminal action
- ❑ termination of a contract or surrender of a license before expiration or allowing a contract/license to expire in lieu of enforcement action
- ❑ any federal or state Medicaid or Medicare sanctions or penalties relating to the operation of the agency including, but not limited to, Medicaid abuse or fraud
- ❑ any federal or state civil and/or criminal felony convictions
- ❑ operation of an agency that has been decertified in any state under Medicare or Medicaid
- ❑ citations for client abuse, neglect, injury, financial exploitation or inadequate care in any state
- ❑ None

ATTACHMENT: Business Practice Documentation

For any items checked, attach narrative and copy of determination issued by the applicable licensing body, business issuer, court or federal/state agency.

2. REFERENCES

Provide a minimum of five references from individuals and/or businesses which can attest to your agency's qualifications relevant to providing CCP services. Do not include any relatives.

Name/Phone Number:	Relationship with Agency/How long:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

PART F: SERVICE INFORMATION

1. SERVICE FOR CERTIFICATION: ❑ **In-Home** ❑ **ADS** ❑ **EHRS** ❑ **AMD**

2. EXPERIENCE

a. In-Home Service Providers:

A **minimum of three years** experience in business operations providing In-home Service is required, **one** of which must be **in Illinois.** Does your agency meet this requirement?

1. My agency has been providing In-home Service for a minimum of three years.
   ❑ **Yes** ❑ **No**
2. My agency has been providing In-home Service in Illinois for at least one year.
   ❑ **Yes** ❑ **No**

If you answered "No" to either of the above questions, the Department must approve one of the following rule-based exceptions. Please indicate below the experience exception you are requesting.

3. Accreditation by a national organization as specified in Community Care Program rule Section 240.1505 (check the applicable organization):
   - ❑ Accreditation Commission for Health Care (ACHC)
   - ❑ Community Health Accreditation Program (CHAP)
   - ❑ The Joint Commission (JCOA)
   - ❑ Other (specify organization): _____
4. ❑ Other adjustment to the experience requirement (i.e., substituting management team experience for agency experience)

Attachment: Experience/Exception Documentation for **In-Home Service** Providers

Attach documentation of experience, accreditation or exception for in-home service applicants.

b. Adult Day Service Providers:

A **minimum of two years** experience in business operations providing Adult Day Service is required. Does your agency meet this requirement?

1. My agency has been providing Adult Day Service for a minimum of two years.
   ❑ **Yes** ❑ **No**

If you answered "No" to the above question, the Department must approve one of the following rule-based exceptions. Please indicate below the experience exception you are requesting.

2. Accreditation by a national organization as specified in Community Care Program rule Section 240.1505 (check the applicable organization):
   - ❑ Commission on Accreditation of Rehabilitation Facilities (CARF)
   - ❑ Other (specify organization):_____
3. ❑ Other adjustment to the experience requirement (i.e., substituting management team experience for agency experience)

Attachment: Experience Documentation for **Adult Day Service** Providers

Attach documentation of experience, accreditation or exception for Adult Day Service applicants.

c. Emergency Home Response Providers:

A **minimum of <u>five</u> years** experience in business operations providing Emergency Home Response Service is required. Does your agency meet this requirement?

1. My agency has been providing <u>Emergency Home Response Service</u> for a minimum of five years. ❑ **Yes** ❑ **No**
2. ❑ Other adjustment to the experience requirement (i.e., substituting management team experience for agency experience).

Attachment: Experience Documentation for **Emergency Home Response Service Providers**

Attach documentation of experience or exception for Emergency Home Response Service applicants.

d. Automated Medication Dispenser Providers:

A **minimum of <u>five</u> years** experience in business operations providing Automated Medication Dispenser Service is required. Does your agency meet this requirement?

1. My agency has been providing <u>Automated Medication Dispenser Service</u> for a minimum of five years. ❑ **Yes** ❑ **No**
2. ❑ Other adjustment to the experience requirement (i.e., substituting management team experience for agency experience).

Attachment: Experience Documentation for **Automated Medication Dispenser Service Providers**

Attach documentation of experience or exception for Automated Medication Dispenser Service applicants.

PART G: PERSONNEL

Attachments: Policies and Procedures for:

- job descriptions
- wage ranges
- employee benefits
- promotion and evaluation criteria
- grievance procedures

PART H: APPLICANT CERTIFICATIONS

By my **notarized** signature below,

I certify that information in this Legal Entity Application for Provider Certification 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).

ATTACHMENT CHECK LIST

All items must be completed and attached, **in the order requested**, to both copies of the application at the time it is submitted so the Department can evaluate the application for approval. Do not leave any items blank. If an item does not apply, indicate "N/A." If additional space is needed, attach a separate sheet using the same format as below and labeling items as appropriate.

PART A. APPLICANT INFORMATION

_____ Organization chart

PART B. ORGANIZATIONAL INFORMATION

Required Legal Structure Documentation

Individual/Sole Proprietorship or Partnership:

_____ "Certificate of Ownership of Business" issued by the county clerk for each county in which the provider is proposing to provide CCP service

Corporation or Limited Liability Company:

_____ "Certificate of Good Standing" from the Office of the Illinois Secretary of State certifying that the corporation has complied with the requirement to file an annual report and has paid required franchise taxes

Not-for Profit Corporation:

_____ "Certificate of Good Standing" from the Office of the Illinois Secretary of State certifying that the corporation has complied with the requirement to file an annual report,

AND

_____ A current letter from the Office of the Illinois Attorney General certifying that the corporation is in full compliance with **OR** is exempt from the charitable trust laws of the State of Illinois

Unit of State Government

_____ Letter from the Director or head of the agency citing statutory authority for the agency to enter into a Provider Agreement to provide the proposed CCP service

Unit of Local Government

_____ Copy of a resolution or ordinance, passed by the governing body, authorizing application for certification and execution of the Provider Agreement. List designated individual for signature.

PART C. FINANCIAL INFORMATION

_____ Completed W-9 form for your agency

_____ Audited financial report

_____ Agency business plan

_____ Bank reference(s)

_____ Budget narrative

PART E. BUSINESS PRACTICE HISTORY

_____ Narrative and copy of determination issued by the applicable licensing body, business issuer, court, or federal/state agency, **if applicable**

_____ Five Reference Letters or Letters of Recommendation

PART F. SERVICE INFORMATION

_____ Documentation of experience, accreditation or exception for in-home service applicants

_____ Documentation of experience, accreditation or exception for adult day service applicants

_____ Documentation of experience or exception for emergency home response service

_____ Documentation of experience or exception for automated medication dispenser service

PART G. PERSONNEL

_____ Policies and procedures for job descriptions, wage ranges, employee benefits, promotion and evaluation criteria, and grievances

PART H. APPLICANT CERTIFICATIONS

_____ Signed and notarized document