



COMMUNITY CARE PROGRAM PROVIDER APPLICATION FOR **ADULT DAY SERVICE**

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

Applicant:

PART A. PROPOSED SERVICE AREA

- 1.** PLANNING AND SERVICE AREA (PSA) IN WHICH ADULT DAY SERVICE SITE IS LOCATED:
PSA NUMBER: _____

Indicate below the geographic area which you propose to serve from the adult day service site.

Attach a map of the proposed area.

- 2.** MARK ALL EXCEPTIONS WHICH APPLY TO YOUR AGENCY:

- 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, sub-area or township.
Provide details: _____

- 3.** CAN TRANSPORTATION TO/FROM YOUR FACILITY BE COMPLETED IN A REASONABLE PERIOD OF TIME? Yes No

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.**

5. ADULT DAY SERVICE SITE

A. NAME (if different from Administrative Office):

B. ADDRESS (if different from Administrative Office)

Street: _____

City: _____ State: _____ Zip Code: _____

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

C. CONTACT PERSON

Name: _____

Title: _____

E-Mail: _____

PART C. OPERATION INFORMATION

1. SERVICE HOURS OF SITE: _____ **A.M.** TO _____ **P.M.**

2. DAYS OF OPERATION?

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

3. DAYS/DATES WHEN SERVICE WILL NOT BE PROVIDED:

4. ATTACH ADMISSION POLICY

5. ATTACH DISCHARGE POLICY

6. WHAT IS THE TOTAL SQUARE FEET OF ACTIVITY AREA PER CLIENT? _____

7. WHAT IS THE MAXIMUM NUMBER OF CCP CLIENTS THAT WILL BE SERVED AT THIS SITE? _____

8. INDICATE BELOW THE NUMBER OF REQUIRED ADULT DAY SERVICE STAFF AT THE SITE:

	None	Employ		Subcontract		Other
		Full Time	Part Time	Full Time	Part Time	
Program Administrator						
Program Coordinator/Director						
Program Nurse						
Certified Nutrition Staff						
Nutrition Consultant/Dietitian						
Transportation Driver/Escort						

IF "NONE" OR "OTHER" IS MARKED, EXPLAIN: _____

PART D. SERVICE INFORMATION

Check (X) Yes or No for questions 1 – 10

- 1.** I have read and understand **all** applicable Community Care Program (CCP) rules set forth in [89 Illinois Administrative Code Part 240](#). **Yes** **No**
- 2.** I have read and understand the definition of Adult Day Service as stated in [Section 240.230](#). **Yes** **No**
- 3.** I have read and understand that I must provide the specific service components of Adult Day Service as stated in [Section 240.230](#) of the CCP rules, when required by the Plan of Care, including:
 - a. assessment of the client’s strengths and needs, and development of an individual written plan of care for each client that establishes specific client goals for all service components to be provided or arranged for by the service provider; **Yes** **No**
 - b. a balance of purposeful activities to meet the client’s interrelated needs and interests (social, intellectual, cultural, economic, emotional, physical and spiritual) designed to improve or maintain the optimal functioning of the client; **Yes** **No**
 - c. assistance with or supervision of activities of daily living (e.g., walking, eating, toileting and personal care), as needed; **Yes** **No**
 - d. provision of health-related services appropriate to the client’s needs as identified in the provider’s assessment and/or physician’s orders, including health monitoring, nursing intervention on a moderate or intermittent basis for medical conditions and functional limitations, medication monitoring, medication administration or supervision or self-administration, and coordination of health services; **Yes** **No**
 - e. a nutritious daily meal, supplementary snacks, and special diets as directed by the client’s physician; **Yes** **No**
 - f. agency provision or arrangement for transportation, with at least one vehicle physically accessible, to enable clients to receive adult day service at the adult day service provider’s site and participate in sponsored outings; and **Yes** **No**
 - g. provision of emergency care as appropriate in accordance with established adult day service provider policies and [Section 240.1510](#) of this Part. **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 specified in CCP rule [Section 240.1520](#), including not deviating from:
- a. I have read and understand that I must comply with the insurance requirements specified in CCP rule Section 240.1520. **Yes** **No**
 - b. I have read and understand that my agency must accept all CCP client referrals except under the conditions specified in CCP rule Section 240.1520(f).
 Yes **No**
 - c. I have read and understand that my agency shall not deviate from a CCP client's plan of care without specific direction from the Department or the Case Coordination Unit except under the conditions specified in CCP rule Section 240.1520 (g). **Yes** **No**
 - d. I have read and understand that my agency must advise the CCU of any changes in the client's physical, mental or environmental needs when the changes would affect the client'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**
 - e. I have read and understand that my agency must respond to all client requests within 15 calendar days from the date of the request, as specified in CCP rule Section 240.1520(i). **Yes** **No**
 - f. I have read and understand that my agency must bill the Department electronically as specified in CCP rule Section 240.1520(j). **Yes** **No**
 - g. I have read and understand that my agency must bill a CCP client for any incurred expense for care in compliance with CCP rule Section 240.1520(k).
 Yes **No**
- 8.** I will comply with all Standards Requirements for Adult Day Service Providers specified in CCP rule [Section 240.1550](#). **Yes** **No**
- 9.** I will comply with all General Adult Day Service Staffing Requirements specified in CCP rule [Section 240.1555](#). **Yes** **No**
- 10.** I will comply with all standards for Adult Day Service Staff specified in CCP rule [Section 240.1560](#). **Yes** **No**

PART E. SUBCONTRACTS

- 1.** How will transportation be provided to CCP clients?
- Client transportation will be provided in a vehicle(s) owned or leased by this agency.
 - Client transportation will be provided by a subcontractor. "Part F., Request for Approval to Subcontract" form, must be submitted before an agreement can be executed.
 - Arrangements have not yet been made for the provision of client transportation.
- 2.** How will meals be provided to CCP clients?
- Meals will be provided by the adult day service.
 - Meals will be provided by a subcontractor. "Part F., Request for Approval to Subcontract" form, must be submitted before an agreement can be executed.
 - Arrangements have not yet been made for meal provision to clients.

**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)

