State of Illinois
Illinois Department of Public Health

Home Health Agency Initial Licensure Application

BEFORE ATTEMPTING TO COMPLETE THE APPLICATION, REVIEW THE HOME HEALTH, HOME SERVICES, AND HOME NURSING AGENCY LICENSING ACT and IDPH ADMINISTRATIVE CODE. The rules and regulations can be downloaded from *https://dph.illinois.gov*.Search Home Health Agency. Scroll to bottom of page to Laws and Rules. Open and print Illinois Home Health, Home Services, and Home Nursing Agency Code (77 Illinois Administrative Code 245).

Enclose the completed application and appropriate attachments, accompanied by the required licensing fee.

$ 1,500 license fee for single home health agency license every two years.

License fee made payable to the Illinois Department of Public Health (check or money order), sent to:

Illinois Department of Public Health
Health Care Facilities and Programs, 4th Floor
525 W. Jefferson St.
Springfield, IL 62761-0001

NOTE: Retain a copy of the application for future reference.

IF YOU DO NOT TYPE THE APPLICATION USING ADOBE AND CHOOSE TO COMPLETE THE APPLICATION IN WRITING, **BE SURE TO MAKE NOTE OF DROP-DOWN BOXES** TO PROPERLY COMPLETE THE APPLICATION.

The application shall be accompanied by a certificate of insurance documenting minimum liability coverage of $1 million per occurrence and $3 million in the aggregate.

Provide copies of policies and procedures for the following:

- Complaint resolution as required per Section 245.30(b)(3)
- Employee health and safety as required per section 245.30 I(1)(H) and(I)
- Infection control as required per Section 245.75
- Health care worker background check compliance per section 245.72 and mandated reporting compliance per Section 245.250
- Supervisory visits of various disciplines as per 245.40
- Client records management, retention, and release requirements per Section 245.200(b)
- Employee training as required in Section 245.70, 245.71 and 245.211
- Criteria for acceptance of patients and clients as required per Section 245.200(d)
- Documents demonstrating the agency is registered with the IDPH Web Portal and granted access to the Health Care Worker Registry.

IMPORTANT NOTICE: Pursuant to the Home Health Agency Licensing Act (210 ILCS 55/1 et seq.) and the rules and regulations of the Illinois Department of Public Health, titled “Home Health, Home Service, and Home Nursing Agency Code" (77 Ill. Adm. Code 245), this state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under the act and the attendant rules. **Disclosure of this information is mandatory.** This form has been approved by the Forms Management Center.

FOR OFFICE USE ONLY

License Number _____

Medicare Number _____

State of Illinois
Illinois Department of Public Health

Home Health Agency Initial Licensure Application

GENERAL INFORMATION

Agency Name and Physical Address

Agency Name | Agency Phone Number

DBA | Agency Fax Number *optional*

Address | Illinois county of agency Headquarters

City

State | ZIP Code | Email Address

Mailing Address **(If agency's mailing address is different from the physical address listed above.)**

Address

City | State | ZIP Code

Business Hours | a.m. to | p.m. | Days of operation.

Fiscal Period (i.e., MONTH/DAY) | to | (MONTH/DAY)

AFFIDAVIT OF AGREEMENT

The date contained in this application has been reviewed by me and is accurate to the best of my knowledge. I will comply with all rules and regulations governing the licensing of this agency.

Signature - Agency Administrator / Agency Manager (ORIGINAL **ONLY)** | Date Signed

Print Name of Agency Administrator / Agency Manager | Administrator's / Agency Manager's Title

Contact Person

Must be Different from Agency Phone Number

Contact Person - Name | Phone Number

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OWNERSHIP

Select one TYPE OF ORGANIZATION from the drop-down menu that corresponds to the type of agency registered with the Secretary of State or county registrar (CHOOSE ONE TYPE)

GOVERNMENTAL (NA) NON-PROFIT (NA) PROPRIETARY (NA)

***RA - Registered agent required, see below**. **(Add appropriate response from drop down box)**

****Note: If organization is a sole proprietorship, the declaration on Page 8 must be completed.**

AGENCY INFORMATION

List the name of corporation or LLC as registered with the Secretary of State or county - Do not list shareholder names

Legal Entity Name

Street Address

City State ZIP Code

Phone Number

The Illinois Registered agent's address must be in Illinois. If you are unable to identify the registered agent by name or have misplaced a copy of the agent's ownership papers as registered, contact the Office of the Secretary of State to identify the registered agent of record **apps.ilsos.gov/corporatellc/.**

ILLINOIS REGISTERED AGENT - As listed in the Secretary of State Corporation File Detail Report.

Name of Illinois Registered Agent

Street Address

City State ZIP Code

Phone Number of Registered Agent

STOCKHOLDER INFORMATION (Corporations only)

List the number of shares held and the percentage of total shares held by shareholders with more than 5% of common stock.

Name of Shareholder	Business Address	Shares Held	% of Shares

If a corporation or LLC, name of corporation or company

State of incorporation of the company

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GOVERNING BODY - Complete only for agencies registered with the Secretary of State as a corporation. Identify the officers of the governing body of your agency. The governing body has legal authority and responsibility for the conduct of the agency (Section 245.30 of the Illinois Administrative Code 245).
Note: President and secretary positions are required.

Office	Name	Address	State	ZIP Code
President				
Vice President *Optional				
Secretary				
Treasurer *Optional				

Have any of the following been convicted of a felony or of two or more misdemeanors involving moral turpitude in the last FIVE years? (If yes, attach explanation as Exhibit A)

1) Applicant ◯ Yes ◯ No

2) Any officer or director of a corporation ◯ Yes ◯ No

3) Administrator or manager of agency ◯ Yes ◯ No

Does the **administrator/agency manager** have responsibility for more than one Illinois agency? If yes, list additional license numbers and agency names.

◯ Yes ◯ No

License Number _____ Agency Name _____

License Number _____ Agency Name _____

Does the **home health agency supervisor** have responsibility for more than one Illinois agency?

◯ Yes ◯ No

License Number _____ Agency Name _____

License Number _____ Agency Name _____

HOME HEALTH

AGENCY CONTRACTS (add additional copies of this form if necessary) Provide a signed copy of the affiliation agreement with other health care providers. Section 5(a) of the act.
Note that SKILLED NURSING may not be contracted unless it is to cover vacations of regular staff or for specialized skills not routinely offered. SKILLED NURSING must be directly provided by the agency plus ONE OTHER RECOGNIZED SERVICE in order to qualify as a home health agency pursuant to Illinois law. If you use contracted SKILLED NURSING, provide the rationale.

Indicate which services your agency intends to offer.

☐ H-Skilled Nursing ☐ J-Speech Therapy ☐ I-Physical Therapy
☐ M-Home Health Aide ☐ L-Med. Social Worker ☐ K-Occupational Therapy

A HHA must have as their primary service skilled nursing. The agency must have an RN listed (can be part time) as a separate employee from the supervisor.

Provide a copy of the job description for each service the agency intends to offer as required per Section 245.30(c).

Legal Name and Address of Organization

Legal Name and Address of Organization	Type of Service
	☐ H-Skilled Nursing ☐ I-Physical Therapy ☐ J-Speech Therapy ☐ K-Occupational Therapy ☐ L-Med. Social Worker ☐ M-Home Health Aide
	☐ H-Skilled Nursing ☐ I-Physical Therapy ☐ J-Speech Therapy ☐ K-Occupational Therapy ☐ L-Med. Social Worker ☐ M-Home Health Aide
	☐ H-Skilled Nursing ☐ I-Physical Therapy ☐ J-Speech Therapy ☐ K-Occupational Therapy ☐ L-Med. Social Worker ☐ M-Home Health Aide
	☐ H-Skilled Nursing ☐ I-Physical Therapy ☐ J-Speech Therapy ☐ K-Occupational Therapy ☐ L-Med. Social Worker ☐ M-Home Health Aide

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Geographic Service Area

Identify the counties or portions of counties where the home health agency intends to serve patients. If you are intending to serve only a portion of a county, indicate that county with an asterisk (*). **All service areas must be contiguous.** Do not include radius miles as a description of the service area. **It is recommended for initial licenses to start with 3-5 counties. Additional counties may be requested to be added the agency's service area after the agency is operational.**

County	County

SOLE PROPRIETOR DECLARATION

Pursuant to Section 16 of the Illinois Administrative Procedures Act, the licensee is required to complete the Sole Proprietor Declaration page if the organization is set up as a sole proprietorship. **Check NA if not applicable.**

PLEASE CHECK ONLY ONE BOX

PURSUANT TO SECTION 16 OF THE ILLINOIS ADMINISTRATIVE PROCEDURES ACT, THE LICENSEE IS REQUIRED TO ANSWER THE FOLLOWING:

- ◯ I certify under penalty of perjury that I am not more than 30 days delinquent in complying with a child support order. Failure to do so may result in a denial of the renewal license. Making a false statement may subject the licensee to contempt of court.
- ◯ I am more than 30 days delinquent in complying with a child support order.
- ◯ I certify under penalty of perjury that I am not subject to any child support order.
- ◯ NA

Licensee Signature

Date

Home Health Agency Initial Licensure Application

LICENSED OR REGISTERED EMPLOYEES. **List ALL licensed, certified, and contractual employees. List at least ONE contracted employee for each applicable specialty (PT, OT, SP, or MSW). FOR HOME HEALTH AIDE, PROVIDE INITIALS OF EMPLOYEE**. If home health aide services are provided by registered nurses or licensed practical nurses, indicate by placing a **pound sign (#) in front of the initials** of the person providing the services.

Provide a copy of the job description for each service the agency intends to offer as required per Section 245.30(c)(1)(D).

F/T=Full Time, P/T=Part Time and Contract=Contractual Employees. ***SUBMIT COPIES OF LICENSES FOR PROFESSIONAL STAFF (Staff Nurses, PT/OT/ST, etc.)***

Job Title/Name	License Number	Expiration Date	F/T	P/T
			○	○
Administrator				
			○	
Agency Supervisor				

Job Title/Name	License Number	Expiration Date	F/T	P/T	Contract
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○

Copy and attach additional pages as needed.

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Check the types of revenue sources of income of the agency.

Sources of Revenue

Local Funds

- ☐ Local Health Department

Government Funds

- ☐ Medicare Parts A & B (Home Health Only)
- ☐ Medicaid
- ☐ Other Government Funds ☐ VA ☐ Other_____

Other Funds

- ☐ Self-Pay
- ☐ HMO/PPO
- ☐ Commercial Insurance
- ☐ Other Revenue

X Indicates that an attachment is required for submission with application for the specific license type. Administrative Code citing referenced in parenthesis.

	Home Health
Fee Schedule (245.90a)3) g)	X
Affiliation Agreements	X
Description of Services (See Below)	X

Agencies provide a description of the services to be provided (245.90a)3) C).

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HOME HEALTH AGENCY
Attachment A - Administrator Qualification Review Form

Home Health Agency Name

Address

City State ZIP Code

Administrator Information

Last Name First Name Middle Initial

Address

City State ZIP Code

Daytime Phone Number Extension

Check one of the following categories. Section 245.20 "Home Health Agency Administrator" requires that the administrator must be one of the following, with experience in health services administration and at least one year of supervisory or administrative experience in home health care or a related health provider program:

- ◯ Physician ◯ Registered Nurse
- ◯ Individual who meets the requirements for a public health administrator as defined in 77 IL Administrative Code 660.310.
- ◯ Individual with an undergraduate degree and at least one-year supervisory experience in home health care or related health provider program.

Indicate the highest education level obtained: ◯ High School ◯ ADN ◯ Diploma R.N. ◯ B.S.N. ◯ B.A. ◯ B.S. ◯ Master's ◯ Doctorate ◯ M.D.

List the college(s) attended, the address, date of graduation, specialty, and degree obtained.

Name of College

Address of College

City State ZIP Code

Date of Graduation Specialty / Degree

Name of College

Address of College

City State ZIP Code

Date of Graduation Specialty / Degree

List the high school attended, the address, and the date of graduation.

Name of High School Date of Graduation

Address of High School

City State ZIP Code

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List applicable professional licenses, registrations, and/or certifications currently held with the license number, date of expiration, and state that issued the license, registration, or certification. **ATTACH A COPY OF YOUR CURRENT ILLINOIS LICENSE, IF APPLICABLE. YOUR CURRENT EMPLOYER MUST BE THE AGENCY IDENTIFIED IN THIS APPLICATION. Also include a letter of intentions with this application (i.e., the applicant must write a letter stating that if he/she will be working part time elsewhere, as well as for this agency, both agencies are aware of the situation, and it presents no conflict of interest).**

Describe your relevant work experience for the last five years.
(1) List your most recent position with **THIS AGENCY FIRST** and work backward.
(2) Give the starting and ending dates (month and year) for each employment and the weekly hours worked.
(3) Describe the administrative and financial functions performed for each position, with each agency, that qualify you to function as the administrator of a home health agency.
(4) Include the names, addresses, and telephone numbers of organizations.

You may use an additional sheet of paper to complete this section. Resumes are not accepted in lieu of completion of this portion of the form.

Current Employer Name

Address of Current Employer

City State ZIP Code

Starting (month and year) Ending (month and year) Total Hours Worked Weekly

Duties

Previous Employer Name

Address of Previous Employer

City State ZIP Code

Starting (month and year) Ending (month and year) Total Hours Worked Weekly

Duties

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Previous Employer Name

Address of Previous Employer

City State ZIP Code

Starting (month and year) Ending (month and year) Total Hours Worked Weekly

Duties

Have you ever been convicted of a criminal offense? Yes No

Are there any pending or administratively resolved issues concerning your professional license in Illinois or in another state? Yes No

If you answered "yes" to either or both of the above statements, describe the criminal offense and/or the pending or administratively resolved licensure issues in detail, including the state of administrative action [Section 245.130 b) 2]. You may attach an additional sheet of paper if necessary for the explanation.

I signify that the information contained in this form is true and correct to the best of my knowledge and belief. I realize that misrepresentation of this information at any time may be cause for denial of this application or future revocation of a license.

Signature of Applicant (*Original Only*) **Date Signed**

Attachment A -Administrator Qualification Review Form Page 3

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HOME HEALTH AGENCY
Attachment B - Agency Supervisor Qualification Review Form

Section 245.30 of the 77 Illinois Administrative Code requires this position to be filled by an individual who is a registered nurse who has completed a baccalaureate degree in Science of Nursing (BSN) program and has at least one year of nursing experience as a BSN; or a registered nurse without a baccalaureate degree, who has at least three years of nursing experience as a registered nurse within the last five years (two of those years in a home health agency, a community health program caring for the sick, or a family centered nursing program in a community health agency). Section 245.20 defines a registered nurse as a person currently licensed as an RN under the Illinois Nursing Act.

Home Health Agency Name

Address

City State ZIP Code

Agency Supervisor Information

Last Name First Name Middle Initial

Address

City State ZIP Code

Daytime Phone Number (include area code and extension)

Section 245.30 requires that the agency supervisor must be a registered nurse.

Indicate the highest educational level obtained. ○ ADN ○ R.N. ○ B.S.N. ○ B.A. ○ B.S. ○ Master's ○ Doctorate

List the college(s) attended, the address, date of graduation, specialty and degree obtained.

Name of College

Address of College

City State ZIP Code

Date of Graduation Specialty/Degree

Name of College

Address of College

City State ZIP Code

Date of Graduation Specialty/Degree

List the high school attended, the address, and date of graduation.

Name of High School Date of Graduation

Address of High School

City State ZIP Code

Home Health Agency Initial Licensure Application

List applicable professional licenses, registrations and/or certifications currently held with the license number, date of expiration and state that issued the license, registration, or certification. **ATTACH A COPY OF YOUR CURRENT ILLINOIS LICENSE. YOUR CURRENT EMPLOYER MUST BE THE AGENCY IDENTIFIED IN THIS APPLICATION. Include an intentions letter with this application (the agency supervisor position is required to be full time upon licensure. Provide documentation that the applicant is resigning present employment upon licensure or, if working part time elsewhere, provide documentation that the applicant's other employment is outside the agency's hours of operation (nights/weekends).**

Describe your relevant work experience for the last five years.
(1) List your most recent position with **THIS AGENCY FIRST** and work backward.
(2) Give the starting and ending dates (month and year) for each employment and the weekly hours worked.
(3) Describe the administrative functions performed for each position, with each agency, that qualify you to function as the agency supervisor of a home health agency.
(4) Include the names, addresses, and telephone numbers of the organization.

You may use an additional sheet of paper to complete this section.
Resumes are not accepted in lieu of completion of this portion of the form.

Current Employer Name

Address of Current Employer

City State ZIP Code

Starting (month and year) Ending (month and year) Total Hours Worked Weekly

Duties

Previous Employer Name

Address of Previous Employer

City State ZIP Code

Starting (month and year) Ending (month and year) Total Hours Worked Weekly

Duties

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Previous Employer Name

Address of Previous Employer

City State ZIP Code

Starting (month and year) Ending (month and year) Total Hours Worked Weekly

Duties

Have you ever been convicted of a criminal offense? Yes No

Are there any pending or administratively resolved issues concerning your professional license in Illinois or in another state? Yes No

If you answered "yes" to either or both of the above statements, describe the criminal offense and/or the pending or administratively resolved licensure issues in detail, including the state of administrative action [Section 245.130 b) 2]. You may attach an additional sheet of paper if necessary for the explanation.

I signify that the information contained in this form is true and correct to the best of my knowledge and belief. I realize that misrepresentation of this information at any time may be cause for denial of this application, or future revocation of a license.

Signature of Applicant (*Original Only*) **Date**

Home Health Agency Initial Licensure Application

HOME HEALTH - If Applicable

Attachment D - Medical Social Worker/Social Work Assistant Qualification Review Form

Attachment D must be completed for each social worker and social work assistant used by your home health agency, whether directly employed or employed by contract. Section 245.20 of the 77 Illinois Administrative Code 245 requires that the medical social worker be a licensed social worker/clinical social worker under the Clinical Social Work and Social Work Practice Act.

Before forwarding Attachment D to the social worker for completion, fill in the name, address, and city of your home health agency at the top of the form.

The person(s) completing Attachment D should also appear on the (licensed or registered employees) page for Home Health and, check if F/T, P/T, or contract.

HHA Agency Name

Address

City State ZIP Code

Applicant Name

Last Name First Name Middle Initial

Address

City State ZIP Code

Daytime Phone Number Extension

Home Health Agency Initial Licensure Application

THE FOLLOWING TO BE COMPLETED BY MEDICAL SOCIAL WORKER

Section 245.20 requires that the **medical social worker** be a ***licensed*** social worker/clinical social worker under the Clinical Social Work and Social Work Practice Act.

List applicable professional licenses, registrations, and/or certifications currently held. **Attach a copy of your current Illinois license.**

Date MSW Degree Awarded (if applicable) _____ Date of Initial License _____

Expiration Date of Current License _____ State of Issuance _____

Name of College _____ Date of Graduation _____

Address of College _____

City _____ State _____ ZIP Code _____

Specialty Degree _____

Describe your relevant work experience to meet the requirements of Section 245.20.

Employer Name _____

Address of Employer _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total Hours Worked Weekly _____

Duties _____

Employer Name _____

Address of Employer _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total Hours Worked Weekly _____

Duties _____

IF YOU ARE A MEDICAL SOCIAL WORKER, PROCEED TO THE SIGNATURE BLOCK AND SIGN AT THE BOTTOM OF PAGE FOUR.

HOME HEALTH

THE FOLLOWING SECTION MUST BE COMPLETED BY THE SOCIAL WORK ASSISTANT

Section 245.20 requires that the **social work assistant** have a ***baccalaureate degree*** in social work, psychology, sociology, or related field and at least ***one year of social work experience*** in a health care setting. For persons initially licensed by a state or seeking initial qualifications as a social work assistant prior to December 31, 1977, refer to 77 Illinois Administrative Code.

List the college(s) attended, the address, date of graduation, specialty, and degree obtained.

Name of College

Address of College

City State ZIP Code

Date of Graduation Specialty/Degree

Describe your relevant work experience to meet the requirements of Section 245.20.

Employer Name

Address of Employer

City State ZIP Code

Starting (month and year) Ending (month and year) Total Hours Worked Weekly

Duties

Employer Name

Address of Employer

City State ZIP Code

Starting (month and year) Ending (month and year) Total Hours Worked Weekly

Duties

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Section 245.40 requires a social work assistant to be under the supervision of a social worker (social worker as defined in Section 245.20). Both social work assistant and supervising licensed social worker should complete Page 1 of Attachment D.

Name of licensed social worker providing supervision (if applicable) _____

I signify that the information contained in this form is true and correct to the best of my knowledge and belief. I realize that misrepresentation of this information at any time may be cause for denial of this application, or future revocation of a license.

_____ _____

Signature of Medical Social Worker Applicant (*Original Only*) **Date**

_____

Signature of Social Worker Assistant (*if applicable*) (*Original Only*)

Attachment D - Medical Social Worker/Social Work Assistant Qualification Review Form Page 4