State of Illinois
Illinois Department of Public Health

Home Nursing Application

DUE DATE IS 60 DAYS PRIOR TO THE EXPIRATION OF THE CURRENT LICENSE

The completed application and appropriate attachments, accompanied by the required license fee made payable to the Illinois Department of Public Health (check or money order), should be sent to:

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
HEALTH CARE FACILITIES AND PROGRAMS SECTION
525 W. JEFFERSON ST., FOURTH FLOOR
SPRINGFIELD, IL 62761-0001

Enclose the completed application and appropriate attachments, accompanied by the required licensing fee (**electronic submissions and payments are not accepted at this time**).

$1,500 license fee for home nursing agency

The license fee is non-refundable. Filing an application is not a guarantee that a license will be issued. If you have questions regarding this application, call 217-782-7412 or TTY number (for hearing impaired) 800-547-0466.

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.**

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 Services 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.

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◯ **Initial Application** ◯ **Renewal** ◯ **Change of Ownership (CHOW)**
-Final Legal bill of sale is required

Home Nursing Agency License Number _____ **Expiration Date** _____

GENERAL INFORMATION

(Any change in address/phone number requires completion of the Facility Change of Information Form located on the IDPH website at https://dph.illinois.gov/topics-services/health-care-regulation/health-care-facilities/home-nursing.html).

Agency Name and Physical Address

Agency Name _____ Agency Phone _____

DBA _____ Agency Fax (optional) _____ N/A

Address _____ Business Hours _____ a.m. to _____ p.m.

City _____ Days of the Week _____

State _____ ZIP Code _____ Email Address _____

Illinois County of Agency _____

Fiscal Period (i.e., Month/Day) _____ to Month/Day _____

Mailing Address (If agency's mailing address is <u>different</u> from the physical address above.)

Address _____

City _____ State _____ ZIP Code _____

Manager Contact Person **Must be different than agency phone number.**

_____ _____

Name of Contact Person **Phone Number**

BRANCH OFFICE/DROP-SITE INFORMATION

Does your agency maintain branch offices? ◯ Yes ◯ No

Does your agency maintain drop-sites? ◯ Yes ◯ No

***Is this a change in information from the previous year's application?** ◯ Yes ◯ No

List the location of each branch office/drop-site and indicate which type for each location.

Address	County	Phone #	Type		Date Approved
			Branch	Drop-site	

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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)

Did the type of organization change from previous year's application? Yes No

AGENCY INFORMATION

List the name of corporation or LLC as registered with the Secretary of State or county. Do not list shareholder names (https://apps.ilsos.gov/corporatellc/).

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 agency's ownership papers as registered, contact the Office of the Secretary of State to identify the agency's registered agent of record (https://apps.ilsos.gov/corporatellc/).

ILLINOIS REGISTERED AGENT

Name of Illinois Registered Agent (As listed on the Secretary of State Corporation File Detail Report)

Phone Number

Street Address, City, State, ZIP Code

STOCKHOLDER INFORMATION (Corporations only)

List the number of shares held and the percentage of total shares held by shareholders with more than 5%percent of common stock. **For any change in stockholder from the previous renewal, submit a copy of the document to support this change.**

Name of Shareholder	Business Address	Shares Held	% of Shares

If a corporation or LLC, name of corporation or company

State of incorporation of company

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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 N/A if not applicable. CHECK ONLY ONE BOX. Sign and date below selection.**

☐ 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.
☐ N/A

Licensee Signature _____ Date _____

GOVERNING BODY -

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 for entities listed as corporations with the Secretary of State website. For all other entity types, list only the president.**

Office	Name of Individual	Address of Business	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? ◯ Yes ◯ No

If "Yes," list additional license numbers and agency names.

License Number _____ Agency Name _____

License Number _____ Agency Name _____

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Sources of Revenue

Local Funds

☐ Local Health Department

Government Funds

☐ Medicaid

☐ Other Government Funds ○ VA ○ DHS ○ CCP ○ Other _____

Other Funds (must select at least one option under this section)

☐ Self-pay

☐ HMO/PPO

☐ Commercial Insurance

☐ Other Revenue

Record the total number of clients, including duplicated clients, for the admissions and discharges during the fiscal (reporting) period.

DO NOT include client services exclusively under the Community Care Program (CCP) or Illinois Department of Human Services. If there are no clients in any section, indicate with a zero.

# of admissions of most recent fiscal period	
How many of the admissions were ages 65 or older at time of admission?	
How many of the admissions were 18 or younger at time of admission?	
# of discharges for the most recent fiscal period	
Total # current clients at the time of application submission	

*A **duplicated patient or client** is an individual receiving services from an agency who is subsequently discharged and later readmitted during the same reporting fiscal period. Such an individual is to be considered a new admission. An individual should be counted each time he/she is readmitted during the same reporting period.

TOTAL NUMBER OF DUPLICATED PATIENTS SERVED OUTSIDE OF ILLINOIS _____

If you did not render services during the most recent fiscal period, check this box. ☐

If you rendered services to three or less clients during the most recent fiscal period, the following must be provided via fax to 217-524-0488 for one of the clients noted in the table:

☐ **Physician Order**

☐ **Signed client contract.**

☐ **Plan of Care for said client.**

☐ **First and last week of daily care notes for said client.**

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GEOGRAPHIC SERVICE AREA

Identify the counties or portions of counties where the home nursing agency has been approved to serve patients. If the agency is approved to serve only a portion of a county, **place an asterisk (*) in front of the county.** Include all approved counties even if no patients were served in a particular county in the last fiscal year if you wish to retain the county in your service area. Do not include radius miles as a description of the service area. **All service areas must be contiguous.**

Counties

RENEWALS ONLY: Requests for additional or removed geographic area will not be processed from the application. To submit a request for additional counties or removal of counties, submit the request per the guidance on the IDPH website at https://dph.illinois.gov/topics-services/health-care-regulation/health-care-facilities/home-nursing.html.

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LIST ALL EMPLOYEES. **Only licensed or certified nursing staff are qualified to be employed by a home nursing agency.** F/T=Full Time, P/T=Part Time, and Contract=Contractual Employees.

- List the employee's initials, DO NOT include a Social Security number.
- **If the RN/LPN/CNA/HHA is contracted, provide a copy of the contract between the agency and the individual contracted worker as identified below.**
- **Provide the employee's active license or certification.**

Job Title/Name			F/T	P/T
			☐	☐
Administrator Name				
			☐	☐
Alternate Agency Manager				
			☐	☐
Nursing Supervisor	License Number	Expiration Date		

Certified/Licensed Staff:	License Number	Expiration Date	F/T	P/T	Contract
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

Please copy and attach additional pages as needed.

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Required Documentation to be provided with this application:

- ☐ Provide a copy of the current contract per 245.220 for Home Nursing
  - Provide any attachments noted in the current client contract (e.g., rights and responsibilities, plan of care, rate sheet).
- ☐ Provide a copy of your scope of services.
- ☐ Provide a copy of the agency's fee schedule.

Initial Applicants ONLY- provide the following:

- ☐ Copy of Job Description for all positions as per (245.30 c)1 D)
- ☐ Provide your proof of general liability coverage that meets the requirements of (245.90 a) 2)
- ☐ Complaint resolution policy (245.30 b) 3)
- ☐ Employee health and safety policy (245.30 c) 1) I)
- ☐ Infection control policy (245.75)
- ☐ Health care worker background check process (955.145, 955.165, 955.220)
- ☐ Supervisory visit for client policy (245.40 b) 4)
- ☐ Supervisory visit for HHA/CNA policy(245.30 b) 4 B)
- ☐ Client records management and release requirements (245.205 g)
- ☐ Employee training procedures (245.70)
- ☐ Acceptance of client policy (245.205 d)
- ☐ Sample Plan of Care form (245.205 e)
- ☐ Proof of access to the IDPH Health Care Worker Registry (955.115)

AFFIDAVIT

This is to attest that the following named staff members serve in the position indicated. **Be sure to check the change/no change box for each position.**

Home Nursing Agency Manager ☐ Change ☐ No Change

Name of Agency Manager

Home Nursing Agency Manager

Authorized Agent Signature

☐ Attached are the completed qualification review forms and current Illinois license(s) for the above change(s).

AFFIDAVIT OF AGREEMENT

The data 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. 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 Agency Administrator/Agency Manager (ORIGINAL ONLY)

Date Signed

Print Name of Agency Administrator/Agency

Administrator's Title

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(PAGES 9 AND 10 ONLY REQUIRED IF: 1) THIS IS AN INITIAL APPLICATION or 2) THERE HAS BEEN A CHANGE IN THE AGENCY MANAGER)

Attachment E-Agency Manager Qualification Review Form

Home Nursing Agency Name _____ License # _____

Address, City, State, ZIP Code _____

Agency Manager Information

Last Name _____ First Name _____ MI _____

Address, City, State, ZIP Code _____

Daytime Phone Number (include area code and extension) _____

Email _____

See Section 245.30f for the requirements for the agency manager.

Describe your relevant work experience.

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

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

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.**

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**