State of Illinois
Illinois Department of Public Health

Home Services Placement 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**).

$500 license fee for home services placement 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.

State of Illinois
Illinois Department of Public Health

Home Services Placement Application

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

Home Services Placement 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-services-nursing-placement.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 different 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**

Sources of Revenue

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

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

State of Illinois
Illinois Department of Public Health

Home Services Placement Application

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% 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

State of Illinois
Illinois Department of Public Health

Home Services Placement Application

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 _____

State of Illinois
Illinois Department of Public Health

Home Services Placement Application

Record the total number of clients, including duplicated clients who received a placed worker during the fiscal (reporting) period.

# of clients from the most recent fiscal period.	
How many of clients that were ages 65 or older at time of placement?	

*A **duplicated placement** is an individual receiving placement services during the reporting fiscal year. (For example, a client who has used the agency's placement services for more than one worker during the same reporting period).

TOTAL NUMBER OF DUPLICATED PATIENTS SERVED OUTSIDE OF ILLINOIS: _____

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

If you rendered services 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:

☐ **Signed client contract.**

☐ **Signed placed worker contract.**

LIST ALL placed workers.

- List the home service workers initials.

Administrator/Agency Manager Name _____

Alternate Agency Manager Name _____

Home Service Workers (HSWs)			

Copy and attach additional pages as needed.

Home Services Placement Application

GEOGRAPHIC SERVICE AREA

Identify the counties or portions of counties where the home service placement 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-services-nursing-placement.html

State of Illinois
Illinois Department of Public Health

Home Services Placement Application

Required Documentation to be provided with this application:

- ☐ Provide a copy of the current contract per 245.225 for Home Services Placement
  - Provide any attachments noted in the current client contract (e.g., rights and responsibilities, service plan, rate sheet)
- ☐ Provide a copy of your scope of services.

Initial Applicants ONLY- provide the following:

- ☐ Provide your proof of general liability coverage that meets the requirements of (245.90 a) 2)
- ☐ Complaint resolution policy (245.30 b) 3)
- ☐ Worker 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)
- ☐ Client records management, and release requirements (245.30 b) 1)
- ☐ Worker training procedures (245.214 e)
- ☐ Acceptance of client policy (245.30 b) 1)
- ☐ 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 Services Placement Agency Manager ☐ Change ☐ No Change

Name of Agency Manager

Home Services Placement 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

State of Illinois
Illinois Department of Public Health

Home Services Placement Application

(PAGES 8 AND 9 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 Service Placement 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

Home Services Placement Application

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**