Home Health, Home Services, Home Nursing Agency Initial Licensure Application

BEFORE ATTEMPTING TO COMPLETE THE APPLICATION, PLEASE REVIEW THE HOME HEALTH, HOME SERVICES AND HOME NURSING AGENCY LICENSING RULES AND REGULATIONS. The rules and regulations can be downloaded from www.idph.state.il.us under "A" Administrative Rules, "Administrative Rules Only". Open and print Illinois Home Health, Home Services and Home Nursing Agency Code (77 Illinois Administrative Code 245).

Please enclose the completed application and appropriate attachments, accompanied by the required licensing fee:
$ 25 license fee for single home health license
$1500 license fee for for home nursing agency
$1500 license fee for home service agency
$ 500 license fee for home nursing placement agency
$ 500 license fee for home services placement agency

*****Applicants for multiple licenses shall pay the higher licensure fees applicable.***

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 Street, 4th Floor
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.

Home Health, Home Services, Home Nursing Agency Initial Licensure Application

THIS PAGE IS PART OF THE APPLICATION AND MUST BE FILLED OUT WHERE NECESSARY. PLEASE CHECK ALL APPLICABLE AGENCY TYPES THAT YOU ARE APPLYING FOR.

IMPORTANT NOTICE: Pursurant 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.

Type of Agency

- ☐ Home Health Agency (complete pages 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30)
- ☐ Home Services Agency (complete pages 1, 2, 3, 4, 5, 7, 8, 10, 12, 26, 27, 28)
- ☐ Home Nursing Agency (complete pages 2, 3, 4, 5, 6, 7, 10, 11, 13, 15, 17, 31, 32, 33)
- ☐ Home Nursing Placement Agency (complete pages 2, 3, 4, 5, 6, 8, 10, 11, 13, 16, 17, 31, 32, 33)
- ☐ Home Services Placement Agency (complete pages 2, 3, 4, 5, 6, 8,10,11, 13, 16, 17, 31, 32, 33)

FOR OFFICE USE ONLY

License Number _____

License Number _____

License Number _____

Home Health, Home Services, Home Nursing Agency Initial Licensure Application

GENERAL INFORMATION

Agency Name and Address

Agency Name _____ Agency Telephone number _____

_____ Agency Fax number _____

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

City _____ Days of the Week _____

State _____ ZIP Code _____ E-Mail Address _____

Facility Address **(If agency's physical location is different from the mailing address above)**

Address _____

City _____ State ____ ZIP Code _____

Illinois County of Agency Headquarters _____ **(Select from drop down box)**

Fiscal Year data beginning _____ , 20 _____ and ending _____ , 20 _____

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.

_____ _____

Signature-Agency Administrator Agency Manager (ORIGINAL ONLY) Date Signed

_____ _____

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

Contact Person

_____ _____

Contact Person - Name Phone Number

Home Health, Home Services, Home Nursing Agency Initial Licensure Application

OWNERSHIP

Select the TYPE OF ORGANIZATION that corresponds to your agency

GOVERNMENTAL _____ NON-PROFIT _____ PROPRIETARY _____

*__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

Name of Legal Owner _____

Street Address _____

City _____ State _____ ZIP Code _____

Telephone Number _____

The Illinois Regsitered 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 Secretary of State's office to identify the registered agent of record.

ILLINOIS REGISTERED AGENT

Name of Iliniois Registered Agent _____

Street Address _____

City _____ State _____ ZIP Code _____

Telephone Number of Registered Agent _____

STOCKHOLDER INFORMATION

If the organization is a corporation, list the number of shares held and the percentage of total shares held by shareholders with more than 5 percent of common stock or by the top five stockholders, whichever is less.

NAME OF STOCKHOLDER	SHARES HELD	PERCENTAGE OF SHARES

If a corporation or LLC, name of corporation or company _____

State of incorporation of the company _____

Home Health, Home Services, Home Nursing Agency Initial Licensure Application

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)

Office	Name	Address	State	ZIP Code
President				
Vice President				
Secretary				
Treasurer				

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

AGENCY CONTRACTS (add additional copies of this form if necessary)
Please 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, please provide rationale.

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

____
____
____

Type of Service

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

____
____
____

Type of Service

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

____
____
____

Type of Service

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

____
____
____

Type of Service

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

Home Health, Home Services, Home Nursing Agency Initial Licensure Application

GEOGRAPHIC SERVICE AREA

Identify the counties or portions of counties where the home health, home service, home nursing agency, home services placement agency, home nurse placement 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.** Please do not include radius miles as a description of the service area.

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.

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

- ◯ 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.

- ◯ NOT APPLICABLE

Licensee signature _____ Date _____

Home Health, Home Services, Home Nursing Agency Initial Licensure Application

HOME HEALTH AGENCY ONLY

LICENSED OR REGISTERED EMPLOYEES. **List ALL licensed, certified and contractual employees. List at least ONE contracted employee by specialty (PT, OT, SP, or MSW). FOR HOME HEALTH AIDE PROVIDE INITIALS OF EMPLOYEE**. If home health aide services are provided by RNs or LPNs, please indicate by placing a **pound sign (#) in front of the initials** of the person providing the services. **F/T=Full-Time, P/T=Part-Time and Contract=Contractual Employees**..

Job Title	License Number	Expiration Date	F/T	P/T	Contract
Administrator Name			☐	☐	
Agency Supervisor Name			☐	☐	
Supervising Nurse Name			☐		
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

Please copy and attach additional pages as needed.

Home Health, Home Services, Home Nursing Agency Initial Licensure Application

HOME HEALTH SERVICES/HOME NURSING ONLY

LICENSED OR REGISTERED EMPLOYEES. **List ALL licensed, certified and contractual employees.**

F/T=Full-Time, P/T=Part-Time and Contract=Contractual Employees.. **CERTIFIED NURSE AID, HOMEMAKER, PROVIDE INITIALS OF EMPLOYEE.**

Job Title	License Number	Expiration Date	F/T	P/T	Contract
			☐	☐	☐
Agency Manager Name					
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

HOME NURSING/HOME SERVICES PLACEMENT ONLY

List **ALL** licensed, certified registry persons. **HOMEMAKER OR CERTIFIED NURSE AIDE, LIST INITIALS OF REGISTRY PERSON**.

Job Title	License Number	Expiration Date	F/T	P/T	Contract
Agency Manager Name			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

Please 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
- ◯ Medicaid
- ◯ Other Government Funds

Other Funds

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

ATTACHMENTS REQUIRED

Attach a copy of the *Charges for Services* by types of services provided by the agency (**ALL** Agencies) 245.90a)3)G)

Home Health Agency ONLY, attach a copy of any affiliation agreements with other health care providers. 245.90a)3)H)

*All agencies **EXCEPT** Home Health Agencies* shall attach a sample copy of the Client Service Contracts as per Section 245.210b), 245.220 and 245.225.

Placement Agencies shall attach a sample copy of the worker contract as per Section 245.214 e) and 245.212.e).

Provide a description of the services to be provided: 245.90a)3)C)

_____

_____

_____

_____

HOME SERVICES AGENCIES ONLY shall attach a copy of the list of types of services offered by the agency and the scope of the work to be provided under each area. 245.210(a)

Home Health, Home Services, Home Nursing Agency Initial Licensure Application

HOME HEALTH AGENCY ONLY
Attachment A - Administrator Qualification Review Form

HHA Agency Name _____

Address _____

City _____ State _____ ZIP Code _____

Administrator Information

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ ZIP Code _____

Daytime Telephone 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:

○ Physician ○ RN

○ individual who meets the requirements for a public health administrator as defined in 77 IL Adm. Code 660.310

○ individual with at least 1 yr. supervisory or administrative experience in home health care or in a related health program.

Indicate the highest educational level obtained:

○ High School ○ ADN ○ Diploma RN ○ BSN

○ BA ○ BS ○ Masters ○ Doctorate ○ MD

Please 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 _____

Please 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, Home Services, Home Nursing 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 IF APPLICABLE. YOUR CURRENT EMPLOYER MUST BE THE AGENCY IDENTIFIED IN THIS APPLICATION.**

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 names of organizations, the addresses and telephone numbers.

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 _____

Home Health, Home Services, Home Nursing Agency Initial Licensure Application

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, please 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 Date Signed

Home Health, Home Services, Home Nursing Agency Initial Licensure Application

HOME HEALTH AGENCY ONLY
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 physician; a registered nurse who has completed a baccalaureate degree program....and has at least one year of nursing experience as a BSN; or a registered nurse without a baccalaureate degree, but who has at least three years of nursing experience as an RN 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.

HHA Agency Name _____

Address _____

City _____ State _____ ZIP Code _____

Agency Supervisor Information

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ ZIP Code _____

Daytime Telephone number (include area code and extension) _____

Check one, Section 245.30 requires that the agency supervisor must be one of the following: ○ Physician ○ RN

Indicate the highest educational level obtained

○ADN ○Diploma RN ○BSN ○ BA ○ BS ○ Masters ○ Doctorate ○MD

Please 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 _____

Please 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, Home Services, Home Nursing 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 IF APPLICABLE. YOUR CURRENTLY EMPLOYER MUST BE THE AGENCY IDENTIFIED IN THIS APPLICATION.**

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 names of organizations, the addresses and telephone numbers.

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 _____

Home Health, Home Services, Home Nursing Agency Initial Licensure Application

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, please 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 Date

Home Health, Home Services, Home Nursing Agency Initial Licensure Application

HOME HEALTH AGENCY ONLY
Attachment C - Supervising Nurse Qualification Review Form

HHA Agency Name _____

Address _____

City _____ State _____ ZIP Code _____

Supervising Nurse Information

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ ZIP Code _____

Daytime Telephone number (include area code and extension) _____

Section 245.30 requires that the supervising nurse must be a ***FULL-TIME*** registered nurse with the licensed/to be licensed agency.

Indicate the highest educational level obtained

○ ADN ○ Diploma RN ○ BSN ○ BA ○ BS ○ Masters ○ Doctorate

Please 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 _____

Please 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, Home Services, Home Nursing 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 IF APPLICABLE. YOUR CURRENT EMPLOYER MUST BE THE AGENCY IDENTIFIED IN THIS APPLICATION.**

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 an agency.
(3) Include names of organizations, the addresses and telephone numbers.
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 PreviousEmployer _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total hours worked weekly _____

Duties _____

Home Health, Home Services, Home Nursing Agency Initial Licensure Application

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, please 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 Date

HOME HEALTH ONLY - 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, please 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 page 21 (Licensed or Registered Employees) and, if contracted, an asterisk should be placed before the name(s).

Your home health agency application will not be considered complete until Attachment D is completed correctly, signed and dated, and the relevant starting/ending dates of employment and total weekly hours worked for each employment is indicated.

If you have any questions regarding this form, please contact the Illinois Department of Public Health, Division of Health Care Facilities and Programs, Central Office Operations Section, 525 W. Jefferson St., Springfield, IL 62761; or telephone 217-782-7412. The Department's TTY number is 800-547-0466, for use by the hearing impaired. The Departments fax number is 217-782-0382.

HHA Agency Name _____

Address _____

City _____ State _____ ZIP Code _____

Applicant Name

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ ZIP Code _____

Daytime Telephone number _____ Extension _____

Home Health, Home Services, Home Nursing 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 and **have one year of social work experience in a health care setting.**

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 ONLY

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 12/31/1977 refer to 77 Illinois Administrative Code.
Please 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 _____

_____

_____

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 applicant Date

_____

Signature of social worker assistant (if applicable)

Home Health, Home Services, Home Nursing Agency Initial Licensure Application

ALL AGENCIES EXCEPT HOME HOME

Attachment E-Agency Manager Qualification Review Form

If the agency is applying for more than one type of agency, complete an additional Attachment E form for each manager.

☐ Home Nursing Name

☐ Home Service Agency Name _____

Address _____

City _____ State _____ ZIP Code _____

Agency Manager Information

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ ZIP Code _____

Daytime Telephone Number (include area code and extension) _____

See Section 245.30 for the requirements for the Agency Manager

Home Health, Home Services, Home Nursing 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 IF APPLICABLE. YOUR CURRENT EMPLOYER MUST BE THE AGENCY IDENTIFIED IN THIS APPLICATION.**

Describe your relevant work experience for the last five years.

(1) List the Agency this application applies to as **CURRENT** employer, and work backwards. For INITIAL application, start date can be "upon licensure". Provide intentions at any other positions you may hold (i.e., resigning upon licensure, working part-time, if so how many hours per week).
(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 agency manager of a Home Services/Home Nursing Agency, Home Services Placement Agency, Home Nursing Placement Agency.
(4) Include names or organizations, the addresses and telephone numbers. 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 _____

Previous Employer Address _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total.hours worked (weekly) _____

Duties _____

Home Health, Home Services, Home Nursing Agency Initial Licensure Application

Previous Employer Name _____

Previous Employer Address _____

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, please 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.

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 _____ Date _____

ATTACH A COPY OF YOUR CURRENT ILLINOIS LICENSE, IF APPLICABLE