

State of Illinois  
Illinois Department of Public Health  
**Home Health, Home Services, Home Nursing Agency  
Renewal/Change of Ownership Licensure Application**



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

Please enclose the completed application and appropriate attachments, accompanied by the required licensing fee:

- \$ 25 license fee for single home health license
- \$1,500 license fee for home nursing agency
- \$1,500 license fee for home services agency
- \$ 500 license fee for home nursing placement agency
- \$ 500 license fee for home services placement agency

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

**NOTE: Please 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.**

State of Illinois  
Illinois Department of Public Health  
**Home Health, Home Services, Home Nursing Agency  
Renewal/Change of Ownership Licensure Application**



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

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)
- Home Services Agency (complete pages 1, 2, 3, 4, 5, 6, 7, 10, 11, 13, 15, 17, 28, 29, 30)
- Home Nursing Agency (complete pages 2, 3, 4, 5, 6, 7, 10, 11, 13, 15, 17, 28, 29, 30)
- Home Nursing Placement Agency (complete pages 2, 3, 4, 5, 6, 8, 10, 11, 13, 16, 17, 28, 29, 30)
- Home Services Placement Agency (complete pages 2, 3, 4, 5, 6, 8, 10, 11, 13, 16, 17, 28, 29, 30)

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**FOR OFFICE USE ONLY**

License Number \_\_\_\_\_

License Number \_\_\_\_\_

License Number \_\_\_\_\_



**Home Health, Home Services, Home Nursing Agency  
Renewal/Change of Ownership Licensure Application**

Renewal License Expiration Date \_\_\_\_\_ License Number \_\_\_\_\_

Change of Ownership Medicare Number \_\_\_\_\_ License Number \_\_\_\_\_

License Number \_\_\_\_\_

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.

**GENERAL INFORMATION**

**Agency Name and Address**

Agency Name \_\_\_\_\_ Agency Phone \_\_\_\_\_

\_\_\_\_\_ Agency Fax \_\_\_\_\_

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 \_\_\_\_\_

Fiscal Period (i.e Month/Day) \_\_\_\_\_ to Month/Day \_\_\_\_\_

**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 Title

**Contact Person**

\_\_\_\_\_  
Name of Contact Person Phone Number



**BRANCH OFFICE INFORMATION**

Does your agency maintain branch offices?  Yes  No

If yes, list the location of each branch office.

Address/City	County	ZIP Code	Phone Number	Date Branch Location Approved*

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

**OWNERSHIP**

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

Select one TYPE OF ORGANIZATION from the drop down list that corresponds to the type of agency you have.

**(CHOOSE ONE TYPE)**

GOVERNMENTAL \_\_\_\_\_ NON-PROFIT \_\_\_\_\_ PROPRIETARY \_\_\_\_\_

\*RA - Registered agency required, see below.

\*\*Note: If organization is a sole proprietorship, the declaration on Page 13 must be completed.

**AGENCY INFORMATION**

Name of Legal Owner \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Phone Number \_\_\_\_\_



**Home Health, Home Services, Home Nursing Agency  
Renewal/Change of Ownership Licensure Application**

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 Secretary of State's Office to identify the agency's registered agent of record.

**ILLINOIS REGISTERED AGENT**

Name of Illinois Registered Agent \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
Phone Number \_\_\_\_\_

**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.

Name of Shareholder	Shares Held	Percentages 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 Health, Home Services, Home Nursing Agency  
 Renewal/Change of Ownership 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	City	State	ZIP Code
President					
Vice President					
Secretary					
Treasurer					

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 \_\_\_\_\_

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/HOME SERVICES/HOME NURSING SERVICES ONLY**

**PERSONNEL**

Record the total number of FTE\* employees that the agency had in the job classifications specified in the most recent fiscal (reporting) period. **An employee is one who is on your payroll and for whom taxes are normally withheld.**

\*FTE = Full time equivalent (40 hrs/wk = 1 FTE, 32 hrs/wk = .80 FTE, 24 hrs/wk = .60 FTE, 16 hrs/wk = .40 FTE, 8 hrs/wk = .20 FTE, less than 8 hrs/wk = .10 FTE)

Personnel	Number of FTE Home Health	Number of FTE Home Services	Number of FTE Home Nursing
<b>Administration</b>			
Administrator _____		Manager _____	Manager _____
Agency Supervisor _____		Medical Dir. (Optional) _____	Medical Dir. (Optional) _____
Sup.Nurse (Optional) _____		Home Service Worker _____	
Medical Dir. (Optional) _____		Other Personnel (clerical, janitorial, etc.) _____	
<b>Nursing Staff</b>			
Registered Nurse _____			Registered Nurse _____
Licensed Practical Nurse _____			Licensed Practical Nurse _____
Home Health Aide _____			Home Health Aide _____
<b>Therapeutic Staff</b>			
Occupational Therapist _____			Other Personnel (clerical, janitorial, etc.) _____
Physical Therapist _____			
Speech Therapist _____			
Medical Social Worker _____			
Other Personnel (clerical, janitorial, etc.) _____			
<b>COLUMN TOTAL</b> _____		<b>COLUMN TOTAL</b> _____	<b>COLUMN TOTAL</b> _____



**HOME SERVICES PLACEMENT AGENCY/HOME NURSING PLACEMENT AGENCY ONLY**

Record the total number of registry persons that the agency had in the classifications specified in the most recent fiscal (reporting) period.

Classifications	Number of Registry Persons
Administration Manager	
Nursing Registered Nurse	
Licensed Practical Nurse	
Home Service Worker	
Other (Clerical, janitorial, etc.)	
<b>COLUMN TOTAL</b>	



**HOME HEALTH AGENCY 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

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Type of Service

- |                                               |                                                 |
|-----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> H-Skilled Nursing    | <input type="checkbox"/> I-Physical Therapy     |
| <input type="checkbox"/> J-Speech Therapy     | <input type="checkbox"/> K-Occupational Therapy |
| <input type="checkbox"/> L-Med. Social Worker | <input type="checkbox"/> M-Home Health Aide     |

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Type of Service

- |                                               |                                                 |
|-----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> H-Skilled Nursing    | <input type="checkbox"/> I-Physical Therapy     |
| <input type="checkbox"/> J-Speech Therapy     | <input type="checkbox"/> K-Occupational Therapy |
| <input type="checkbox"/> L-Med. Social Worker | <input type="checkbox"/> M-Home Health Aide     |

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Type of Service

- |                                               |                                                 |
|-----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> H-Skilled Nursing    | <input type="checkbox"/> I-Physical Therapy     |
| <input type="checkbox"/> J-Speech Therapy     | <input type="checkbox"/> K-Occupational Therapy |
| <input type="checkbox"/> L-Med. Social Worker | <input type="checkbox"/> M-Home Health Aide     |

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Type of Service

- |                                               |                                                 |
|-----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> H-Skilled Nursing    | <input type="checkbox"/> I-Physical Therapy     |
| <input type="checkbox"/> J-Speech Therapy     | <input type="checkbox"/> K-Occupational Therapy |
| <input type="checkbox"/> L-Med. Social Worker | <input type="checkbox"/> M-Home Health Aide     |

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Type of Service

- |                                               |                                                 |
|-----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> H-Skilled Nursing    | <input type="checkbox"/> I-Physical Therapy     |
| <input type="checkbox"/> J-Speech Therapy     | <input type="checkbox"/> K-Occupational Therapy |
| <input type="checkbox"/> L-Med. Social Worker | <input type="checkbox"/> M-Home Health Aide     |





**Home Health, Home Services, Home Nursing Agency  
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Please check the types of revenue sources of income of this agency.

Sources of Revenue

**Local Funds**

- Local Health Department

**Government Funds**

- Medicare Parts A & B (**Home Health only**)  
 Medicaid  
 Other Government Funds

**Other Funds**

- Self-pay  
 HMO/PPO  
 Commercial Insurance  
 Other Revenue



**HOME HEALTH AGENCY ONLY**

**Services Provided**

Patients by Service

Record the total number of patients, including duplicated\* patients, receiving care in Illinois, in each category of service during the last fiscal period. A duplicated patient could simultaneously be receiving multiple services.

COLUMN ONE - Record the total number of patients who received each service in Illinois.

COLUMN TWO - Record the total number of visits for each service provided in Illinois.

\*A **duplicated patient** is an individual receiving service from a home health agency who is subsequently discharged and later readmitted during the same reporting fiscal period. Such a patient is to be considered a new admit. A patient should be counted each time he/she is readmitted during the same reporting period.

Type of Service	Total Number of Patients and Duplicated Patients by Service	Total Number of Visits
Skilled Nursing		
Physical Therapy		
Speech Therapy		
Occupational Therapy		
Medical Social Work		
Home Health Aide		
Other		
TOTAL		

**Only patients receiving home health services**



**THIS PAGE IS TO BE COMPLETED BY ALL AGENCIES**

**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), Department of Human Resources or Veteran Affairs.**

\*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.

	Home Health	Home Services	Home Nursing Agency
# of admissions of most recent fiscal period	_____	_____	_____
# of discharges of most recent fiscal period	_____	_____	_____
# of admissions for patients 65 or older at time of admission of most recent fiscal period	_____	_____	_____
patient/client census on last day of most recent fiscal period	_____	_____	_____

\*A **duplicated placement** is an individual receiving placement services during the reporting fiscal year. Such an individual is to be counted as many times as he/she receives a placement service during the same reporting period.

	Home Services Placement Agency	Home Nursing Placement Agency
# of placements	_____	_____
# of placements for clients 65 years old or older	_____	_____
# of clients on last day of most recent fiscal period	_____	_____

**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**

<input type="checkbox"/> 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.
<input type="checkbox"/> I am more than 30 days delinquent in complying with a child support order.
<input type="checkbox"/> I certify under penalty of perjury that I am not subject to any child support order.
<input type="checkbox"/> N/A

\_\_\_\_\_  
 Licensee Signature

\_\_\_\_\_  
 Date



**HOME HEALTH AGENCY ONLY**

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, 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/Name	License Number	Expiration Date	F/T	P/T
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Administrator Name				
_____	_____	_____	<input type="checkbox"/>	
Agency Supervisor Name				

Job/Title	License Number	Expiration Date			Contract
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please copy and attach additional pages as needed.



**HOME 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. FOR CERTIFIED NURSE AID OR  
 HOMEMAKER, PROVIDE INITIALS OF EMPLOYEE.**

Job Title	License Number	Expiration Date	F/T	P/T	Contract
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	
Agency Manager Name					
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**HOME NURSING/HOME SERVICES PLACEMENT ONLY**

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

Job Title	License Number	Expiration Date
Agency Manager Name		



**HOME HEALTH/HOME SERVICES/HOME NURSING AGENCY ONLY**

Please remember to include a copy of the employee's current Illinois license. If you have submitted a change during the reporting year and received an approval letter from the Illinois Department of Public Health, it is not considered a change with this application.

**AFFIDAVIT**

Please include a copy of each of the following employee's current Illinois license, if applicable.

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

**It is NOT necessary to complete a qualification review form if there has been no change.**

Home Health Administrator  Change  No Change  
\_\_\_\_\_ Name of Administrator

Home Health Agency Supervisor  Change  No Change  
\_\_\_\_\_ Name of Agency Supervisor

Home Services/Home Nursing Agency Manager  Change  No Change  
\_\_\_\_\_ Name of Agency Manager

Social Worker  Change  No Change  
\_\_\_\_\_ Name of Social Worker

Social Worker's Assistant  Change  No Change  
\_\_\_\_\_ Name of Social Worker's Assistant

\_\_\_\_\_  
**Authorized Agent Signature**

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



**HOME HEALTH AGENCY ONLY  
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:

- Physician
- Registered Nurse
- Individual who meets the requirements for a public health administrator as defined in 77 IL Adm. Code 660.310
- Individual with at least one year supervisory or administrative experience in home health care or in a related health program  
Indicate the highest educational level obtained:
  - High School
  - ADN
  - Diploma R.N.
  - B.S.N.
  - B.A.
  - B.S.
  - Master's
  - Doctorate
  - M.D.

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  
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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. Please also include a letter of intentions with this application (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).**

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**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 \_\_\_\_\_

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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 \_\_\_\_\_

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State of Illinois  
Illinois Department of Public Health  
**Home Health, Home Services, Home Nursing Agency  
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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, 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 (Original Only) Date Signed



**Home Health, Home Services, Home Nursing Agency  
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**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 registered nurse who has completed a baccalaureate degree program and has at least one year of nursing experience as a Bachelors of Science of Nursing; or a registered nurse without a baccalaureate degree, who has at least three years of nursing experience as an 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 Registered Nurse 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     Diploma R.N.     B.S.N.     B.A.     B.S.     Master's     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  
Renewal/Change of Ownership 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. Please include a letter of intentions with this application (the agency supervisor position is required to be full time. Provide documentation that the applicant is resigning present employment, or if working part time elsewhere, provide documentation that the applicant's other employment is outside the agency's hours of operation).**

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**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 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 \_\_\_\_\_

State of Illinois  
Illinois Department of Public Health  
**Home Health, Home Services, Home Nursing Agency  
Renewal/Change of Ownership 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 (Original Only)

\_\_\_\_\_  
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 also should appear on the (Licensed or Registered Employees) page for Home Health and check F/T, P/T or contract.**

Home Health Agency Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Medical Social Worker Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_ Extension \_\_\_\_\_



**Home Health, Home Services, Home Nursing Agency  
Renewal/Change of Ownership 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 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 December 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 \_\_\_\_\_

\_\_\_\_\_

State of Illinois  
Illinois Department of Public Health  
**Home Health, Home Services, Home Nursing Agency  
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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)



**Home Health, Home Services, Home Nursing Agency  
Renewal/Change of Ownership Licensure Application**

**ALL AGENCIES EXCEPT HOME HEALTH  
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 Phone Number (include area code and extension) \_\_\_\_\_

**See Section 245.30 for the requirements for the agency manager**

State of Illinois  
Illinois Department of Public Health  
**Home Health, Home Services, Home Nursing Agency  
Renewal/Change of Ownership 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.**

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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 qualifies you to function as the agency manager of a home services/home nursing agency, home services placement agency, home nursing placement 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 \_\_\_\_\_

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Previous Employer Name \_\_\_\_\_

Previous Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

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

Duties \_\_\_\_\_

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State of Illinois  
Illinois Department of Public Health  
**Home Health, Home Services, Home Nursing Agency  
Renewal/Change of Ownership 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 (Original Only)

\_\_\_\_\_

Date

**ATTACH A COPY OF YOUR CURRENT ILLINOIS LICENSE, IF APPLICABLE**