HHA Renewal/Change of Ownership Licensure Application

The completed application and appropriate attachments, accompanied by the required $25 license fee made payable to the Illinois Department of Public Health (check or money order), should be sent to:

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF FINANCIAL SERVICES
VALIDATIONS UNIT
535 WEST JEFFERSON ST., FOURTH FLOOR
SPRINGFIELD, IL 62761-0001

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

HHA Renewal/Change of Ownership Licensure Application

◯ Renewal
◯ Change of Ownership

License Expiration Date _____ License Number _____

Medicare 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 "Illinois Home Health 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 MAILING ADDRESS

Agency Name _____ Agency Phone _____

_____ Agency Fax _____

Address _____ Business Hours _____ am to _____ pm

City _____ Days of Week _____

State _____ Zip Code _____ E-Mail Address _____

FACILITY ADDRESS **(If agency's physical location is <u>different</u> from the mailing address above)**

Address _____

City _____ State _____ Zip Code _____

ILLINOIS COUNTY OF AGENCY HEADQUARTERS _____

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 home health agency.

_____ _____

Signature-Agency Administrator (ORIGINAL ONLY) Date Signed

_____ _____

Name of Agency Administrator Administrator's Title

CONTACT PERSON

_____ _____

Name of Contact Person Phone Number

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BRANCH OFFICE INFORMATION

Does your agency maintain branch offices? ◯ Yes ◯ No

If yes, list the location of each branch.

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 the TYPE OF ORGANIZATION that corresponds to the type of agency you have.

GOVERNMENTAL [▼] NON-PROFIT [▼] PROPRIETARY [▼]

*__RA - Registered agency required, see below__.

****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 of Legal Owner _____

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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 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 _____

Telephone Number of Registered Agent _____

STOCKHOLDERS 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 company _____

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GOVERNING BODY

Identify the officers of the governing body of your home health agency. The governing body has legal authority and responsibility for the conduct of the home health 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** have responsibility for more than one Illinois parent agency? ◯ Yes ◯ No

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

License Number _____ Agency Name _____

License Number _____ Agency Name _____

Does the **agency supervisor** have responsibility for more than one Illinois parent agency? ◯ Yes ◯ No

License Number _____ Agency Name _____

License Number _____ Agency Name _____

HHA Renewal/Change of Ownership Licensure Application

Personnel

Record the total number of FTE* employees that the home health agency had in the job classifications specified in the most recent fiscal (reporting) year. **An employee is one who is on your home health payroll and for whom taxes are normally withheld.**
Any other services you operate out of the same business address that are not part time or intermittent home health services should not be included in this section.
***FTE = Full time equivalent**

Personnel	Number of FTE
Administration	
Administrator	
Agency Supervisor	
Supervising Nurse	
Medical Director (optional)	
Nursing Staff	
Nursing Supervisor	
RN	
LPN	
Home Health Aide	
Therapeutic Staff	
Occupational Therapist	
Physical Therapist	
Speech Therapist	
Other Staff	
Medical Social Worker	
Other Personnel (clerical, janitorial, etc.)	
COLUMN TOTAL	

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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 Organization
Type of Service

☐ H-Skilled Nursing ☐ I-Physical Therapy
☐ J-Speech Therapy ☐ K-Occupational Therapy
☐ L-Medical Social Work ☐ M-Home Health Aide

____
____
____

Type of Organization
Type of Service

☐ H-Skilled Nursing ☐ I-Physical Therapy
☐ J-Speech Therapy ☐ K-Occupational Therapy
☐ L-Medical Sociar Work ☐ M-Home Health Aide

____
____
____

Type of Organization
Type of Service

☐ H-Skilled Nursing ☐ I-Physical Therapy
☐ J-Speech Therapy ☐ K-Occupational Therapy
☐ L-Medical Sociar Work ☐ M-Home Health Aide

____
____
____

Type of Organization
Type of Service

☐ H-Skilled Nursing ☐ I-Physical Therapy
☐ J-Speech Therapy ☐ K-Occupational Therapy
☐ L-Medical Sociar Work ☐ M-Home Health Aide

____
____
____

Type of Organization
Type of Service

☐ H-Skilled Nursing ☐ I-Physical Therapy
☐ J-Speech Therapy ☐ K-Occupational Therapy
☐ L-Medical Sociar Work ☐ M-Home Health Aide

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GEOGRAPHIC SERVICE AREA

Identify the counties or portions of counties where the home health agency is approved to serve patients. If the agency is approved to serve only a portion of a county, please **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. Please do not include radius miles as a description of the service area. **All service areas must be contiguous.**

Geograhic Service Area

County/City	County/City

TOTAL NUMBER OF DUPLICATED PATIENTS SERVED OUTSIDE OF ILLINOIS: _____

See page 11 for definition of duplicated patients.

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Financial

Indicate total revenues received by funding source(s) for ONLY home health agency services. If your agency does private nursing or shift work, do not include revenue for these services in this section.

REVENUE INFORMATION (nearest dollar amount)

SOURCES OF REVENUE	Total Revenue Received
LOCAL FUNDS	
Local Health Department	
GOVERNMENT FUNDS	
Medicare Parts A and B	
Medicaid	
Other Government Funds	
OTHER FUNDS	
Self Pay	
HMO/PPO	
Commercial Insurance	
Other Revenue	
GRAND TOTAL	

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Financial

Indicate the amount of money expended by type of expense listed during your reporting year. Round to the nearest dollar. **Expenditures should only apply to home health, part-time, or intermittent services. Do not include private nursing or shift work.**

TOTAL EXPENDITURE BY EXPENSE INCURRED

EXPENDITURE TYPE	AMOUNT
Salaries and Benefits (Administration and Clerical)	
Salaries and Benefits (Clinical)	
Contracted Services (Clinical)	
Contracted Services (Non-Clinical)	
Medical Supplies/Equipment	
Insurance (Malpractice, Employee, Building and Other)	
Mortgage and Rent	
Depreciation	
Bad Debts	
Transportation	
Other Expenses (Interest, Advertising, Office, etc.)	
TOTAL	

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Services Provided

PATIENTS BY SERVICE
Record the number of duplicated* patients receiving care in Illinois, in each category of service during the last fiscal year. A duplicated patient could simultaneously be receiving multiple services.
COLUMN ONE - Record the total number of duplicated 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 year. 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 NO. OF DUPLICATED PATIENTS BY SERVICE	TOTAL NO. OF VISITS
Skilled Nursing		
Physical Therapy		
Speech Therapy		
Occupational Therapy		
Medical Social Work		
Home Health Aide		
Other		
TOTAL		

Only patients receiving home health part-time care in Illinois.

Admissions and Discharges during the Fiscal (Reporting) Year. Only patients receiving home health part-time or intermittent care in Illinois.

A. Number of duplicated admissions during the agency's most recent fiscal year. _____

B. Number of duplicated discharges during the agency's most recent fiscal year. _____

C. Number of duplicated admissions where patient was 65 years of age or older at admission during the agency's most recent fiscal year. _____

D. Patient census on the last day of the agency's most recent fiscal year. _____

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.

☐ 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.

_____ _____

LICENSEE SIGNATURE DATE

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LICENSED OR REGISTERED EMPLOYEES. **List ALL licensed, certified and *contractual employees. List at least ONE contracted employee by specialty (PT, OT, SP, or MSW). Identify the contracted employees by an asterisk (*).**

If home health aide services are porvided by RNs or LPNs, please indicate by placing a **pound sign (#) in front of the name** of the person providing the services. For home health aides, list Social Security numbers in the license certification column.

JOB TITLE	EMPLOYEE'S NAME	LICENSE OR CERTIFICATION NUMBER	FULL-TIME	PART-TIME
ADMINISTRATOR			☐	☐
AGENCY SUPERVISOR			☐	☐
SUPERVISING NURSE			◯	
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Please copy and attach additional pages as needed.

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It is NOT necessary to complete a qualification review form if there has been no change, but please remember to include a copy of the employee's current IL license. If you have submitted a change during the reporting year and received an approval letter from IL Dept. 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 staff members continue to serve in their previous capacity and that their credentials have been previously submitted.

☐ No Changes

Administrator _____
Name of Administrator

Agency Supervisor _____
Name of Agency Supervisor

Supervising Nurse _____
Name of Supervising Nurse

Social Worker _____
Name of Social Worker

Social Worker's Assistant _____
Name of Social Worker's Assistant

_____
(Authorized Agent Signature)

☐ Staff changes in the following positions have been made during this application reporting period, but not yet submitted to IL Dept. of Public Health for approval.

- ☐ Administrator
- ☐ Agency Supervisor
- ☐ Supervising Nurse
- ☐ Social Worker
- ☐ Social Worker's Assistant

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

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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 (include area code and extension) _____

Check one of the following categories. Section 245.20 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 _____

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 _____

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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.** Your current employer must be the home health 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

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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 Date Signed

HHA Renewal/Change of Ownership Licensure Application

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).

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 _____

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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.** Your current employer must be the home health 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 PreviousEmployer _____

City _____ State _____ Zip Code _____

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

Duties _____

_____

_____

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Previous Employer Name _____

Address of Previous Employer _____

City _____ State _____ Zip Code _____

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

Duties _____

_____

_____

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

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

If you answered "yes" to either or both of the above statements, 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

HHA Renewal/Change of Ownership Licensure Application

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 _____

HHA 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.** Your current employer must be the home health 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) 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

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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 Date

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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 (include area code and extension) _____

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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 _____ Date of initial license _____

Expiration date of current license _____ State of Issuance _____

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.

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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 _____

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 _____

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)