Completing the Application

How does my agency know what data IDPH is seeking? Instructions for each page of the application are on the preceding (facing) page. The number of each instruction is the same as the question to which it applies.

How does my agency present the data? Please answer all questions that are applicable to your agency and type your answers. Insert only ONE ANSWER PER LINE.

What if the item does not apply to my home health agency? If an item does not apply to your home health agency, e.g., if a particular service is not offered, please insert “NA” (not applicable).

Questions?

BEFORE you call or write this office with questions regarding completion of the application

1) Read the Illinois Department of Public Health rules and regulations for home health agencies available at www.idph.state.il.us or from the Illinois Secretary of State Index Department.

2) Compare the personnel requirements with proposed employee resumes.

3) Ask your legal counsel about corporate structures, legal affiliations, etc. The application is only intended for the licensure of the home health agency. All information provided should represent the proposed home health agency licensee.

The phone number for IDPH’s Division of Health Care Facilities and Programs is 217-782-7412. The TTY phone number for the hearing impaired is 800-547-0466.
Checklist

Please verify the following before submitting the application:

- All applicable sections of the form are **complete** and **signed** by the administrator or his/her designee (page 1).

- The name and telephone number of the contact person are completed in the event IDPH has any questions concerning the data submitted.

- A $25 application fee (check or money order, no cash), payable to the **Illinois Department of Public Health**, is included.

- A **copy of the application has been retained for future reference**.

Submit the application and fee to:

Illinois Department of Public Health
Division of Financial Services
ATTENTION: Validation Unit
535 W. Jefferson St., Fourth Floor
Springfield, IL 62761-0001

**NOTE:** DO NOT MAIL APPLICATION AND FEE TO THE DIVISION OF HEALTH CARE FACILITIES AND PROGRAMS.
INSTRUCTIONS - SECTION I
Administrative

I. GENERAL INFORMATION

A. INTENDED LICENSING/MAILING ADDRESS
   Please complete name and address along with the ZIP code plus four to be used for licensing and mailing purposes.

B. ACTUAL FACILITY ADDRESS/LOCATION
   Please fill in name and address along with the ZIP code plus four of the address where home health business will be conducted/located.

C. ILLINOIS COUNTY
   Illinois county where the agency headquarters (parent) is located.

D. FISCAL YEAR DATA - REPORTING YEAR
   The reporting year is the same as the last completed fiscal year of operation. A fiscal year is any 12-month period chosen as the inclusive dates of your budget (e.g., April 1, 2003 through March 31, 2004), or it may be the same as the calendar year.

E. AFFIDAVIT OF AGREEMENT
   The administrator’s signature attests to the accuracy of the data being supplied. Application is considered incomplete if the administrator has failed to sign the application. It must be an ACTUAL SIGNATURE. No signature stamps or photocopies of signatures will be accepted.

F. CONTACT PERSON
   This section must be completed with the telephone number; include area code, number and extension for the contact person.
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.

I. General Information

A. COMPLETE MAILING ADDRESS

Agency Phone _____/_____ - ____________
Agency Fax _____/_____ - ____________
Business Hours _____ a.m. to _____ p.m.
(Circle days) M,T,W,Th,F through M,T,W,Th,F
E-mail Address ____________________

B. FACILITY ADDRESS (if facility is located at an address different from the one above)

C. ILLINOIS COUNTY OF AGENCY HEADQUARTERS______________________________

D. FISCAL YEAR DATA BEGINNING______, 20___ AND ENDING__________, 20___

E. AFFIDAVIT OF AGREEMENT

The data contained in this application have been reviewed by me and are 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

__________________________________________  ____________________________
Typed Name of Agency Administrator  Administrator’s Title

F. CONTACT PERSON

__________________________________________  (_____ ) _____ - ____________
Typed Name of Contact Person  Office Phone with Extension
INSTRUCTIONS

II. Ownership

A. TYPE OF ORGANIZATION
   Identify whether the organization is a 1.) governmental, 2.) non-profit or 3.) proprietary (for profit) agency. Then indicate the ownership type of the home health agency (circle only one letter that corresponds to the correct type of organization).

   **Note: If the organization is a sole proprietorship, the Sole Proprietor Declaration on page 13 must be completed.

B. AGENCY INFORMATION
   Indicate the name, address (including the ZIP code plus four) and telephone number of the legal owner of the agency. This information is required for all agencies.
II. Ownership

A. TYPE OF ORGANIZATION Circle the letter (A through J) that corresponds to the type of agency you have.

<table>
<thead>
<tr>
<th>1.) Governmental</th>
<th>2.) Non-Profit</th>
<th>3.) Proprietary</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. City/Township</td>
<td>C. Corporation (*RA)</td>
<td>E. Sole Proprietor (Note)**</td>
</tr>
<tr>
<td>B. County</td>
<td>D. Other Non-Profit</td>
<td>F. Partnership, (Registered with County)</td>
</tr>
</tbody>
</table>

*RA - Registered agent required; see page 5.

**RA - Registered agent required; see page 5.

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

B. AGENCY INFORMATION

Name of Legal Owner

_____________________________

Street Address

_____________________________

City, State, ZIP Code plus 4 digits

_____________________________

Telephone Number of Legal Owner (____) - ________________ ext ____
II. Ownership (Continued)

C. ILLINOIS REGISTERED AGENT
   If licensee/applicant ownership in question II. A. is followed by an (*RA), you must complete this section. The registered agent is a person or company specializing in representing CORPORATIONS, LIMITED PARTNERSHIPS, LIMITED LIABILITY PARTNERSHIPS and/or LIMITED LIABILITY COMPANIES; the registered agent cannot be the parent agency. The RA must be an Illinois resident or company and must be Illinois-based. The 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.

D. 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.

E. IDENTIFY 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).
C. ILLINOIS REGISTERED AGENT

Name of Illinois Registered Agent __________________________________________

Registered Agent Address __________________________________________

City, State, ZIP Code plus 4 digits ____________________________________________

Telephone Number of Registered Agent (_____) - _______ ext.

D. STOCKHOLDERS INFORMATION

List names of stockholders and number of shares held (record number of shares and the percentage of total shares; see instructions).

<table>
<thead>
<tr>
<th>Name of Stockholder</th>
<th>Shares Held</th>
<th>Percentage of Shares</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

If a corporation, name of corporation __________________________________________

State of incorporation _______________________________________________________

E. PLEASE PROVIDE THE INFORMATION ON YOUR GOVERNING BODY

<table>
<thead>
<tr>
<th>Office</th>
<th>Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>ZIP Plus Four Digits</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td></td>
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<tr>
<td>Vice President</td>
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<tr>
<td>Secretary</td>
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<tr>
<td>Treasurer</td>
<td></td>
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</tr>
</tbody>
</table>
INSTRUCTIONS

III. Administrative Responsibility

A. ADMINISTRATIVE RESPONSIBILITY
   If the administrator has responsibility for more than one parent home health agency, record the license number and agency name for each additional agency.

B. AGENCY SUPERVISOR RESPONSIBILITY
   If the agency supervisor has responsibility for more than one parent home health agency, record the license number and agency name for each additional agency.
A. Does the **administrator** have responsibility for more than one Illinois parent agency?  
Yes _____ No _____  
If “Yes”, list additional parent license numbers and agency names.  
  
<table>
<thead>
<tr>
<th>License Number</th>
<th>Agency Name</th>
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<table>
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<tr>
<th>License Number</th>
<th>Agency Name</th>
</tr>
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</tr>
</tbody>
</table>

B. Does the **agency supervisor** have responsibility for more than one Illinois parent agency?  
Yes _____ No _____  
If “Yes”, list additional parent license numbers and agency names.  
  
<table>
<thead>
<tr>
<th>License Number</th>
<th>Agency Name</th>
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<tr>
<th>License Number</th>
<th>Agency Name</th>
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</table>
INSTRUCTIONS - SECTION II
Personnel

Personnel Contracts  (Add extra copies of Form II if needed)

AGENCY CONTRACTS
If the agency contracts for services, indicate the name, address, type of contracted organization and type of service(s) provided. The legal address should include the name and street number, city, state and ZIP plus four. Type of organization and type of each service should be marked by inserting the proper letter from the selections listed below.

TYPE OF ORGANIZATION (only use one for each organization)
A. Direct Service - Home Health Care
B. Public Health Agency
C. Public Welfare
D. Voluntary Non-Profit Health
E. Voluntary Non-Profit Welfare
F. Proprietary
G. Contract with Individuals

TYPE OF SERVICE PROVIDED (may use more than one)
H. Skilled Nursing
I. Physical Therapy
J. Speech Therapy
K. Occupational Therapy
L. Medical Social Work
M. Home Health Aide

If the agency has more contractors, PHOTOCOPY page 9.

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 the rationale.
## II. AGENCY CONTRACTS  (Add extra copies of this form if necessary)

<table>
<thead>
<tr>
<th>Legal Name of Organization, Address, City, State, Zip Plus Four Digits</th>
<th>Type of Organization</th>
<th>Types of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAMPLE Organization</td>
<td>F</td>
<td>H, I, J, K, L, M</td>
</tr>
<tr>
<td>1111 Wellness Avenue, Springfield, IL 62707-8613</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
INSTRUCTIONS - SECTION III
Geographic Area

I. Geographic Service Area Information

1. Identify the counties or portions of counties where the home health 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.

2. Please do not include radius miles as a description of the service area.
**(ILLINOIS COUNTIES ONLY)**

1. Geographic Service Area Information

<table>
<thead>
<tr>
<th>County/City</th>
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</table>
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.
SOLE PROPRIETOR DECLARATION

The following question must be answered only if the applicant is a sole proprietor.

_____ A. 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 SO CERTIFY MAY RESULT IN A DENIAL OF THE RENEWAL LICENSE. MAKING A FALSE STATEMENT MAY SUBJECT THE LICENSEE TO CONTEMPT OF COURT.

_____ B. I AM MORE THAN 30 DAYS DELINQUENT IN COMPLYING WITH A CHILD SUPPORT ORDER.

_____ C. I CERTIFY UNDER PENALTY OF PERJURY THAT I AM NOT SUBJECT TO ANY CHILD SUPPORT ORDER.

LICENSEE SIGNATURE ___________________________ DATE ___________________________
LISTED OR REGISTERED EMPLOYEES.

List ALL licensed, certified, and contracted 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 provided by RNs or LPNs, please indicate by placing a pound sign # in front of the name of the person providing services. For home health aides, list Social Security numbers in the license certification column.

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Employee's Name</th>
<th>License or Certification Number</th>
<th>Full-Time</th>
<th>Part-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator</td>
<td></td>
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<tr>
<td>Agency Supervisor</td>
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<tr>
<td>Supervising Nurse</td>
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</table>

Please copy and attach additional pages as required.
Illinois Department of Public Health
HHA Administrator Qualification Review Form
(Attachment A)

Please type the following information. Resumes not accepted in lieu of form.

HHA Name and Address ____________________________________________________________

Agency Name

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>ZIP code w/four digit ext</th>
</tr>
</thead>
</table>

******************************************************************************************

Name

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
</tr>
</thead>
</table>

Address

<table>
<thead>
<tr>
<th>Street address/Apt.# and/or P.O. Box</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>County</th>
<th>State</th>
<th>ZIP code w/four digit ext</th>
</tr>
</thead>
</table>

Daytime Telephone Number ( )

<table>
<thead>
<tr>
<th>Area Code</th>
<th>Extension</th>
</tr>
</thead>
</table>

Check one of the following categories.
Section 245.20 requires that the administrator be one of the following: Physician _____, RN _____ an individual who meets the requirements for a public health administrator as defined in 77 IL Adm. Code 600.310, or an individual with at least one year of supervisory or administrative experience in home health care or in a related health program _____.

CIRCLE the highest educational level obtained: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12
ADN, Diploma RN, BSN, BA, BS, Masters, Doctorate or MD.

Please list the college(s) attended, the address, date of graduation, specialty and degree obtained.

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Please list the high school with the address and date of graduation.

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________
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 copy of your current Illinois license. Your current employer must be the home health agency identified in this application, not a past employer.

_____________________________________________________________________________

_____________________________________________________________________________

Describe your relevant work experience for the last five years.
(1) List your most recent position 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 you performed for each position with each agency that you feel 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.

(1) Current Employer-Name, Address, Phone

Starting _____ / _____ Ending _____ / _____

Total Hours Worked Weekly __________

Duties

__________________________________________________________________________

(2) Previous Employer-Name, Address, Phone

Starting _____ / _____ Ending _____ / _____

Total Hours Worked Weekly __________

Duties

__________________________________________________________________________

(3) Previous Employer-Name, Address, Phone

Starting _____ / _____ Ending _____ / _____

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
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 approved by the National League for Nursing 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 registered nurse as a person currently licensed as an RN under the Illinois Nursing Act.

Please type the following information. Resumes not accepted in lieu of form.

<table>
<thead>
<tr>
<th>HHA Name and Address</th>
<th>Agency Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
</tr>
<tr>
<td></td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>ZIP code w/four digit ext</td>
</tr>
</tbody>
</table>

**Name**  
Last Name  
First Name  
Middle Name  

**Address**  
Street address/Apt.# and/or P.O. Box  
City  
County  
State  
ZIP code w/four digit ext  

Daytime Telephone Number (_______)  
Area Code  
Extension  

Section 245.30 requires that the agency supervisor be one of the following: Physician__RN______.

**CIRCLE** the highest educational level obtained: ADN, Diploma RN, BSN, BA, BS, Masters, Doctorate, or MD.

For each college attended, please list the address, date of graduation, specialty and degree obtained.

Please list the high school with the address and date of graduation.
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 copy of your current Illinois license.

<table>
<thead>
<tr>
<th>Type of License</th>
<th>License #</th>
<th>State Issuing</th>
<th>Expiration Date</th>
<th>Initial Date Issued</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Describe your relevant work experience for the last five years.

1. List your most recent position 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 you performed for each position that you feel 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.

(1) Current Employer-Name, Address, Phone  Starting____ / ____ Ending____ / ____
Total Hours Worked Weekly __________

Duties

(2) Previous Employer-Name, Address, Phone  Starting____ / ____ Ending____ / ____
Total Hours Worked Weekly __________

Duties

(3) Previous Employer-Name, Address, Phone  Starting____ / ____ Ending____ / ____
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 Ayes@ 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
Illinois Department of Public Health
HHA Supervising Nurse Qualification Review Form
(Attachment C)

Please type the following information. Resumes are not accepted in lieu of form.

<table>
<thead>
<tr>
<th>HHA Name and Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Name</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>ZIP code w/four digit ext</th>
</tr>
</thead>
</table>

Name
- Last Name
- First Name
- Middle Name

Address
- Street address/Apt.# and/or P.O. Box

<table>
<thead>
<tr>
<th>City</th>
<th>County</th>
<th>State</th>
<th>ZIP code w/four digit ext</th>
</tr>
</thead>
</table>

Daytime Telephone Number (_______) _____________________________
- Area Code
- Extension

Section 245.30 requires that the supervising nurse be a full-time registered nurse.
CIRCLE the highest educational level obtained: ADN, Diploma RN, BSN, BA, BS, Masters or Doctorate.

For each college attended, please list the address, date of graduation, specialty and degree obtained.

__________________________________________________________

__________________________________________________________

__________________________________________________________

Please list the high school with the address and date of graduation.

__________________________________________________________

__________________________________________________________
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 copy of your current Illinois license.

<table>
<thead>
<tr>
<th>License</th>
<th>Date of Expiration</th>
<th>Issuing State</th>
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Describe your relevant work experience for the last five years.

(1) List your most recent position 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/supervisory functions you performed for each position that you feel qualify you to function as the supervising nurse 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.

<table>
<thead>
<tr>
<th>Current Employer</th>
<th>Starting</th>
<th>Ending</th>
<th>Total Hours Worked Weekly</th>
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Duties

<table>
<thead>
<tr>
<th>Previous Employer</th>
<th>Starting</th>
<th>Ending</th>
<th>Total Hours Worked Weekly</th>
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</thead>
<tbody>
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Duties

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</thead>
<tbody>
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</table>

Duties

HHA Supervising Nurse Qualification Review Form
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 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
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. The form will not be accepted unless typed or printed. 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 and have **one year of social work experience in a health care setting**.

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.

Attachment D should indicate social work experience equal to 1,800 hours in a hospital, home health agency, hospice or long term care facility. Such work experience should occur after the initial date of social work licensure for the medical social worker or for the social work assistant after the baccalaureate degree is obtained.

The person(s) completing Attachment D **should also appear on page 15** (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. You may fax the division at 217-782-0382.
Illinois Department of Public Health  
HHA Medical Social Worker/Social Work Assistant Qualification Review Form  
(Attachment D)

Please type or print the following information. Resume not accepted in lieu of form.

HHA Name and Address   

Agency Name

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>ZIP code w/our digit ext</th>
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</table>

Name  

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
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<table>
<thead>
<tr>
<th>Address</th>
<th>Street address/Apt.# and/or P.O. Box</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>County</th>
<th>State</th>
<th>ZIP code w/our digit ext</th>
</tr>
</thead>
</table>

Daytime Telephone Number (______)  

<table>
<thead>
<tr>
<th>Area Code</th>
<th>Extension</th>
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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 copy of your current Illinois license.**

<table>
<thead>
<tr>
<th>Date MSW Degree Awarded</th>
<th>Initial License date</th>
<th>Current License Expiration</th>
<th>State of Issue</th>
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Describe your relevant work experience to meet the requirements of Section 245.20.

(1) Employer-Name, Address, Phone  

<table>
<thead>
<tr>
<th>Starting</th>
<th>Ending</th>
<th>Total Hours Worked Weekly</th>
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Duties  

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(2) Employer-Name, Address, Phone  

<table>
<thead>
<tr>
<th>Starting</th>
<th>Ending</th>
<th>Total Hours Worked Weekly</th>
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Duties  

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IF YOU ARE A MEDICAL SOCIAL WORKER PROCEED TO THE SIGNATURE BLOCK AND SIGN AT THE BOTTOM OF PAGE TWO.
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.

_______________________________________________________________________________
_______________________________________________________________________________

List employer and dates of employment to meet requirements.

1) Employer-Name, Address, Phone Starting / Ending /
   Total Hours Worked Weekly __________

Duties

_______________________________________________________________________________

2) Employer-Name, Address, Phone Starting / Ending /
   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). Please list name of licensed social worker providing supervision. Both social work assistant and supervising licensed social worker should be listed on Attachment D.

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     Date

____________________________________________  __________________________
Signature of Social Work Assistant (if applicable)  Date

Medical Social Worker/Social Work Assistant .QRF
To apply for **INITIAL HOME HEALTH LICENSURE**, please submit the following information:

- Initial Application for Home Health Agency Licensing
- Attachment A (Administrator qualification review form)
- Attachment B, (Agency Supervisor qualification review form)
- Attachment C, (Supervising Nurse qualification review form)
- Attachment D, (Medical Social Worker/Social Worker Assistant qualification review form)
- Copy of the employee’s current IL license when applicable
- $25 fee; check or money order, no cash, made payable to the Illinois Department of Public Health. (License fee is non-refundable).

Please note the Home Health Agency must be licensed by the State of Illinois prior to receiving certification from the Center for Medicare and Medicaid Services.

See [www.cms.hhs.gov/forms/cms485](http://www.cms.hhs.gov/forms/cms485) for applicable certification forms.