



COMMUNITY CARE PROGRAM PROVIDER CERTIFICATION APPLICATION FOR **IN-HOME SERVICE PSA 10**

INSTRUCTIONS: Please print or type (no pencil). Write "N/A" if question is not applicable.

Applicant:

PART A. PROPOSED SERVICE AREA

1. Put a check mark (☑) in all counties your agency is applying to serve in PSA 10:

- | | |
|--|--|
| <input type="checkbox"/> Crawford County | <input type="checkbox"/> Richland County |
| <input type="checkbox"/> Edwards County | <input type="checkbox"/> Wabash County |
| <input type="checkbox"/> Hamilton County | <input type="checkbox"/> Wayne County |
| <input type="checkbox"/> Jasper County | <input type="checkbox"/> White County |
| <input type="checkbox"/> Lawrence County | |

IF the geographic area is **smaller** than a county, identify municipalities or relevant portions of County(ies), Township(s) and/or Sub-area(s)/Zip Code(s):

ATTACH A MAP OF THE PROPOSED AREA.

2. If the geographic area is smaller than a county, you must meet one of the following exceptions:

- a. Serving limited or non-English speaking clients

Identify language group(s) served: _____

- b. Unit of local government

Provide details: _____

- c. Benevolent, charitable, social or religious organization providing services under organization charter to a specific population or in an area smaller than a county, township or sub-area.

Provide details: _____

PART B. APPLICANT INFORMATION

1. **LEGAL NAME OF AGENCY** _____

2. **ADDRESS OF ADMINISTRATIVE OFFICE**
Street: _____
City: _____ State: _____ Zip Code: _____
Telephone: () _____ Ext. _____ Fax: () _____

3. **CONTACT PERSON AT ADMINISTRATIVE OFFICE**
Name: _____ Title: _____
E-Mail: _____

4. **BUSINESS HOURS OF ADMINISTRATIVE OFFICE:** _____ a.m. to _____ p.m.

Complete questions 5–11 for each local office in the PSA for which you are applying. Attach additional sheets as necessary.

5. **ADDRESS OF LOCAL OFFICE** (if **different** from Administrative Office)
Street: _____
City: _____ State: _____ Zip Code: _____
Telephone: () _____ Ext. _____ Fax: () _____

6. **LOCAL OFFICE CONTACT PERSON**
Name: _____ Title: _____
E-Mail: _____

7. **BUSINESS HOURS OF LOCAL OFFICE:** _____ a.m. to _____ p.m.

8. **SERVICE HOURS OF LOCAL OFFICE:** _____ a.m. to _____ p.m.

9. **DAYS OF OPERATION OF LOCAL OFFICE:**
 Monday Tuesday Wednesday Thursday Friday Saturday Sunday

10. **DAYS/DATES WHEN SERVICE WILL NOT BE PROVIDED:** _____

11. **Number of Supervisors** _____ **Number of Home Care Aides** _____

PART C. SERVICE INFORMATION

Check (X) Yes or No for questions 1 – 12

1. I have read and understand **all** applicable Community Care Program rules set forth in [89 Illinois Administrative Code Part 240](#). Yes No
2. I have read and understand the definition of In-Home Service as stated in [Section 240.210](#) of the CCP rules. Yes No
3. I have read and understand that I must provide the specific service components of In-Home Service as stated in Section 240.210(a) of the CCP rules, when required by the Plan of Care, including:
 - a. teaching/performing of meal planning and preparation; routine housekeeping skills/tasks; shopping skills/tasks; and home maintenance and repairs; Yes No
 - b. performing/assisting with essential shopping/errands and handling the client's money, performing as specifically required by the plan of care and monitored by the homecare supervisor; Yes No
 - c. assisting with self-administered medication which shall be limited to: reminding the client to take his/her medications, reading instructions for utilization, uncapping medicine containers, and providing the proper liquid and utensil with which to take medications; Yes No
 - d. assisting with following a written special diet plan and reinforcement of diet maintenance; Yes No
 - e. observing client's functioning and condition and reporting to the supervisor as defined by the plan of care; Yes No
 - f. performing/assisting with personal tasks that are not medical in nature as defined by the plan of care; and Yes No
 - g. escort/transportation to medical facilities, or for essential errands/shopping, or for essential client business with or on behalf of the client as defined by the plan of care. Yes No
4. I will comply with all aspects of the Plan of Care specified in CCP rule [Section 240.730](#). Yes No
5. I will comply with all Administrative Requirements for Certification specified in CCP rule [Section 240.1505](#). Yes No
6. I have read and understand that my agency must establish and comply with all written policies and procedures specified in CCP rule Section 240.1510. Yes No

7. I will be accountable for all Provider Responsibilities as specified in CCP rule Section 240.1520,
- a. I have read and understand that my agency must accept all CCP client referrals except under the conditions specified in CCP rule Section 240.1520 (f).
 Yes **No**
 - b. I have read and understand that my agency shall not deviate from a CCP client's plan of care without specific direction from the Department or the Case Coordination Unit except under the conditions specified in CCP rule Section 240.1520 (g). **Yes** **No**
 - c. I have read and understand that my agency must advise the CCU of any changes in the client's physical, mental or environmental needs when the changes would affect the client's eligibility or service level or would require a change in the plan of care, as specified in CCP rule Section 240.1520 (h).
 Yes **No**
 - d. I have read and understand that my agency must respond to all client requests within 15 calendar days from the date of the request, as specified in CCP rule Section 240.1520 (i). **Yes** **No**
 - e. I have read and understand that my agency must bill the Department electronically as specified in CCP rule Section 240.1520 (j). **Yes** **No**
 - f. I have read and understand that my agency must bill a CCP client for any incurred expense for care in compliance with CCP rule Section 240.1520 (k).
 Yes **No**
8. I have read and understand as stated in CCP rule Section 240.1525 (a) that In-home service providers must maintain a physical facility in each planning and service area and must have all of the following:
- a. designated locked storage space for client records; **Yes** **No**
 - b. accessibility of records for all clients served in the PSA when required by Department review staff or designees; **Yes** **No**
 - c. a primary business telephone listed under the name of the business locally that allows for reliable, dependable and accessible communication; **Yes** **No**
 - d. internet, facsimile and email access; and **Yes** **No**
 - e. sufficient office space, office equipment and office support to fulfill the requirements of the contract. **Yes** **No**
9. I have read and understand as stated in Section 240.1525 (b), that the annual audit report required by the Department must include an independent Certified Public Accountant's opinion concerning the provider's compliance with financial Reporting requirements. **Yes** **No**
10. I have read and understand as stated in Section 240.1525 (c) that management staff of the in-home service provider shall be required to complete in-home service management training prior to the award of a CCP in-home service provider agreement from the Department. **Yes** **No**

11. I have read and understand the staffing requirements required for in-home service provision as stated in CCP rule Section 240.1530, including the following:
- a. I have read and understand as stated in Section 240.1530 (c), that supervisors must maintain a maximum 15 minute response time when homecare aides they supervise are serving in a client's home; Yes No
 - b. I have read and understand as stated in Section 240.1530 (d), that in-home service providers shall not sub-contract for management, supervisory or in-home staff; Yes No
 - c. I have read and understand as stated in Section 240.1530 (e), that in-home service providers shall make one hour service segments available when needed to meet applicant/client needs; Yes No
 - d. I have read and understand as stated in Section 240.1530 (g), that in-home service providers shall make extended evening weekday service and weekend service available to CCP clients as required by the plan of care and that a supervisor must be on-call and available whenever service is being provided; and Yes No
 - e. I have read and understand, as stated in Section 240.1530 (i), the restriction imposed on the hiring of family caregivers. Yes No
12. I have read and understand the required In-Home staff positions, qualifications, training and responsibilities as stated in Section 240.1535. Yes No

PART D. TRANSPORTATION

1. How will transportation be provided to CCP clients when required by the Plan of Care?
- Client transportation is only provided in a vehicle(s) owned or leased by this agency.
 - Client transportation is provided directly by the homecare aide.
 - Client transportation will be provided by a subcontractor. "Part E., Request for Approval to Subcontract" form, must be submitted before an agreement can be executed.
 - Client transportation is provided through public transportation.
 - Arrangements have not yet been made for the provision of client transportation.

**PART E. ILLINOIS DEPARTMENT ON AGING
REQUEST FOR APPROVAL TO SUBCONTRACT**

MAKE COPIES AS NEEDED

A. REQUESTING AGENCY

Name: _____

SITE ADDRESS

Street: _____

City: _____ State: _____ Zip Code: _____

CONTACT PERSON

Name: _____

Title: _____

Telephone: () _____ Fax: () _____

B. SUBCONTRACTOR

Name: _____

ADDRESS

Street: _____

City: _____ State: _____ Zip Code: _____

Authorized Subcontractor Representative

Name: _____

Title: _____

Telephone: () _____ Fax: () _____

C. PURPOSE OF SUBCONTRACT

Signature (Authorized Representative/Requesting Agency) **Date**

Type or Print Name/Title (Authorized Representative/Requesting Agency)

