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

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

Please enclose the completed application and appropriate attachments, accompanied by the required licensing fee:
$ 25 license fee for single home health license
$1,500 license fee for for home nursing agency
$1,500 license fee for home service agency
$ 500 license fee for home nursing placement agency
$ 500 license fee for home services placement agency

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

License fee made payable to the Illinois Department of Public Health (check or money order), should be sent to:

Illinois Department of Public Health
Health Care Facilities and Programs Section
525 W. Jefferson St., Fourth Floor
Springfield, IL 62761-0001

NOTE: Retain a copy of the application for future reference.

IF YOU DO NOT TYPE THE APPLICATION USING ADOBE AND CHOOSE TO COMPLETE THE APPLICATION IN WRITING, **BE SURE TO MAKE NOTE OF DROP-DOWN BOXES** TO PROPERLY COMPLETE THE APPLICATION.

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

IMPORTANT NOTICE: 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.

Type of Agency

- ☐ Home Health Agency (complete pages 2, 3, 4, 5, 6, 7, 8, 9,12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22)
- ☐ Home Services Agency (complete pages 2, 3, 4, 5, 7, 8, 10, 12, 23, 24)
- ☐ Home Nursing Agency (complete pages 2, 3, 4, 5, 7, 8, 10, 12, 23, 24)
- ☐ Home Nursing Placement Agency (complete pages 2, 3, 4, 5, 7, 8, 11, 12, 23, 24)
- ☐ Home Services Placement Agency (complete pages 2, 3, 4, 5, 7, 8, 11, 12, 23, 24)

FOR OFFICE USE ONLY

License Number _____

License Number _____

License Number _____

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

GENERAL INFORMATION

Agency Name and Physical Address

Agency Name _____

_____

Address _____

City _____

State _____ ZIP Code _____

Agency Phone Number _____

Agency Fax Number _____

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

Days of the Week _____

E-mail Address _____

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

Address _____

City _____ State ____ ZIP Code _____

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

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 /Agency Manager's Title

Contact Person **Must be different than agency phone number**

_____ _____

Contact Person - Name Phone Number

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

OWNERSHIP

Select one TYPE OF ORGANIZATION from the drop down list that corresponds to your agency
(CHOOSE ONE TYPE)

GOVERNMENTAL _____ NON-PROFIT _____ PROPRIETARY _____

***RA - Registered agent required, see below**. **(Add appropriate response from drop down box)**

****Note: If organization is a sole proprietorship, the declaration on Page 8 must be completed.**

AGENCY INFORMATION

List the name of corporation or LLC as registered with the Secretary of State or County-Do not list Shareholder names

Name of Legal Owner _____

Street Address _____

City _____ State _____ ZIP Code _____

Phone Number _____

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 agent's ownership papers as registered, contact the Secretary of State's office to identify the registered agent of record.

ILLINOIS REGISTERED AGENT

Name of Illinois Registered Agent _____

Street Address _____

City _____ State _____ ZIP Code _____

Phone Number of Registered Agent _____

STOCKHOLDER INFORMATION

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

NAME OF STOCKHOLDER	SHARES HELD	PERCENTAGE OF SHARES

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

State of incorporation of the company _____

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

GOVERNING BODY

Identify the officers of the governing body of your agency. The governing body has legal authority and responsibility for the conduct of the agency (Section 245.30 of the Illinois Administrative Code 245).

Office	Name	Address	State	ZIP Code
President				
Vice President (Optional)				
Secretary				
Treasurer				

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

◯ Yes ◯ No

License Number _____ Agency Name _____

License Number _____ Agency Name _____

Does the **home health agency supervisor** have responsibility for more than one Illinois agency?

◯ Yes ◯ No

License Number _____ Agency Name _____

License Number _____ Agency Name _____

HOME HEALTH ONLY

AGENCY CONTRACTS (add additional copies of this form if necessary)
Please note that SKILLED NURSING may not be contracted unless it is to cover vacations of regular staff or for specialized skills not routinely offered. SKILLED NURSING must be directly provided by the agency plus ONE OTHER RECOGNIZED SERVICE in order to qualify as a home health agency pursuant to Illinois law. If you use contracted SKILLED NURSING, please provide rationale.

Legal Name and Address of Organization

_____
_____
_____

Type of Service

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

_____
_____
_____

Type of Service

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

_____
_____
_____

Type of Service

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

_____
_____
_____

Type of Service

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

_____
_____
_____

Type of Service

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

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GEOGRAPHIC SERVICE AREA

Identify the counties or portions of counties where the home health, home service, home nursing agency, home services placement agency, home nurse placement agency intends to serve patients. If you are intending to serve only a portion of a county, indicate that county with an asterisk (*). **All service areas must be contiguous.** Please do not include radius miles as a description of the service area. **It is recommended for initial licenses to start with 3-5 counties. Additional counties may be requested to be added the agency's service area after the agency is operational.**

County	County

SOLE PROPRIETOR DECLARATION

Pursuant to Section 16 of the Illinois Administrative Procedures Act, the licensee is required to complete the Sole Proprietor Declaration page if the organization is set up as a sole proprietorship. **Check NA if not applicable.**
PLEASE CHECK ONLY ONE BOX

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.

○ NA

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. ***PLEASE SUBMIT COPIES OF LICENSES FOR PROFESSIONAL STAFF (Staff Nurses, PT/OT/ST, etc.)***

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

Job Title/Name	License Number	Expiration Date			Contract
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

Please copy and attach additional pages as needed.

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

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, HOMEMAKER, PROVIDE INITIALS OF EMPLOYEE.**

Job Title	License Number	Expiration Date	F/T	P/T	
			☐	☐	
Agency Manager Name					
					Contract
Nursing Supervisor (For Home Nursing Only)					
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

HOME NURSING/HOME SERVICES PLACEMENT ONLY

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

Job Title	License Number	Expiration Date
Agency Manager Name		

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

Please check the types of revenue sources of income of the agency:

Sources of Revenue

Local Funds

- ◯ Local Health Department

Government Funds

- ◯ Medicare Parts A & B (Home Health Only)
- ◯ Medicaid
- ◯ Other Government Funds

Other Funds

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

X Indicates that an attachment is required for submission with application for the specific license type. Administrative Code citing referenced in parenthesis.

	Home Health	Home Nursing	Home Services	Home Nursing Placement	Home Services Placement
Fee Schedule (245.90a)3)g)	X	X	X	X	X
Sample Client Contract		X (245.220)	X (245.220)	X (245.225)	X 245.225
Sample Placed Worker Contract				X (245.212)	X (245.214)
Affiliation Agreements	X	Optional	Optional		
List of Services/ Scope of Work			x (245.210a)		
Description of Services (Please See Below)	X	X	X	X	X

All Agencies provide a description of the services to be provided for <u>each license type</u> you are applying for: 245.90a)3)C)

_____

_____

_____

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

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 Initial Licensure Application

List applicable professional licenses, registrations and/or certifications currently held with the license number, date of expiration and state that issued the license, registration or certification. **ATTACH A COPY OF YOUR CURRENT ILLINOIS LICENSE IF APPLICABLE. YOUR CURRENT EMPLOYER MUST BE THE AGENCY IDENTIFIED IN THIS APPLICATION. Please also include a letter of intentions with this application (i.e. 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).**

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 _____

_____

_____

Previous Employer Name _____

Address of Previous Employer _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total Hours Worked Weekly _____

Duties _____

_____

_____

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

Previous Employer Name _____

Address of Previous Employer _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total Hours Worked Weekly _____

Duties _____

_____

_____

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

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

If you answered "yes" to either or both of the above statements, please describe the criminal offense and/or the pending or administratively resolved licensure issues in detail, including the state of administrative action [Section 245.130 b) 2]. You may attach an additional sheet of paper if necessary for the explanation.

_____

_____

_____

_____

I signify that the information contained in this form is true and correct to the best of my knowledge and belief. I realize that misrepresentation of this information at any time may be cause for denial of this application, or future revocation of a license.

_____ _____

Signature of Applicant (Original Only) Date Signed

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

HOME HEALTH AGENCY ONLY
Attachment B - Agency Supervisor Qualification Review Form

Section 245.30 of the 77 Illinois Administrative Code requires this position to be filled by an individual who is a registered nurse who has completed a baccalaureate degree program and has at least one year of nursing experience as a Bachelor of Science of Nursing; or a registered nurse without a baccalaureate degree, who has at least three years of nursing experience as a 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 RN 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 Initial Licensure Application

List applicable professional licenses, registrations and/or certifications currently held with the license number, date of expiration and state that issued the license, registration or certification. **ATTACH A COPY OF YOUR CURRENT ILLINOIS LICENSE IF APPLICABLE. YOUR CURRENT EMPLOYER MUST BE THE AGENCY IDENTIFIED IN THIS APPLICATION. Please include an intentions letter with this application (the agency supervisor position is required to be full time upon licensure. Provide documentation that the applicant is resigning present employment upon licensure, or if working part time elsewhere, provide documentation that the applicant's other employment is outside the agency's hours of operation (nights/weekends).**

_____

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 the organization.

You may use an additional sheet of paper to complete this section. Resumes are not accepted in lieu of completion of this portion of the form.

Current Employer Name _____

Address of Current Employer _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total Hours Worked Weekly _____

Duties _____

_____

_____

Previous Employer Name _____

Address of Previous Employer _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total Hours Worked Weekly _____

Duties _____

_____

_____

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

Previous Employer Name _____

Address of Previous Employer _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total Hours Worked Weekly _____

Duties _____

_____

_____

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

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

If you answered "yes" to either or both of the above statements, please describe the criminal offense and/or the pending or administratively resolved licensure issues in detail, including the state of administrative action [Section 245.130 b) 2]. You may attach an additional sheet of paper if necessary for the explanation.

_____

_____

_____

_____

I signify that the information contained in this form is true and correct to the best of my knowledge and belief. I realize that misrepresentation of this information at any time may be cause for denial of this application, or future revocation of a license.

_____ _____

Signature of Applicant (Original Only) Date

Attachment B - Agency Supervisor Qualification Review Form Page 3

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 if F/T, P/T or contract.

HHA Agency Name _____

Address _____

City _____ State _____ ZIP Code _____

Applicant Name

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ ZIP Code _____

Daytime Phone Number _____ Extension _____

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

THE FOLLOWING TO BE COMPLETED BY MEDICAL SOCIAL WORKER

Section 245.20 requires that the **medical social worker** be a ***licensed*** social worker/clinical social worker under the Clinical Social Work and Social Work Practice Act.

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 _____

_____

_____

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

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 Initial Licensure Application

ALL AGENCIES EXCEPT HOME HEALTH

Attachment E-Agency Manager Qualification Review

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

Choose one: _____ _____

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 245.30g for the requirements for the agency manager.

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.**

_____

_____

_____

Previous Employer Name _____

Address of Previous Employer _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total Hours Worked Weekly _____

Duties _____

_____

_____

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

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/Agency Manager (Original Signature) | Date