



Home Health Agency Management Status Form

The Illinois Department of Public Health has received notification that your agency has changed a member of the management team. In order to determine that your agency continues to maintain compliance with the Illinois Department of Public Health's Home Health Agency Rules and Regulations, the following information must be provided.

Date management team changed _____ License Number

Name of home health agency _____

Address _____

City _____ State _____ Zip Code _____

License number _____ Medicare number _____

Illinois Parent Office

Name of administrator _____

1. Agency's designation of the administrator position if different than "Administrator" (such as Executive Director, President, etc)

2. Is the agency administrator serving another HHA in any capacity: If so, please list the name(s) of the agency(s) and the identification number(s).

Name of agency supervisor _____

1. Agency's designation of the agency supervisor position if different from the "Agency Supervisor" (such as Director of Nursing, Clinical Director, etc.)

2. Is the agency supervisor serving another HHA in any capacity: If so, please list the name(s) of the agency(s) and the identification number(s).



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If your Illinois home health agency has any branch offices, please complete the following:

Branch of Illinois Parent Agency
Approved Branch Office Management

Branch location _____

Supervisor name _____

Title of individual _____

This supervisor reports to:

Name _____

Title _____

If your agency has more than one branch, please provide the same information for each branch office or attach an additional page.

Please return this form to:

***Illinois Department of Public Health
525 West Jefferson Street
4th Floor
Springfield, IL 62761***

Be sure to include the appropriate qualification review form and a copy of the employee's current Illinois license, if applicable.