Renewal Application is due not less than 60 days or more than 90 days of the EXPIRATION OF THE CURRENT LICENSE

The completed application and appropriate attachments, accompanied by the required 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

Enclose the completed application and appropriate attachments, accompanied by the required licensing fee:

$ 1,500 license fee for single home health license for two years.

The license fee is non-refundable. Filing an application is not a guarantee that a license will be issued.

If you have questions regarding this application, call 217-782-7412 or TTY number (for hearing impaired) 800-547-0466.

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.**

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 Services 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.

FOR OFFICE USE ONLY

License Number

Secretary of State Active Not in Good Standing

Medicare Number

State of Illinois
Illinois Department of Public Health

Home Health Agency 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 "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.

GENERAL INFORMATION

Agency Name and Physical Address

Agency Name _____ Agency Phone _____

DBA _____ Agency Fax _____ N/A ☐

Address _____

City _____ Illinois county of agency _____

State _____ ZIP Code _____ Email Address _____

Mailing Address **(If the agency's mailing address is <u>different</u> from the physical address above.)**

Address _____

City _____ State _____ ZIP Code _____

Business hours _____ a.m. to _____ p.m. Days of the Week _____

Fiscal Period (i.e., Month/Day 12/31) _____ 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 (ORIGINAL ONLY) **Date Signed**

_____ _____

Print Name of Agency Administrator **Administrator's Title**

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

_____ _____

Name of Contact Person **Phone Number**

BRANCH OFFICE INFORMATION

Does your agency maintain branch offices? ◯ Yes ◯ No

If yes, list the location of each branch office.

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 one TYPE OF ORGANIZATION from the drop-down menu that corresponds to the type of agency registered with the Secretary of State or county registrar.

(CHOOSE ONE TYPE)

GOVERNMENTAL (NA) NON-PROFIT (NA) PROPRIETARY (NA)

***RA - Registered agency required, see below**.

****Note: If organization is a sole proprietorship, the declaration on Page 9 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.**

Legal Entity Name

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 agency's ownership papers as registered, contact the Secretary of State's Office to identify the agency's registered agent of record (*apps.ilsos.gov/corporatellc/*).

ILLINOIS REGISTERED AGENT - As listed on the Secretary of State Corporation File Detail Report.

Name of Illinois Registered Agent

Street Address

City State ZIP Code

Phone Number or

STOCKHOLDER INFORMATION (Corporations only)
List the number of shares held and the percentage of total shares held by shareholders with more than 5% of common stock.
For any change in stockholder from the previous renewal, submit a copy of the document to support this change.

Name of Shareholder	Business Address	Shares Held	% of Shares

If a corporation or LLC, name of corporation or company

State of incorporation or company

GOVERNING BODY - Complete only for agencies registered with the Secretary of State as a corporation.
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).
Note: President and Secretary positions are required.

Office	Name of Individual	Address of Business	State	ZIP Code
President				
Vice-President **Optional*				
Secretary				
Treasurer **Optional*				

Have any of the following been convicted of a felony or of two or more misdemeanors involving moral turpitude in the last FIVE years? (If yes, attach explanation as Exhibit A)

1. Applicant ◯ Yes ◯ No
2. Any officer or director of a corporation ◯ Yes ◯ No
3. Administrator or manager of agency ◯ Yes ◯ No

Does the **administrator** have responsibility for more than one Illinois agency?

◯ Yes ◯ No

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

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 _____

Check the types of revenue sources of income of this agency. Sources of

Revenue

Local Funds

- ☐ Local Health Department

Government Funds

- ☐ Medicare Parts A and B **(Home Health only)**
- ☐ Medicaid
- ☐ Other Government Funds ☐ VA ☐ Other _____

Other Funds

- ☐ Self-pay
- ☐ HMO/PPO
- ☐ Commercial Insurance
- ☐ Other Revenue

Please List:

Services Provided

Patients by Service

Record the total number of patients, including duplicated* patients, receiving care in Illinois in each category of service during the last fiscal period. A duplicated patient could simultaneously be receiving multiple services.

COLUMN ONE - Record the total number of 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 period. 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 Number of Patients and Duplicated Patients by Service	Total Number of Visits
Skilled Nursing		
Physical Therapy		
Speech Therapy		
Occupational Therapy		
Medical Social Work		
Home Health Aide		
Other		
TOTAL		

Record the total number of clients, including duplicated clients, for the admissions and discharges during the fiscal (reporting) period. Do not include client services exclusively under the Community Care Program (CCP), Illinois Department of Human Services or Veteran Affairs. If there are no clients in any section, indicate with a zero.

	Home Health
# of admissions of most recent fiscal period	
# of discharges of most recent fiscal period	
# of admissions for patients 65 or older at time of admission of most recent fiscal period	
patient/client census on last day of most recent fiscal period	

*A **duplicated patient or client** is an individual receiving services from an agency who is subsequently discharged and later readmitted during the same reporting fiscal period. Such an individual is to be considered a new admission. An individual should be counted each time he/she is readmitted during the same reporting period.

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 N/A if not applicable. CHECK ONLY ONE BOX.

◯ 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.
◯ N/A

Licensee Signature

Date

GEOGRAPHIC SERVICE AREA

Identify the counties or portions of counties where the home health agency has been approved to serve patients and **distinguish if the counties are different for each license**. If the agency is approved to serve only a portion of a county, **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. Do not include radius miles as a description of the service area. **All service areas must be contiguous.**

Note: To request additional geographic service area or remove a portion, submit the request per the guidance on the IDPH website: ***https://dph.illinois.gov***

County	County

TOTAL NUMBER OF DUPLICATED PATIENTS SERVED OUTSIDE OF ILLINOIS: _____

See page 8 for definition of duplicated patients.

AGENCY CONTRACTS (add additional copies of this form if necessary)
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, provide the 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

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, DO NOT INCLUDE SOCIAL SECURITY NUMBER**. If home health aide services are provided by registered nurses or licensed practical nurses, 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.

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

Name/Job Title	License Number	Expiration Date	F/T	P/T	Contract
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○
			○	○	○

Copy and attach additional pages as needed.

AFFIDAVIT

A copy of the employee's current Illinois license is required for each of the following employees listed below, if applicable.

This is to attest that the following named staff members serve in the position indicated. Be sure to check the change/no change box for each position.

It is NOT necessary to complete a qualification review form if there has been no change.

Home Health Administrator _____ ☐ Change ☐ No Change ◯ License attached (if applicable)
Name of Administrator

Home Health Agency Supervisor _____ ☐ Change ☐ No Change ◯ License attached (if applicable)
Name of Agency Supervisor

Social Worker _____ ☐ Change ☐ No Change ◯ License attached (if applicable)
Name of Social Worker

Social Worker's Assistant _____ ☐ Change ☐ No Change ◯ License attached (if applicable)
Name of Social Worker's Assistant

Home Health _____
Authorized Agent Signature

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

HOME HEALTH AGENCY
Attachment A - Administrator Qualification Review Form

Home Health Agency Name _____ License # _____

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 and have experience in health service administration, with at least one year of supervisory or administrative experience in home health care or in a related health provider program.

◯ Physician ◯ Registered Nurse

◯ Individual who meets the requirements for a public health administrator as defined in 77 IL Adm. Code 660.310

◯ Individual with an undergraduate degree and 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.

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 _____

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 _____

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. Also include a letter of intentions with this application (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

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, 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**

Attachment A -Administrator Qualification Review Form Page 3

HOME HEALTH AGENCY
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 in a Science of Nursing (BSN) program and has at least one year of nursing experience as a BSN; or an R.N. 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 an R.N. as a person currently licensed as a registered nurse under the Illinois Nursing Act.

Home Health Agency Name _____ License # _____

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 ○ R.N. ○ B.S.N. ○ B.A. ○ B.S. ○ Master's ○ Doctorate

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 _____

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 _____

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 AGENCY IDENTIFIED IN THIS APPLICATION. Include a letter of intentions with this application (the agency supervisor position is required to be full time. Provide documentation that the applicant is resigning present employment or, if working part time elsewhere, provide documentation that the applicant's other employment is outside the agency's hours of operation).**

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 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

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 above statements, 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 - 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, 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 the (Licensed or Registered Employees) page for Home Health and check F/T, P/T, or contract.

Home Health Agency Name _____ License # _____

Address _____

City _____ State _____ ZIP Code _____

Medical Social Worker Information

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ ZIP Code _____

Daytime Phone Number _____ Extension _____

THE FOLLOWING IS TO BE COMPLETED BY THE 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 AGENCY

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.

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

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)