

DIRECT SUPPORT PERSON (DSP) ILLINOIS HEALTH CARE WORKER REGISTRY

INSTRUCTION MANUAL

JUNE 2013 (revised 9-9-16)

**THIS BOOKLET INCLUDES STEP-BY-STEP
INSTRUCTIONS FOR SUBMITTING DSPs TO THE
ILLINOIS HEALTH CARE WORKER REGISTRY**



**Illinois Department of Human Services
Division of Developmental Disabilities
600 East Ash, Building 400, 2nd Floor
Springfield, IL 62703**

DIRECT SUPPORT PERSON (DSP) ILLINOIS HEALTHCARE REGISTRY

INSTRUCTION MANUAL

TABLE OF CONTENTS

WHEN TO SUBMIT THE DSP HEALTH CARE WORKER REGISTRY.....	3
COMPLETING THE DIRECT SUPPORT PERSONS REGISTRY FORM.....	3
SUBMITTING THE DSP REGISTRY ONLINE	5
ILLINOIS HEALTH CARE WORKER REGISTRY FOLLOW UP CHECK.....	6
ILLINOIS HEALTH CARE WORKER REGISTRY APPLICATION FORM – REPORT OF DIRECT SUPPORT (DSP) TRAINING.....	7

WHEN TO SUBMIT THE DSP REGISTRY PACKET

A DSP should be submitted to the Illinois Health Care Worker Registry when he/she has successfully completed **120 hours of DSP training from a training program that has been approved by the Illinois Department of Human Services.** The DSP Registry must be **accurately completed and submitted online within 30 days of the program completion date.**

Any DSP Registry that are beyond 30 days following the successful completion of the 120 hours of DSP training will **require a waiver letter** from the Illinois Department of Human Services.

COMPLETING THE DIRECT SUPPORT PERSON REGISTRY FORM

An ILLINOIS HEALTH CARE WORKER REGISTRY APPLICATION FORM - REPORT OF DIRECT SUPPORT (DSP) TRAINING must be completed for each DSP. Follow the Marking Directions located on each Illinois Health Care Worker Application Form. All information requested **MUST** be written on the Application Form. Each form includes 12 sections (A-L).

A. Signature

The DSP's signature on the application certifies that the information provided is accurate and grants permission to the State of Illinois and any affiliate on behalf of the State of Illinois to place information from the form onto the Illinois Health Care Worker Registry.

B. Race

Check the box that identifies the Race of the DSP - OPTIONAL.

C. Sex

Check the box that identifies the Sex of the DSP - OPTIONAL.

D. Eye Color

Check the box for the eye color of the individual - OPTIONAL.

COMPLETING THE DIRECT SUPPORT PERSON REGISTRY FORM (continued)

E. Name

Print the last name, the first name, and the middle name (if applicable) of the DSP.

F. Height

Write the height of the DSP in feet and inches - OPTIONAL.

G. Date of Birth

Write the month, the date, and the year the DSP was born.

H. Mailing Address

Print the DSP's complete street address, apartment number (if applicable), city, state, and the 5- digit zip code where the DSP receives mail in the provided spaces.

I. Social Security Number

Write the DSP's Social Security number in the provided spaces. This number is used as the unique identifier for the Illinois Health Care Worker Registry.

J. Telephone Number

Write the telephone number where the DSP can be reached during the day in the provided spaces.

K. 4 – Digit Program Code

Write the agency 4–digit program code in the provided space. If you do not know this code, please call the Bureau of Quality Management at (217) 782-9438.

L. Program Completion Date

Write in the date the **DSP successfully completed the 120 hours of DSP training** in the provided space.

The month, date and year must be the same as the date listed on the DSP Core Competency Area checklist.

SUBMITTING THE DSP REGISTRY ONLINE

All DSP agencies with a training program that has been **approved** by the Illinois Department of Human Services are eligible to submit their DSP application online.

The DSP Online Registry Website:

<https://dspr.dxrgroup.com>

Request for login credentials

If you do not have your login credentials, please call (618) 453-1962 or email to dsp.email@siu.edu to request one.

Inquiry by Mail, Telephone, or Fax

Illinois Nurse Assistant/Aide Training
Competency Evaluation Program
DSP Training Project
Southern Illinois University
Mail Code 4340
Carbondale, IL 62901

Tel: (618) 453-1962

Fax: (618) 453-4300

NOTE: Southern Illinois University does not process reimbursements. DSP Training Reimbursement information may be found in the Bureau of Community Reimbursement's *"Staff Training Reimbursement and Billing Manual, April 2000."* If you have specific questions regarding reimbursement, please call the (217) 782-3248. Requests for reimbursement should be mailed to the following address:

Illinois Department of Human Services
Attention: Bureau of Community
Reimbursement Unit
600 East Ash, Building 400, 2nd Floor
Springfield, IL 62703

ILLINOIS HEALTH CARE WORKER REGISTRY FOLLOW-UP CHECK

After submitting an online registry to Southern Illinois University, allow 3 working days turnaround time for the process, and then check the Health Care Worker Registry to ensure that the DSP's name appears on the Registry. This can be done on the Illinois Department of Public Health website at <https://hcwrpub.dph.illinois.gov/Search.aspx> or by calling the Illinois Department of Public Health's Nurse Aide Registry at (844) 789-3676.

NOTE: Section 350.683 c. of the Illinois Administrative Code requires that an individual shall notify the Nurse Aide Registry OF ANY CHANGE OF ADDRESS WITHIN 30 DAYS and of any name change within 30 days and shall submit proof of any name change to the Department. (Section 3-206.01 of the Act)

[Illinois Health Care Worker Registry Application Form – Report of Direct Support \(DSP\) Training IL462-1292 \(R-3-13\)](#)



State of Illinois Department of Human Services
Division of Developmental Disabilities

ILLINOIS HEALTH CARE WORKER REGISTRY APPLICATION FORM - REPORT OF DIRECT SUPPORT (DSP) TRAINING

(Please type or print legibly)

Applicant Information

Name: _____
Last First Middle

Date of Birth: _____ **Social Security Number:** _____ - _____ - _____
Month / Day / Year

Address: _____
Street Address / P.O. Box / Rural Route Apt.

_____ *City* _____ *State* _____ *Zip Code*

Telephone Number: _____ - _____ - _____ **Program Code:** _____

Program Completion Date: _____
Month / Day / Year

Optional Information

Race Asian / Pacific Islander American Indian / Alaskan Native
 White Black Unknown

Sex Male Female

Eye Color Blue Green Brown
 Hazel

Height _____ (feet) _____ (inches)

Consent to Place Information on Registry

Your signature on this application certifies that the information provided is accurate and grants permission to the State of Illinois and any affiliate acting on the behalf of the State of Illinois to place information from this form on the Illinois Care Worker Registry.

Signature