Department of Human Services
Management Information Services

Information Transfer and System Access Instructions

Each community provider must register with the Illinois Department of Human Services (DHS), Management Information Services, in order to submit their Mental Health, Developmental Disabilities, and/or Alcohol and Substance Abuse information to the department using File Transfer Protocol (FTP) and to receive appropriate system access. The community provider will be assigned a "FTP Provider ID" that will be used to identify their information when submitting and receiving the appropriate files through FTP. If the provider wishes files to be returned to different locations within their provider, they must have a satellite code assigned using the normal procedure. The new satellite code does not change the data entry process; it only creates a new mailing address.

Registration Procedure

The community provider must complete the "Community Provider FTP Registration Request" form to receive a FTP Provider ID. This form only needs to be completed once for each location. Next, each staff member at the community provider that will be responsible for the FTP process or requires system access must also complete the "Community Provider User ID and System Access Request" form to receive a DHS User ID. The forms must be signed by the appropriate staff person and the Executive Director and forwarded to the appropriate MH/DD/ASA authorized person for signature. The list of authorized signatures are included in this document along with the addresses to which providers should submit their requests for approval.

After the forms have been signed by the DHS authorized individual, they are to be forwarded to the Management Information Services, Bureau of Security, Planning, and Quality Assurance (BSPQA) for assignment of the FTP Provider ID and DHS User ID. The forms may be mailed or faxed.

(The following address is for DHS staff use only.)

Mail: Management Information Services
100 South Grand Avenue East, 1st Floor
Springfield, IL 62762
Fax: 217/557-3443

Once the FTP Provider ID and one or more DHS User IDs have been assigned, BSPQA will notify the MIS Provider Claims Section, the requesting DHS individual, and the community provider via e-mail. The initial password for users will be their DHS User ID and they will be required to change the password the first time they use the ID. The MIS Provider Claims Section will send the community provider any additional files required for FTP implementation.

Authorized Signatures

Div	Location	Person	Address	Phone Number
MH	Chicago Metro Child & Adolescent	Myra Kamran, M.D.	Chicago-Read MH Center - Annex 4200 N. Oak Park Avenue Chicago, IL 60634	773/ 794-4895
MH	Chicago Metro-North	Dan Wasmer	Chicago-Read MH Center 4200 N. Oak Park Avenue Chicago, IL 60634	773/ 794-4139
MH	Chicago Metro-South	Robert Granger	Tinley Park MH Center 7400 W. 183rd Street Tinley Park, IL 60477	708/ 614-4002
MH	Chicago Metro-West	Gustavo Espinosa	Madden MH Center 1200 S. First Avenue Hines, IL 60141	708/ 338-7249
MH	Greater Illinois North Region	Amparo Lopez	Elgin MH Center 750 S. State Street Elgin, IL 60123	847/ 742-1040 ext 2979
MH	Greater Illinois Central Region	Jordan Litvak	McFarland MH Center 901 Southwind Road Springfield, IL 62703	217/ 786-6866
MH	Greater Illinois South Region	Jim Novelli	Choate MH Center 1000 North Main Street Anna, IL 62906	618/ 833-5161 ext 2321
DD	Central Office	George Elder	Centrum Building 319 E. Madison, Suite 3M Springfield, IL 62701	217/ 782-3719
ASA	Central Office	Jayne Antonacci	Harris II Building 100 South Grand Avenue East Springfield, IL 62762	217/ 524-4138

Illinois Department of Human Services
Management Information Services - Provider Claims Section
Community Provider FTP Registration Request

Provider Information (*Please Print*)

Provider FEIN _____ Provider Satellite _____ *(If applicable)*

Provider Name _____

Provider Address _____

City _____ State _____ Zip Code _____

Contact Person Information

Last Name _____ First Name _____

Telephone _____

E-Mail Addresses for Results Notification

Primary _____ Secondary _____

I certify that all claims submitted via File Transfer Protocol (FTP) are true, accurate, and complete. I agree to keep and make available such hard copy records and source documents associated with the above-described submissions as necessary to disclose fully the nature and extent of service provided and to furnish such information regarding any payments claimed as State and Federal officials may request. I understand that payment is made from State and Federal funds and that any false claims, statements, or documents, or concealment of material facts may be cause for criminal prosecution or other appropriate legal action.

If DHS billing for a Mental Health service is included in the file, my signature below certifies that all Mental Health claims submitted comply with the appropriate DHS rules for claiming Mental Health Services especially but not limited to Rule 132- "Medicaid Community Mental Health Services Program." I agree that payment received as a result of these claims will be accepted according to the applicable rules particularly but not limited to Rule 132.

If DHS billing for a Developmental Disabilities Service is included in the file, my signature below certifies that all Developmental Disabilities claims submitted comply with appropriate DHS rules for claiming Developmental Disabilities Services especially but not limited to Rule 120- "Medicaid Home and Community based Services Waiver Program for Individuals with Developmental Disabilities." I agree that payment received as a result of these claims will be accepted according to the applicable rules particularly but not limited to Rule 120.

If DHS billing for Alcohol and Substance Abuse Service is included in the file, my signature below certifies that all Alcohol and Substance Abuse claims submitted comply with appropriate DHS rules for claiming Alcohol and Substance Abuse Services especially but not limited to Rules 2060 and 2090 - "Alcohol and Substance Abuse Clinical Program" and "Alcohol and Substance Abuse Medicaid Program." I agree that payment received as a result of these claims will be accepted according to the applicable rules particularly but not limited to Rules 2060 and 2090.

Provider Executive Director _____ Date _____

APPROVAL *(Required)*

MH/DD/ASA Authorization _____ Date _____

FTP Provider ID _____ Assigned by _____ Date _____
(Assigned by DHS/MIS/BSPQA)

Illinois Department of Human Services
Management Information Services - Provider Claims Section
Community Provider User ID and System Access Request

ACTION REQUESTED

☐ Add New User ID	☐ Delete User ID	☐ System Access Only *(User ID Previously Assigned)*

COMMUNITY PROVIDER INFORMATION *(Please Print)*

Provider FEIN (9 digits):	Provider Satellite (2 digits): *(if applicable)*
Provider Name:	

USER INFORMATION: *(Please Print)*

Last Name:	First Name:
Work Address: (Street, City, State, Zip Code)	
e-Mail Address:	
Telephone:	DHS User ID:

SYSTEM ACCESS REQUESTED:

☐ Mobius - DASA Reports	☐ Mobius - DMH Reports	☐ eRIN
☐ Mobius - DDD Reports	☐ FTP Transmissions	Other:

TO BE COMPLETED FOR ALL ACTIONS EXCEPT "DELETE USER ID"

I understand that the use of the IDHS Provider Claims systems, software, programs, data, manuals, and facilities is intended for and may only be used for the purpose of accomplishing the official business of the Department of Human Services. I understand that Illinois statute and IDHS policy prohibit disclosure or discussion of any confidential IDHS information without proper written authorization. I understand that I am personally responsible for all usage under my User ID and I agree not to share to give my User ID or Password to anyone. I further understand that system usage is logged and my access to use the system may be denied or revoked by IDHS.

User Signature _____ Date _____

APPROVAL SIGNATURES *(Required)*

Provider Executive Director	Date
MH/DD/ASA Authorization	Date

TO BE COMPLETED BY DHS/MIS/BSPQA

BSPQA Coordinator	Date

Revised 05/20/2010

Community Provider User ID and System Access Request
Completion Instructions

An accurately completed request form describes your specific needs and helps facilitate the processing of your request in a more efficient and timely manner.

ACTION REQUESTED

Select the desired type of request.

- **Add New User ID** requests a DHS User ID be assigned to the individual.
- **Delete User ID** requests a DHS User ID be removed from accessing the provider's information.
- **System Access Only** requests authority be granted for access to the provider's information to a user possessing a current DHS User ID.

COMMUNITY PROVIDER INFORMATION

Enter the information for the community provider. **Note**: Provider Satellite is a two-digit satellite code assigned by DHS Region/Central Office personnel to your location. Entry of this code is uncommon.

USER INFORMATION

Enter the information for the individual requesting a DHS User ID. **Note**: If a DHS User ID has been previously assigned to the individual, enter the DHS User ID, otherwise leave this area blank.

SYSTEM ACCESS REQUESTED

Select the DHS systems for which the user needs access or specify other system (i.e.,JailLink, etc).

USER SIGNATURE AND DATE

The user's signature indicates he/she agrees to abide by the conditions outlined in the security disclosure statement. Note: User IDs are not to be shared between individuals.

APPROVAL SIGNATURE SECTION

All requests must be approved and signed by the Provider Executive Director and an authorized individual within DHS. A list of DHS individuals authorized to approve and sign requests has been provided to the MIS Bureau of Security, Planning, and Quality Assurance. All requests are checked against this list before being processed.

TO BE COMPLETED BY DHS/MIS/BSPQA

This area will be completed by the MIS Bureau of Security, Planning, and Quality Assurance once the request has been processed. Leave this area blank.