State of Illinois
Department of Human Services - Division of Developmental Disabilities

STAFF TRAINING REIMBURSEMENT REQUEST FOR COMMUNITY & ICF/IDD (FACILITY) PROVIDERS FOR INSULIN AND ENTERAL TUBES

1. Agency or Facility Name:
2. Agency or Facility Payee Name:
3. Agency I.D. Number: (CILA & DT 4 Digits)
4. Agency or Facility FEIN Number: (CILA & DT Agency = 9 Digits) (ICF/IDD Facility = 12 Digits)
5. RN Trainer Name & License No.:
6. Site or Facility City & Zip Code:

7. Training Type Bill Code	8. Staff Social Security Number	9. Staff Name (Last, First)	10. Training Begin Date	11. Training End Date		**These Fields Required for IPC,** IPF, EPC, EPD & EPF Training Type Bill Codes: 12. Person's SSN for whom Insulin or Enteral Tube Training is Required	13. Person's Last Name for whom Insulin or Enteral Tube Training is Required	14. Person's First Name for whom Insulin or Enteral Tube Training is Required

*** Beginning July 1, 2019 CILA or D.T. Site I.D. is required for regional wage rate reimbursement. If blank, the lowest regional wage rate will be used for reimbursement.**

7. TRAINING TYPE BILL CODE DESCRIPTIONS	CILA BILL CODES	DAY PROGRAM TRAINING	ICF/IDD BILL CODES
Insulin Classroom Training	ICC = CILA SITES	ICD = DT SITES*	ICF = ICF/IDD Facilities
Enteral Tube Classroom Training	ECC = CILA SITES	ECD = DT SITES*	ECF = ICF/IDD Facilities
Insulin CBTA** Personal Training	IPC = CILA SITES	IPD = DT SITES*	IPF = ICF/IDD Facilities
Enteral Tube CBTA(s)** Personal Training	EPC = CILA SITES	EPD = DT SITES*	EPF = ICF/IDD Facilities
**CBTA = Competency Based Training Assessments		* Use these codes for DT & ICF/IDD Day Program Training Sites	

I certify that all entries on this claim are true, accurate and complete. I agree to keep and make available to State and Federal officials such records as are necessary to establish compliance with Department regulations and to support this claim. Records will be maintained for not less than five(5) years. I understand that payment will be made from State and Federal funds and that any false claims, statements or documents or concealment of material facts may be cause for prosecution or other appropriate legal action. I further certify that the facility, in compliance with the Civil Rights Act of 1964 or the Rehabilitation Act of 1973, has not discriminated on the grounds of race, color, religion, sex, national origin, or disability.

I acknowledge and accept if the City & Zip Code of a CILA, ICF/IDD or DT Site ID is not completed the reimbursement will be processed at the lowest wage rate and once processed the reimbursement will be final. I acknowledge fields 12 through 14 are REQUIRED for IPC, IPD, EPC and EPD Training Types. Failure to complete these fields will result in the request being denied.

Authorized signature testifies that this request for reimbursement was performed at a certified training site and/or by a certified trainer. The person signing this reimbursement request and the facility/agency may be held liable if information has been falsified.

15. Authorized Signature:
16. Contact Person Name:
17. Date:
18. E-Mail Address:
19. Phone Number:
20. **For IDHS Use Only:** 21.Wage Rate: ☐ 1 ☐ 2 ☐ 3
22. IDHS Nurse Validated RN Trainer Status
23. Date:
24. Copy to Rates Unit Date:

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INSTRUCTIONS FOR COMPLETION OF IL462-1209C

Staff Training Reimbursement Request for Community & ICF/IDD (Facility) Providers for Insulin and Enteral Tubes
(Please Complete this form On-Line and then print for Signature)

1. Enter the officially recognized Agency or ICF/IDD Name.
2. Enter the Agency or ICF/IDD Payee Name.
3. Enter the CILA or DT's Agency IDHS ID Number (4 digits) e.g. (0100) (Not Applicable for ICF/IDD)
4. Enter the Agency or ICF/IDD Facility FEIN Number (CILA & DT 9 Digits) (Federal Employer's Identification Number) (ICF/IDD 12 Digits)
5. Enter the RN Trainer's Name and RN License Number
6. Enter the CILA, DT or ICF/IDD Facility City and Zip Code
7. Enter the Training Type Bill Code for the type of training provided for each staff person who has satisfactorily completed the Insulin or Enteral Tube Classroom Training Course and/or the Individual Insulin and/or Enteral Tube Training.Choices are: CILA: ICC, ECC, IPC, EPC. DT: ICD, ECD, IPD, EPD. ICF/IDD: ICF, ECF, IPF, EPC. Also listed on the IL462-1209C form.
   NOTE: CBTA = Competence Based Training Assessment.
8. Enter the Staff Person's Social Security Number who is receiving training.
9. Enter the Staff Person's LAST and FIRST Name who is receiving training.
10. Enter the date training began using the MM/DD/CCYY format.
11. Enter the date training ended using the MM/DD/CCYY format.
12. Enter the person's Social Security Number who requires Insulin or has an Enteral Tube.
13. Enter the person's LAST Name who requires Insulin or has an Enteral Tube.
14. Enter the person's FIRST Name who requires Insulin or has an Enteral Tube.
15. Authorized Signature
    After reading the certification statement, the executive director, administrator or authorized representative of the agency must sign the billing form. Stamped signatures are not acceptable. Only legally authorized representatives of the agency may sign this form. Only original signatures are acceptable (no faxes).
16. Enter the contact person's FIRST and LAST Name.
17. Enter the date the form was signed.
18. Enter the contact person's E-Mail address.
19. Enter the contact person's Phone number including area code.

    This area is "FOR IDHS USE ONLY"

20. Enter Reimbursement Request computer-assigned number.
21. Enter Wage Rate Reimbursement Indicator
22. Enter Name of DHS Nurse who validated agency/facility RN Trainer Status
23. Enter Date RN Trainer Status was validated
24. Enter Date copy of IPC, EPC, IPD or EPD Training Request was sent to Rates Unit