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

STAFF TRAINING REIMBURSEMENT REQUEST FOR COMMUNITY PROVIDERS FOR INSULIN AND ENTERAL TUBES

1. Agency Name: _____ 2. Agency Payee Name: _____

3. Agency I.D. Number: _____ (4 DIGITS) 4. Agency FEIN Number: _____ (9 DIGITS)

						These Fields Required for IPC, IPD, EPC & EPD Training Types			
5. Training Type	6. Staff Social Security Number	7. Staff Name (Last, First)	8. Training Begin Date	9. Training End Date		10. Person's SSN for whom Insulin or Enteral Tube Training is Required	11. Person's Last Name for whom Insulin or Enteral Tube Training is Required	12. Person's First Name for whom Insulin or Enteral Tube Training is Required	13. * CILA Site I.D. or DT Site I.D.

*** 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.**

CILA TRAINING	TYPE		DAY PROGRAM TRAINING	TYPE
ICC =	CILA - Insulin Classroom Training		ICD =	DT - Insulin Classroom Training
ECC =	CILA - Enteral Tube Classroom Training		ECD =	DT - Enteral Tube Classroom Training
IPC =	CILA - Insulin CBTA** Personal Training		IPD =	DT - Insulin CBTA** Personal Training
EPC =	CILA - Enteral Tube CBTA(s)** Personal Training		EPD =	DT - Enteral Tube CBTA(s)** Personal Training
**CBTA =	Competency Based Training Assessments		**CBTA =	Competency Based Training Assessments

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 a CILA 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 10 through 13 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.

14. Authorized Signature: _____ 15. Contact Person: _____

16. Date: _____ 17. E-Mail Address: _____ 18. Phone Number: _____

19. **For IDHS Use Only:** _____

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

STAFF TRAINING REIMBURSEMENT REQUEST FOR COMMUNITY PROVIDERS FOR INSULIN AND ENTERAL TUBES

INSTRUCTIONS FOR COMPLETION OF IL462-1209C
Staff Training Reimbursement Request for Community Providers for Insulin and Enteral Tubes
(Please Complete this form On-Line and then print for Signature)

1. Enter the officially recognized Agency name.
2. Enter the Agency's Payee Name.
3. Enter the Agency's IDHS ID Number (4 digits) e.g. (0100)
4. Enter the Agency's 9-digit FEIN (Federal Employer's Identification Number).
5. Enter the Training Type 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: ICC, ECC, IPC, EPC, ICD, EDC, IPD and EPD and are also listed on the IL462-1209C form.
   NOTE: CBTA = Competency Based Training Assessment
6. Enter the Staff Person's Social Security Number who is receiving training.
7. Enter the Staff Person's LAST and FIRST Name who is receiving training.
8. Enter the date training began using the MM/DD/CCYY format.
9. Enter the date training ended using the MM/DD/CCYY format.
10. Enter the person's Social Security Number who requires Insulin or has an Enteral Tube.
11. Enter the person's LAST Name who requires Insulin or has an Enteral Tube.
12. Enter the person's FIRST Name who requires Insulin or has an Enteral Tube.
13. Enter the CILA Site ID where the person lives or the DT Site ID where the person receives Community Day Services.
14. 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).
15. Enter the contact person's FIRST and LAST Name.
16. Enter the date the form was signed.
17. Enter the contact person's E-Mail address.
18. Enter the contact person's Phone number including area code.
19. This area is "FOR IDHS USE ONLY" to enter Reimbursement Request computer-assigned number.