



## Home Services Program Application and Redetermination of Eligibility Agreement

My HSP representative: \_\_\_\_\_ HSP Phone Number: \_\_\_\_\_

Local Office: \_\_\_\_\_ HSP Fax Number: \_\_\_\_\_

### General Information and Eligibility

- \* I have been informed that I must contact the HSP office with changes of address, phone number, individuals living in the home, marital status, and significant financial changes.
- \* I have been informed that the HSP office must be notified by myself or another person of the admission and discharge dates of every hospitalization and any admission to a nursing home or rehabilitation center.
- \* I understand that if misrepresentation or fraud occurs while I am receiving HSP, it will be investigated and legal action including criminal prosecution may be taken against those committing the act.
- \* I have been informed that if I am the victim of abuse, neglect or exploitation, I should report this to my HSP representative and to the Office of Inspector General.
- \* I have been informed that my HSP representative will determine the appropriate level of care to best serve my needs.
- \* I understand it will be necessary for me to comply with program requirements and continue to meet all eligibility criteria in order to receive services through HSP.
  - \* Be under the age of 60 at time of application with no age criteria for the AIDS or BI waiver
  - \* Be a resident of the State of Illinois
  - \* Be a citizen of the United States or a legally admitted alien
  - \* Have a severe disability that will last a year or longer
  - \* Have a DON score of 29 points or more
  - \* Have less than \$17,500 in assets or \$35,000 family assets for a child under the age of 18
  - \* Needs will be met at a cost less than or equal to the cost of nursing services in an institutional setting
  - \* A Physician's Certification must be obtained to certify risk of institutionalization and that services can be provided safely in the home
  - \* Fully co-operate with the Medicaid application process
- \* I understand that I must apply for Medicaid and maintain Medicaid eligibility unless informed otherwise by my HSP representative.
- \* I understand that if I am denied Medicaid because I did not cooperate I will be ineligible for HSP.
- \* I understand that I must apply for, and use other available services and goods that would meet my needs. These may affect my eligibility for HSP and will impact the services that I receive.
- \* I understand that my case will be reviewed at least every \_\_\_\_\_ months and I must cooperate with scheduled face-to-face assessments. Failure to cooperate may result in non-payment of services.
- \* I have been informed that I can request a reassessment when there is a change in my condition or needs.

Initials: \_\_\_\_\_ I verify the above information has been given to me.



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### Choice

- \* I have been given the choice of nursing facility placement, and instead choose to apply for and receive services in my home, if I am eligible.
- \* I understand that I have the option to make personal choices concerning how I live my life, but understand that those choices may affect the ability of the HSP program to serve my needs.
- \* I have participated in developing my plan of care and in choosing types of services and providers.
- \* I understand that I will receive a copy of each service plan and any subsequent changes to the plan.

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### Services

- \* I understand that services through HSP are provided to meet my essential needs based on the Determination of Need.
- \* I understand the services that I receive are for my needs addressed on my service plan and not for the needs of other individuals in my home.
- \* I understand I must cooperate with all providers to ensure services can be delivered to meet my needs.
- \* I understand that I can contact the Department of Public Health for information on CNA's or the Department of Financial and Professional Regulation for information on any LPN or RN that I employ for allegations of abuse, neglect or theft.
- \* I have been informed that I can request, and have been encouraged to request, a criminal background check on potential employees. HSP will cover the cost of the background check and it will not affect my services.
- \* If I employ a Personal Assistant (PA), I understand it is my responsibility to ensure the following:
  - \* The HSP office is notified within 24 hours of any incident resulting in injury to the PA at work. The Report of Injury to a Provider form will be completed and mailed or faxed by either the customer or the provider to the HSP office within 24 hours after I reported it.
  - \* All necessary documentation will be provided to the local HSP office prior to the start of employment.
  - \* Only the approved hours actually worked by the PA are submitted for payment.
  - \* The worker and I will review the Time Sheet for accuracy of all information.
  - \* The worker will review the Service Plan with me, understand my needs, have the physical capability to perform the tasks under my direction and not have a medical condition which will be aggravated by the job requirements.
  - \* The PA's Last Day of Employment form will be provided to the HSP office when any PA's employment ends.
  - \* Time Sheets will not be pre-signed nor submitted prior to the last day worked in a billing period.
  - \* My Personal Assistants will receive a copy of my service plan and any changes to it.
  - \* I have been informed that if I need a Personal Assistant at my place of employment, to go on vacation, or while hospitalized, I must first contact my HSP representative to request and obtain approval for paid services.
  - \* I have or will receive a customer packet and was informed that copies of documents concerning my HSP services should be kept in the folder.

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### Rights

- \* I certify the HSP Appeals Fact Sheet has been explained and given to me. I understand I have the right to disagree with, and can appeal any decision or inaction on the part of DRS.
- \* I have been informed that my right to appeal includes the right to appeal my Service Plan.
- \* I understand that I have 30 days from the date I received notice of a decision (oral/written) to file an appeal, or that I have 35 days from the postmarked date on the Service Notice (IL488-0141) if I am notified by mail.
- \* Failure to meet these time frames may result in my appeal request being denied.
- \* I was informed that in-home care services will continue during the appeal process unless HSP determines there is evidence of fraud, abuse, or neglect.

Initials: \_\_\_\_\_ I verify the above information has been given to me.

The HOME SERVICES PROGRAM APPLICATION AND REDETERMINATION OF ELIGIBILITY AGREEMENT has been explained to me and I have been given a copy for my records.

\_\_\_\_\_  
Signature of Customer/Guardian/Customer Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
HSP Representative

\_\_\_\_\_  
Date