As a Customer of the Home Services Program (HSP), you have chosen to use Individual Provider (IP) services to meet the needs identified on your Service Plan. You will be responsible for finding and managing Individual Providers to assist you with your Service Plan needs. As the employer to your Individual Providers, it is your responsibility to ensure they complete all the required documentation and are approved by the Home Services Program before their employment for you begins. If you allow your Individual Provider to work prior to completing the requirements listed in the packet and before you receive approval from the local DRS office, HSP is not responsible for making those payments to your Individual Provider.

You will need to request an Individual Provider packet from your local DRS office or your MCO Care Coordinator for each potential provider. The packet will require the Individual Provider to collect documentation, complete certain forms and return all required documents to the local DRS office. Several of these forms will require your verification and/or signature.

The following is a detailed list of documents that have information for utilizing an Individual Provider. Should you have questions, please contact your local DRS office or your MCO Care Coordinator for assistance.

Please review and/or complete the following documentation according to the icons described below.

- Unless Optional, documents marked with a check box (☐) must be completed, signed and submitted to the local DRS office.
- Documents marked with an exclamation point (!) should be kept for informational or future purposes and not submitted to the local DRS office.
- A brief summary of each document is located on page 2.

### Relevant documents to employing an IP

- ☐ IL488-2112 – Individual Provider Standards
- ☐ Mind Your Business (MYB) Flyer
- ☐ Mind Your Business (MYB) Form (Optional)
- ! IL488-2400 – Last Day of Employment Form
- ! HSP 1W – HSP Appeal Fact Sheet
- ! IL488-1949W – Request for Hearing
- ! HSP Provider Payroll Schedule
- ! CDC Clean Hands Count Brochure
- ! HSP Fraud Brochure

### Local DRS Office

Please use the [DHS Office Locator](#) on the IDHS Website for information on your Local DRS Office.
IL488-2112 – Individual Provider Standards: Complete this form with the Individual Provider. Your signature verifies that all information is correct.

Mind Your Business (MYB) Flyer: Currently the background check is optional for all Customers. We recommend you request a background check to better know who will be working in your home. The Provider will have to agree to the background check and sign the authorization form.

Mind Your Business (MYB) Form: This form is optional. Should you proceed to request a background check, you must submit the form to the address listed on the document. Please allow up to 7 days for MYB to process and return a report.

IL488-2400 – Individual Provider Last Day of Employment Form: This form must be submitted immediately if a Provider is terminated or quits from your employment. The provider may file for Unemployment Compensation Benefits and our program must assure that he/she is entitled to those benefits.

HSP 1W – Home Services Program Appeal Fact Sheet: This guide answers some general and frequently asked questions with regard to appealing a decision made by Home Services Program.

IL488-1949W – Request for Hearing: Should you disagree with a decision made by your Home Services Program (HSP) representative or feel he/she has failed to act on a request you made; complete and submit this form.

HSP Provider Payroll Schedule: This document provides important dates regarding timesheets and pay periods.

CDC Clean Hands Count Brochure: This brochure provides information on how to properly wash your hands and preventing the spread of germs.

HSP Fraud Brochure: As the employer, it is your responsibility to ensure compliance between you, your Individual Provider and HSP. This brochure provides guidance on how to prevent HSP and Medicaid fraud.


If you need assistance to find an Individual Provider, you can reach out to other HSP Customers, family & friends, or the Center for Independent Living (CIL) in your area.

Report Abuse/Neglect: (800) 368-1463
General DHS Helpline: (800) 843-6154
Home Care Ombudsman: (800) 252-8966
Dear Customer,

During the eligibility determination process, it was determined you are capable of supervising an Individual Provider to assist you in your home. Individual Providers are defined as a Personal Assistant, Registered Nurse, Licensed Practical Nurse, Certified Nurse Assistant, Occupational Therapist, Physical Therapist and Speech Therapist. Your Service Plan identifies which types of Individual Providers will be used to meet your needs.

When customers use Individual Provider services, they are required to collect and certify the following information for each Individual Provider used. If you do not complete the information on this form and submit it before the Individual Provider begins employment, it may result in non-payment to the Individual Provider and ineligibility for further services for you.

Please complete a separate form for each Individual Provider you use and submit with other required paperwork to your Home Services Program office.

**Individual Provider Information:**

1. Name: ____________________________________________

2. Gender
   - [ ] Male
   - [ ] Female

3. Birthdate (MM/DD/YYYY): ____________________________

4. Phone Number (include area code): _________________

5. Legal Address
   (Where the Individual Provider actually lives)
   __________________________________________________
   __________________________________________________
   __________________________________________________

6. Mailing Address
   (Where the Individual Provider will receive his/her check)
   __________________________________________________
   __________________________________________________
   __________________________________________________

7. Individual Provider email address, if applicable, (for electronic correspondence such as timesheets and announcements):
   __________________________________________________

8. The Individual Provider is: (please check appropriate category)

   - [ ] 14 or 15 years of age and not employed during school hours, has an employment certificate and meets all other requirements of the Child Labor Law, and will be supervised by an adult 21 years or older
   - [ ] 16 to 18 years of age and enrolled in school (must not be employed during school hours)
   - [ ] 17 to 18 years of age and not enrolled in school
   - [ ] an adult, 18 years of age or older

9. The Individual Provider’s relationship to the Customer?

   - [ ] Family Please specify: ________________________
   - [ ] Friend
   - [ ] Referral
**INDIVIDUAL PROVIDER STANDARDS**

**Individual Provider Information: (continued)**

10. The Individual Provider’s previous experience and/or training are adequate and consistent with the specific tasks performed for me in my home as identified below:

<table>
<thead>
<tr>
<th>Task</th>
<th>Experience/Training</th>
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</thead>
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</tbody>
</table>

11. If the Individual Provider will perform incidental health care tasks, written permission has been obtained from my physician or another appropriate medical professional as approved by the Home Services Program.

☐ Not applicable  ☐ Yes  ☐ No

12. The Individual Provider has demonstrated a satisfactory understanding of Universal Precautions that will meet my needs.

☐ Yes  ☐ No

13. The Individual Provider has provided the Home Services Program with a copy of his/her Social Security card or other documentation verifying this information.

☐ Yes  ☐ No

14. The Individual Provider has provided the Home Services Program with a completed Employment Eligibility Verification form (I-9, U.S. Department of Justice) along with the required information that accompanies it.

☐ Yes  ☐ No

15. The Individual Provider has received, completed and signed the Waiver Program Provider Agreement for Participation in the Illinois Medical Assistance Program form and will submit it to the Home Services Program office.

☐ Yes  ☐ No

I hereby certify the above information is true and accurate to the best of my knowledge. I further certify the Individual Provider named above has satisfactory communication skills and the physical capacity to meet my needs and he/she can satisfactorily follow directions in the completion of tasks performed.

I understand falsification of the above information by me may jeopardize payment to the Individual Provider and my receiving services through the Home Services Program.

________________________________________  __________________________
Signature of Customer                        Date

________________________________________
Printed Name Parent, Guardian or Representative

________________________________________  __________________________
Signature of Parent, Guardian or Representative                        Date

**NOTE:**

NAMES OF INDIVIDUAL PROVIDERS REFERRED TO CUSTOMERS BY THE DEPARTMENT OF HUMAN SERVICES - DIVISION OF REHABILITATION SERVICES SHOULD BE CONSIDERED AS POTENTIAL WORKERS AND NOT RECOMMENDATIONS TO USE THAT INDIVIDUAL. CUSTOMERS MAKE THE INDIVIDUAL PROVIDER(S) SELECTION AND SHOULD CHECK ALL REFERENCES/RECOMMENDATIONS PRIOR TO USING AN INDIVIDUAL.
Free Background Checks

Criminal background checks are available for new Individual Providers.

Just fill out the enclosed form and forward it to:
Mind Your Business, Inc.
500 Beverly Hanks Center
Hendersonville, NC 28792
Phone: (828) 698-9900
Fax: (828) 698-9918

It requires your signature and the signature of your personal assistant.

MYB will gather the background information and return it to you within 3 days if faxed and 5 days if mailed.

✓ You do not need to share this information with your Home Services Program (HSP) counselor. It is strictly between you and your employee. You may hire or retain your IP regardless of any criminal history findings.

✓ The cost of the background check will not affect the amount of services you receive from HSP.

✓ Should you have questions about the enclosed form or the background report you receive, please call MYB toll free at (888) 869-2462.

◆ This is a free service provided by the Department of Human Services, Division of Rehabilitation Services.
FRONT SIDE

To be completed by Personal Assistant

AUTHORIZATION AND RELEASE FOR THE PROCUREMENT OF A CONSUMER AND/OR INVESTIGATIVE REPORT

I, the undersigned consumer, do hereby authorize ______________, by and through its independent contractor, MIND YOUR BUSINESS, INC. (“MYB”), to procure a consumer report and/or investigative consumer report on me.

These above mentioned reports may include, but are not limited to, a social security number verification; criminal and civil history/record; and any other public record; and any other information bearing on my credit standing, credit capacity, worthiness, character, general reputation, personal characteristics, trustworthiness and/or mode of living.

I understand that I am entitled to a complete and accurate disclosure of the nature and scope of any investigative consumer report prepared on me upon written request to MYB that is made within a reasonable time after the date hereof.

I further authorize any person, business entity or governmental agency who may have information relevant to the above to disclose the same to MYB, including but not limited to, any courthouse, any public agency, any and all law enforcement agencies and any and all credit bureaus, regardless of whether such person, business entity or governmental agency compiled the information itself or received it from other sources, including alcohol and controlled substance information from previous employers.

I hereby release MYB and any and all persons, business entities and governmental agencies, whether public or private, from any and all liability, claims and/or demands, of whatever kind, to me, my heirs, or others making such claim or demand on my behalf, for procuring, selling, providing, brokering, and/or assisting with the compilation or preparation of the consumer report and/or investigative consumer report hereby authorized.

PERSONAL ASSISTANT

PRINTED NAME:

<table>
<thead>
<tr>
<th>First</th>
<th>Middle</th>
<th>Last</th>
<th>Maiden/Other</th>
</tr>
</thead>
</table>

SIGNATURE: __________________________ DATE: __________________________

COMPLETE RESIDENCE ADDRESS: __________________________

<table>
<thead>
<tr>
<th>Street Number/P.O. Box</th>
<th>Street Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

SOCIAL SECURITY NUMBER: __________________________

DAYTIME TELEPHONE NUMBER: __________________________

DRIVER’S LICENSE NUMBER: __________________________ STATE ISSUED: __________

DATE OF BIRTH: __________________________ GENDER: __________________________

* This information is voluntary. However, without this information, we will be unable to properly identify you in the event we find adverse information during the course of our background search.
CUSTOMER INFORMATION:

FULL PRINTED NAME (including middle name):

First  Middle  Last

SIGNATURE: ___________________________ DATE: __________________

COMPLETE RESIDENCE ADDRESS:

Street Number/P.O. Box  Street Name

City  State  Zip Code  County

SOCIAL SECURITY NUMBER: ___________________________

HOME SERVICES CASE NUMBER: ___________________________

DAYTIME TELEPHONE NUMBER: ___________________________

EMAIL ADDRESS: ___________________________

🌟 Please note, we are unable to process a background investigation without your Home Services Case Number.

RETURN COMPLETED FORM TO:
Mind Your Business, Inc
500 Beverly Hanks Center
Hendersonville, NC 28792
Phone: (828) 698-9900
Fax: (828) 698-9918
To: Home Services Customer

Many of the individual providers working under the Home Services Program (HSP) will apply for unemployment insurance when they are either terminated by the customer or voluntarily leave employment.

To assist us with documentation, please answer the questions below and return this form to your HSP representative on the individual provider’s last day of employment.

Please identify the type of individual provider and provide the information requested below:

Check One:

☐ Personal Assistant (PA) ☐ Certified Nursing Assistant (CNA)

☐ Licensed Practical Nurse (LPN) ☐ Registered Nurse (RN)

Individual Provider Name: ______________________________________________________________

Date of last day worked by individual provider: _______________________________

Customer Name: _____________________________ Case Number: ___________________________

Did the worker leave voluntarily? ☐ Yes ☐ No

If yes, please indicate the reason: ______________________________________________________

Did you terminate/fire the worker? ☐ Yes ☐ No

If yes, please indicate the reason: ______________________________________________________

If you terminated the worker, did you talk to the worker about the issue or problem before you fired him or her? ☐ Yes ☐ No

Did you give them the opportunity to correct the problem or issue? ☐ Yes ☐ No

If no, please explain:

____________________________________________________________________________________

Signature of Customer/Guardian/Customer Representative: ______________________________________

Date: _____________________________

Please return this form to your HSP representative within 5 days of the individual provider’s last day of employment. Thank You.
What is an appeal?
When you disagree with a decision made by your Home Services Program (HSP) representative or feel he/she has failed to act on a request you have made, you have the right to formally challenge the decision or their lack of action. Your dissatisfaction is communicated through a formal appeal that is heard at an Administrative Hearing. An unbiased person called an Impartial Hearing Officer will conduct the hearing.

Is an appeal my only option?
If you are dissatisfied with a decision or lack of action, you should always arrange a time to discuss your reasons for being dissatisfied with your HSP representative in an effort to resolve the problem before it progresses to an appeal.

Will my services be affected if I request an appeal?
Your services will not be affected unless DRS determines there is evidence of fraud, abuse or neglect.

How do I request an appeal?
1. When a decision is made, you will receive a Service Notice informing you of the decision, as well as a Request for Hearing form. The Request for Hearing form should be completed and mailed to the address on Page 2 of the form and to your local HSP office.
2. If you do not request a hearing in writing, you must call your HSP office and provide the following information:
   a. Date of the decision or inaction
   b. The specific decision made or the request that was not acted on

Can someone help me with the appeal process?
You have several options for assistance. You may:
* Ask someone you know to assist in representing you,
* Contact Home Care Ombudsman Program - HCOP to request their assistance at 1-(800) 252-8966 (Voice) or 1-(888) 206-1327 (TTY), or
* Choose to be represented by a legal professional.

DRS will not be responsible for any legal fees you incur.

How long do I have to request an appeal?
An appeal must be requested either verbally or in writing within
* 30 days of your request that was not acted on, or
* 30 days from the time that your HSP representative informed you of their decision, or
* 35 days if you were notified of the decision by mail.

What is an informal resolution and what is its benefit?
Once you have requested an appeal, you may also request an informal resolution conference. This meeting will involve you and/or any representative you may designate, the HSP representative, and the office supervisor or the manager of the AIDS/HIV or TBI waiver, if appropriate. At an informal resolution, the office supervisor will discuss and clarify everyone’s issues and positions.
1. If a resolution is reached, both you and the supervisor will sign a written agreement and you will request in writing that your appeal be withdrawn.
2. If you withdraw your appeal, you cannot appeal the same decision at a later date.
3. If no agreement is reached, you will proceed to a formal administrative hearing. This will be documented in writing.

What do I need to do before the appeal?
1. You will need to notify the HSP office of any reasonable accommodations you may need. If, because of your disability, you cannot participate in person at the local office, you may request to participate by telephone.
2. You must provide all the evidence you will present at the hearing to the HSP office and the Impartial Hearing Officer at least three days before the hearing. This includes a list of any witnesses who will appear, as well as all documents you will use.
What can I expect to happen before an appeal?

1. You will receive a letter informing you of the date, time and place of the hearing. This letter will also provide detailed information about the hearing. It is important that you read this letter carefully.

2. At least three business days before the hearing, you will receive a packet of information from the HSP office. This will include all the evidence they will present at the hearing. This will also be sent to the Impartial Hearing Officer.

What will happen during the appeal?

You and/or your representative will present your evidence. DRS will present their evidence. The Impartial Hearing Officer will hear the facts of the case.

The hearing will be taped and you can request one copy in an accessible format at no cost.

What will happen after the appeal?

The HSP office will be notified of the final decision and will comply with the action decided upon. You will be notified immediately if there are changes that need to be made and the effective date.

The decision of the Impartial Hearing Officer is final. If you disagree with the decision, you must pursue your case through the local circuit court. This request needs to be made within 35 days of being notified of the decision.
REQUEST FOR HEARING

This information must be completed. (Please Print)
Customer Name: __________________________________________
Customer Date of Birth (Required): _________________________
            month / day / year
Address: __________________________________________________
City/State: ____________________________________ Zip: _________

My DRS counselor's name is: ________________________________

If you need help in completing this form, please ask your Rehabilitation Counselor, HSP Representative, Rehabilitation Instructor or Case Manager. If you need help requesting your appeal, or would like to ask about possible representation, please contact the appropriate program below:

Home Services Program (HSP) Customers
Home Care Ombudsman Program - HCOP
One Natural Resources Way, Suite 100
Springfield, IL 62702-1271
(800) 252-8966 (Voice)
(888) 206-1327 (TTY)

Vocational Rehabilitation (VR) Customers
Bureau of Blind Services (BBS) Customers
Client Assistance Program - CAP
100 South Grand Ave East, PO Box 19429
Springfield, IL 62794-9429
(800) 641-3929 (V/TTY)

☐ I want to appeal a decision made by DRS on the following date: ____________.
☐ I want to appeal DRS' failure to respond to a request I made on the following date: ____________.
☐ I also want to request an informal resolution before the hearing and understand it is my responsibility to contact my DRS representative or the office supervisor for scheduling.
☐ I am a VR or BBS customer and would like to request mediation before the hearing.

Briefly describe the decision(s) or lack of action you would like to appeal:

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
State of Illinois  
Department of Human Services - Division of Rehabilitation Services  
REQUEST FOR HEARING

Check Only Those That Apply:

☐ My disability is deafness or hard of hearing and I will need: (Check One)  
☐ Sign language interpreter  
☐ Tactile interpreter  
☐ Video-phone conference  
☐ CART services

☐ My disability is blindness or visual impairment and I will need: (Check One)  
☐ audiotape or disc  
☐ all materials provided in large print  
☐ all materials provided in Braille  
☐ a reader to assist in my preparation for the hearing

☐ My language preference is ____________________ rather than English. I will need an interpreter to participate in the hearing: (Please fill in your normally spoken language.)

☐ I am unable to attend the hearing in the local DHS-DRS office due to my disability. I am requesting to participate in the hearing by telephone.

☐ I have chosen to be represented by the following person or organization in this appeal: (PLEASE PRINT)

Name/Organization: __________________________________________________________
Address: _________________________________________________________________
City/State/Zip Code: ____________________________  
Telephone with area code: ___________________  Alternate telephone with area code: ________________

NOTE: If this form is not signed by the customer or by the designated representative, the request for hearing will be denied. If signed by the designated representative, attach the written authorization signed by the customer to request a hearing on behalf of the customer

• Sign your name or Make your mark  
Customer: ____________________________  Date: ______________

• If you have made your mark (x) instead of signing your name, two witnesses must sign here

Signature of Witness: ____________________________  Date: ______________

Signature of Witness: ____________________________  Date: ______________

• ___________________________________________________  Relationship to customer

Representative or legal guardian of adult 18 years of age or older

• Parent or guardian signature is required if customer is 17 years of age or younger.

Signature of Parent or Guardian: ____________________________  Date: ______________

I am the parent or guardian of:

______________________________________________________________

Please mail this form to the Bureau of Administrative Hearings, with the notice you received, if any, informing you of the decision you are appealing. You may send a copy of your appeal to the local field office listed below.

Illinois Department of Human Services  
Bureau of Administrative Hearings  
69 W Washington, 4th Floor  
Chicago, IL 60602  

cc: Local Field Office

IL 488-1949W (R-08-17) Request for Hearing
Printed by the Authority of the State of Illinois  Copies _____  P.O. _______  
Page 2 of 2
# Home Services Program Individual Provider Payroll Schedule 2020

<table>
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<tr>
<th>Pay Period</th>
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<th>PA Hotline</th>
<th>Pay Date</th>
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<tbody>
<tr>
<td>December 16-31, 2019</td>
<td>January 1 - 8</td>
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<td>January 1-15</td>
<td>January 16 - 23</td>
<td>January 30</td>
<td>February 13</td>
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<td>January 16-31</td>
<td>February 1 - 7</td>
<td>February 14</td>
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<td>February 1-15</td>
<td>February 16 - 25</td>
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<td>March 16 - 22</td>
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<tr>
<td>December 16-31</td>
<td>January 1 - 8, 2021</td>
<td>January 14</td>
<td>January 28</td>
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</table>

*Timesheet due date falls on a weekend. Please ensure timesheets are signed and delivered prior to the stated deadline to guarantee timely payment.*
**KNOW THE TRUTH TO PROTECT YOURSELF FROM SERIOUS INFECTIONS**

**TRUTH**
On average, healthcare providers clean their hands less than half of the times they should.

**THE NITTY GRITTY:**
This can put you at risk for a serious infection. It’s OK to ask your care team questions like, “Before you start the exam, would you mind cleaning your hands again?” Another way to bring it up is to thank them for cleaning their hands if you are uncomfortable asking.

**TRUTH**
Alcohol-based hand sanitizer kills most of the bad germs that make you sick.

**THE NITTY GRITTY:**
Your hands have good germs on them that your body needs to stay healthy. Your hands can also have bad germs on them that make you sick. Alcohol-based hand sanitizers kill the good and bad germs, but the good germs quickly come back on your hands.

**TRUTH**
Alcohol-based hand sanitizer does not kill *C. difficile*.

**THE NITTY GRITTY:**
If you have a *C. difficile* infection, make sure your healthcare providers wear gloves to examine you. You and your loved ones should wash your hands with soap and water to prevent the spread of *C. difficile*.

**ALCOHOL-BASED HAND SANITIZER**
is a product that contains at least 60% alcohol to kill germs on the hands.

**TRUTH**
Your hands can spread germs.

**THE NITTY GRITTY:**
Make sure you and your visitors are cleaning your hands at these important times:

- **After touching bed rails, bedside tables, remote controls, or phone**
- **Before eating**
- **Before and after changing bandages**
- **After blowing your nose, coughing, or sneezing**
- **After using restroom**

**WHAT IS *C. difficile***?
*C. difficile* or “*C. diff*” is a common healthcare-associated infection that causes severe diarrhea.

---

www.cdc.gov/HandHygiene
What is the Home Services Program (HSP) Fraud Unit?
The HSP Fraud Unit is the delegated authority that conducts investigations related to allegations of fraud within the HSP program.

Does a Customer have to repay any misused funds?
- YES;
- The Fraud Unit works with DHS Bureau of Collections to set up repayment agreements;
- The Fraud Unit works closely with the Department of Healthcare & Family Services (HFS) - Office of Inspector General (OIG); and
- If charged criminally by the Illinois State Police (ISP) or the Federal Bureau of Investigation (FBI), an individual may go to prison, do probation or community service and be ordered to pay restitution.

Note: Fraudulent practices may result in the changing of the IP to a homemaker agency, termination of HSP services and/or prosecution.

Important Phone Numbers

EVV Call in/Call out
English
(855)347-1770
(855)573-0726

Spanish
(855)347-0771
(855)573-1726

Abuse/Neglect Hotline
Adult Protective Services
(866)800-1409

Home Services Program Helpline
(888)713-5139

(866) 324-5553 TTY/Nextalk or 711 TTY Relay

“If you permit it, you promote it”
Rights and Responsibilities of a Customer

The Customer is the employer. This means that as a Customer you are responsible to hire and manage your own Individual Providers (IPs).

The Customer has the responsibility to:
1) Ensure your IP has completed and submitted all paperwork and received their Santrax ID before they begin working for you;
2) Ensure your IP is appropriately using the EVV system and calling in and out each time they provide services to you;
3) Monitor your IP’s hours to ensure the provider is only working the approved hours and tasks indicated on your service plan;
4) Ensure you have a back-up provider for instances where your IP is sick or not able to come to work;
5) Follow DRS policy and procedures (Example: spouses are not allowed to be hired as an individual provider);
6) Report all changes to your HSP counselor; this includes any times you are hospitalized or away from your home. This also includes a change of address, phone number or service needs;
7) Work together with service providers, DHS staff, and representatives to comply with HSP service plans, reassessments of eligibility and other administrative rules;
8) Sign all forms which are required under
   ■ federal or state law;
   ■ federal or state rule;
   ■ the Medicaid Waiver; or
   ■ are necessary to process payment through the Comptroller’s Office.
9) Report any fraudulent activities you are aware of; and
10) Thoroughly review the time sheet before signing it to ensure all information is complete and correct. This includes reviewing the specific days/hours listed that the IP provided care according to the HSP Service Plan, as well as verifying that the listed addresses and telephone numbers are correct and current.

The Customer has the right to:
1) Speak to your HSP counselor for help with problems/issues regarding your care;
2) Terminate an IP that is not performing the duties he/she was hired to provide;
3) File a report with Adult Protective Services (APS) for neglect/abuse;
4) Request homemaker services if you are not able to manage your IP; and
5) Cancel your case at any time.

What is Fraud?
Fraud is a dishonest and deliberate misuse of State or Federal funds, and the intentional misleading or deceitful conduct that deprives the State of its resources or rights.

Fraud is further defined as:
■ The act of deceiving or misrepresenting; and
■ The act of using dishonest methods to take something valuable from an individual.

Why Report Medicaid Fraud?
■ Medicaid fraud should be reported because Medicaid payments are made from federal and state funds supplied by taxpayers; and
■ When Medicaid funds are stolen through fraud, that money is no longer available to help deserving customers.

Examples of Fraud:
■ Submitting a time sheet with days and/or hours that the worker did not work;
■ The Customer requesting the IP to perform duties not authorized on the Service Plan;
■ The Customer signing the time sheet before all services have been completed for the pay period;
■ The customer demanding the IP split their check with them;
■ Calling in and out for your IP with the use of the EVV system; and
■ Fraudulently requesting HSP services for an unwarranted disability.