



Division of Rehabilitation Services – Home Services Program

Individual Provider Employment Packet

Welcome to the Home Services Program (HSP)! The enclosed documents must be reviewed and completed before you can begin receiving payment for services provided to an HSP customer. Many of the enclosed forms require your information and signature and the signature of the customer you want to work for. These forms must be completed in their entirety and returned to your **Customer's local DRS office**. If the Customer is in a Managed Care Organization (MCO), these documents will still be turned into the [Customer's local DRS office](#).

Before You Can Work for An HSP Customer:

1. The HSP Customer you want to work for will be notified of your official start date.
2. A Santrax ID will be given to you for use in HSP's Electronic Visit Verification System (EVV).
3. You will receive a copy of a Vendor Authorization for Services and Customer Service Plan.

NOTE: If you begin working for the Customer before all the above situations occur, you risk non-payment for services.

If you are a New or Inactive IP applying to be a Provider, submit the documents below

These documents must be completed, signed and submitted to the local DRS office. A brief summary of these documents is located on page 2.

- | | |
|---|---|
| <input type="checkbox"/> Copy of a current Photo ID | <input type="checkbox"/> IL488-2112 – IP Standards |
| <input type="checkbox"/> Copy of Social Security Card | <input type="checkbox"/> IL488-1413 – Provider Agreement |
| <input type="checkbox"/> Form I-9 – Employment Eligibility | <input type="checkbox"/> IL488-2252 – IP Payment Policies |
| <input type="checkbox"/> W-4 – Federal Withholding Certificate | <input type="checkbox"/> IL488-2262 – Waiver Agreement |
| <input type="checkbox"/> IL W-4 – State Withholding Certificate | <input type="checkbox"/> IL488-2263 – IMPACT Enrollment |

These documents should be kept for informational or future purposes and not submitted to the local DRS office.

- | | |
|---|---|
| ! IMPACT IP Form Instructional Sheet | ! Santrax (EVV) Call Reference Guide |
| ! IL488-2399 – Report of Injury to a Provider | ! C-95A – Direct Deposit Form |
| ! Timesheet Instructions | ! IL444-0800 – Debit Card Application |
| ! Understanding Work Week vs Pay Period | ! CDC Clean Hands Count Flyer |
| ! HSP Provider Payroll Schedule | ! Official SEIU Healthcare Brochure |

If you are an Active IP applying for a different Customer, submit the documents below:

These documents must be completed, signed and submitted to the local DRS office. A brief summary of these documents is located on page 2.

- | | |
|--|--|
| <input type="checkbox"/> Copy of a current photo ID | <input type="checkbox"/> Form I-9 – Employment Eligibility |
| <input type="checkbox"/> IL488-2112 – IP Standards | <input type="checkbox"/> IL488-2252 – IP Payment Policies |
| <input type="checkbox"/> IL488-1413 – Provider Agreement | |



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Individual Provider Employment Packet

Copy of a Photo ID: Must be current, non-expired and issued through a Government or School Entity. (Examples include: Driver's License, State ID, Passport, Military ID, School ID, etc.)

Federal and IL W-4: These forms are used by the Illinois Department of Revenue and the IRS to collect information about your tax status and your withholding requests. The local office cannot help in completing these forms. If you need help with these forms, please contact a tax consultant.

IL488-2112 – Individual Provider Standards: This form establishes basic information between you and your employer, the HSP Customer.

IL488-1413 – Home Services Program Provider Agreement: This form establishes agreements between you and the HSP Program as well as what service type(s) you will be providing to the customer.

FORM I-9: Please complete page 1. The Customer will complete page 2 after you have provided the Customer with the acceptable documents listed in the instructions. Additional instructions can be found at <https://www.uscis.gov/i-9>, or can be printed at your local DRS office.

IL488-2252 – Individual Provider Payment Policies: This form provides important policies, rules and information concerning payments and potential fraud issues. Customer signature required.

IL488-2262 – Waiver Program Provider Agreement: You must enroll in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system to be an eligible Medicaid Provider.

IL488-2263 – IMPACT Individual Provider Enrollment Form: You must enroll in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system to be an eligible Medicaid Provider.

C-95A – Authorization for Deposit of Recurring Payments: If you would like direct deposit into an account at a financial institution, complete this form and return to:
DHS/Expenditure Accounting Debit Card Project, 100 S Grand Ave E, 1st Fl, Springfield, IL 62762

IL444-0800 – Illinois Debit MasterCard Payment Option Form: If you wish to receive payment through a debit card, please complete this form and return to the address listed on the document.

IL488-2399 – Report of Injury to an Individual Provider: Within 24 hours of a work-related injury, please complete this form and return to the address stated on the document.

For more information on HSP, use the DHS website (<http://www.dhs.state.il.us>) by searching terms like: "DHS Office Locator", "Frequently Asked Questions", "HSP Payroll Schedule", "Report Fraud", "Report Abuse", etc.

You can request Employment Verification, Duplicate W-2's*, or a Gross Earnings Statement by sending your Request, Full Name, Social Security #, Current Address/Phone #, Signature and Date to: FAX (217) 557-9434 or DHS/DRS HSP Labor Relations, PO Box 19429, Springfield, IL 62794-9429

*If requesting a Duplicate W-2, a copy of your photo ID or recent mail is required.

Report Abuse/Neglect: (800) 368-1463

General DHS Helpline: (800) 843-6154

Provider Assistance Line: (800) 804-3833 opt 2

Debit Card/Direct Deposit: (217) 785-7790

Illinois Provider Debit MasterCard: (866) 338-2944

SEIU Union: (866) 933-7348

Please complete, sign and submit the following documents to your Customer's local DRS office!

- Copy of a current Photo ID
- Copy of Social Security Card
- Form I-9 – Employment Eligibility
- W-4 – Federal Withholding Certificate
- IL W-4 – State Withholding Certificate
- IL488-2112 – IP Standards
- IL488-1413 – Provider Agreement
- IL488-2252 – IP Payment Policies
- IL488-2262 – Waiver Agreement
- IL488-2263 – IMPACT Enrollment

If you are currently an ACTIVE IP and applying for a different HSP Customer, please see the instructions on the 1st page of the Individual Provider Employment Packet letter.

Please provide a copy of a current and valid Federal, State, or School issued photo ID. The ID must be valid and have a date of birth. You may copy it to this page or provide a page of your own.

**Please provide a copy of your Social Security Card.
You may copy it to this page or provide a page of your own.**



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

▶ **START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name <i>(Family Name)</i>		First Name <i>(Given Name)</i>		Middle Initial	Other Last Names Used <i>(if any)</i>	
Address <i>(Street Number and Name)</i>			Apt. Number	City or Town		State ZIP Code
Date of Birth <i>(mm/dd/yyyy)</i>	U.S. Social Security Number □□□□ - □□ - □□□□		Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee	Today's Date <i>(mm/dd/yyyy)</i>
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Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date <i>(mm/dd/yyyy)</i>	
Last Name <i>(Family Name)</i>		First Name <i>(Given Name)</i>	
Address <i>(Street Number and Name)</i>		City or Town	State ZIP Code

Employer Completes Next Page



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ **(See instructions for exemptions)**

Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative		Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name (if applicable)			B. Date of Rehire (if applicable)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 	OR	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
 ▶ **Give Form W-4 to your employer.**
 ▶ **Your withholding is subject to review by the IRS.**

2020

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly (or Qualifying widow(er)) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ▶

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents	If your income will be \$200,000 or less (\$400,000 or less if married filing jointly):		
	Multiply the number of qualifying children under age 17 by \$2,000 ▶ \$ _____		
	Multiply the number of other dependents by \$500 ▶ \$ _____		
	Add the amounts above and enter the total here	3	\$ _____
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$ _____
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$ _____

Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	▶ _____ Employee's signature (This form is not valid unless you sign it.)	▶ _____ Date	

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b) – Multiple Jobs Worksheet (Keep for your records.)



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3
2 Three jobs. If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a
b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b
c Add the amounts from lines 2a and 2b and enter the result on line 2c
3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc.
4 Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Step 4(c) of Form W-4 for the highest paying job (along with any other additional amount you want withheld)

Step 4(b) – Deductions Worksheet (Keep for your records.)



- 1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income
2 Enter: { \$24,800 if you're married filing jointly or qualifying widow(er); \$18,650 if you're head of household; \$12,400 if you're single or married filing separately }
3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-"
4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$220	\$850	\$900	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,210	\$1,870	\$1,870
\$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
\$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
\$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
\$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
\$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
\$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
\$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
\$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
\$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
\$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
\$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
\$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
\$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
\$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
\$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
\$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$460	\$940	\$1,020	\$1,020	\$1,470	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040	\$2,040	\$2,040
\$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
\$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
\$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
\$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
\$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
\$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
\$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
\$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
\$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
\$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
\$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
\$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$830	\$930	\$1,020	\$1,020	\$1,020	\$1,480	\$1,870	\$1,870	\$1,930	\$2,040	\$2,040
\$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
\$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
\$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
\$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
\$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
\$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
\$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
\$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
\$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
\$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
\$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240



Note: These instructions are written for employees to address withholding from wages. However, this form can also be completed and submitted to a payor if an agreement was made to voluntarily withhold Illinois Income tax from other (non-wage) Illinois income.

Who must complete Form IL-W-4?

If you are an employee, you must complete this form so your employer can withhold the correct amount of Illinois Income Tax from your pay. The amount withheld from your pay depends, in part, on the number of allowances you claim on this form.

Even if you claimed exemption from withholding on your federal Form W-4, U.S. Employee's Withholding Allowance Certificate, because you do not expect to owe any federal income tax, you may be required to have Illinois Income Tax withheld from your pay (see Publication 130, Who is Required to Withhold Illinois Income Tax). If you are claiming exempt status from Illinois withholding, you must check the exempt status box on Form IL-W-4 and sign and date the certificate. Do not complete Lines 1 through 3.

If you are a resident of Iowa, Kentucky, Michigan, or Wisconsin, or a military spouse, see Form W-5-NR, Employee's Statement of Nonresidence in Illinois, to determine if you are exempt.

Note If you do not file a completed Form IL-W-4 with your employer, if you fail to sign the form or to include all necessary information, or if you alter the form, your employer must withhold Illinois Income Tax on the entire amount of your compensation, without allowing any exemptions.

When must I submit this form?

You should complete this form and give it to your employer on or before the date you start work. You must submit Form IL-W-4 when Illinois Income Tax is required to be withheld from compensation that you receive as an employee. You may file a new Form IL-W-4 any time your withholding allowances increase. If the number of your claimed allowances decreases, you **must** file a new Form IL-W-4 within 10 days. However, the death of a spouse or a dependent does not affect your withholding allowances until the next tax year.

When does my Form IL-W-4 take effect?

If you do not already have a Form IL-W-4 on file with your employer, this form

will be effective for the first payment of compensation made to you after this form is filed. If you already have a Form IL-W-4 on file with this employer, your employer may allow any change you file on this form to become effective immediately, but is not required by law to change your withholding until the first payment of compensation is made to you after the first day of the next calendar quarter (that is, January 1, April 1, July 1, or October 1) that falls at least 30 days after the date you file the change with your employer.

Example: If you have a baby and file a new Form IL-W-4 with your employer to claim an additional allowance for the baby, your employer may immediately change the withholding for all future payments of compensation. However, if you file the new form on September 1, your employer does not have to change your withholding until the first payment of compensation is made to you after October 1. If you file the new form on September 2, your employer does not have to change your withholding until the first payment of compensation made to you after December 31.

How long is Form IL-W-4 valid?

Your Form IL-W-4 remains valid until a new form you have submitted takes effect or until your employer is required by the Department to disregard it. Your employer is required to disregard your Form IL-W-4 if

- you claim total exemption from Illinois Income Tax withholding, but you have not filed a federal Form W-4 claiming total exemption, or
- the Internal Revenue Service (IRS) has instructed your employer to disregard your federal Form W-4.

What is an "exemption"?

An "exemption" is a dollar amount on which you do not have to pay Illinois Income Tax that you may claim on your Illinois Income tax return.

What is an "allowance"?

The dollar amount that is exempt from Illinois Income Tax is based on the number of allowances you claim on this form. As an employee, you receive one allowance unless you are claimed as a dependent on another person's tax return (e.g., your parents claim you as a dependent on their tax return). If you are married, you may claim additional allowances for your spouse and any dependents that you are entitled to claim for federal income tax purposes. You also will receive additional allowances if you or your spouse are age 65 or older, or if you or your spouse are legally blind.

Note: For tax years beginning on or after January 1, 2017, the personal exemption allowance, and additional allowances if you or your spouse are age 65 or older, or if you or your spouse are legally blind, may **not** be claimed on your Form IL-1040 if your adjusted gross income for the taxable year exceeds \$500,000 for returns with a federal filing status of married filing jointly, or \$250,000 for all other returns. You may complete a new Form IL-W-4 to update your exemption amounts and increase your Illinois withholding.

How do I figure the correct number of allowances?

Complete the worksheet on the back of this page to figure the correct number of allowances you are entitled to claim. Give your completed Form IL-W-4 to your employer. Keep the worksheet for your records.

Note If you have more than one job or your spouse works, your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

How do I avoid underpaying my tax and owing a penalty?

You can avoid underpayment by reducing the number of allowances or requesting that your employer withhold an additional amount from your pay. Even if your withholding covers the tax you owe on your wages, if you have non-wage income that is taxable, such as interest on a bank account or dividends on an investment, you may have additional tax liability. If you owe more than \$500 tax at the end of the year, you may owe a late-payment penalty or will be required to make estimated tax payments. For additional information on penalties see Publication 103, Uniform Penalties and Interest. Visit our website at tax.illinois.gov to obtain a copy.

Where do I get help?

- Visit our website at tax.illinois.gov
- Call our Taxpayer Assistance Division at **1 800 732-8866** or **217 782-3336**
- Call our TDD (telecommunications device for the deaf) at **1 800 544-5304**
- Write to
**ILLINOIS DEPARTMENT OF REVENUE
PO BOX 19044
SPRINGFIELD IL 62794-9044**

Illinois Withholding Allowance Worksheet

General Information

Use this worksheet as a guide to figure your total withholding allowances you may enter on your Form IL-W-4.

Complete Step 1.

Complete Step 2 if

- you (or your spouse) are age 65 or older or legally blind, or
- you wrote an amount on Line 4 of the Deductions Worksheet for federal Form W-4.

If you have more than one job or your spouse works, your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

You may reduce the number of allowances or request that your employer withhold an additional amount from your pay, which may help avoid having too little tax withheld.

Step 1: Figure your basic personal allowances (including allowances for dependents)

Check all that apply:

- No one else can claim me as a dependent.
 I can claim my spouse as a dependent.

- 1 Enter the total number of boxes you checked. 1 _____
- 2 Enter the number of dependents (other than you or your spouse) you will claim on your tax return. 2 _____
- 3 Add Lines 1 and 2. Enter the result. This is the total number of basic personal allowances to which you are **entitled**. You are not required to claim these allowances. The number of basic personal allowances that you choose to claim will determine how much money is withheld from your pay. See Line 4 for more information. 3 _____
- 4 Enter the total number of basic personal allowances you choose to claim on this line and Line 1 of Form IL-W-4 below. This number may not exceed the amount on Line 3 above, however you can claim as few as zero. Entering lower numbers here will result in more money being withheld(deducted) from your pay. 4 _____

Step 2: Figure your additional allowances

Check all that apply:

- I am 65 or older. I am legally blind.
 My spouse is 65 or older. My spouse is legally blind.

- 5 Enter the total number of boxes you checked. 5 _____
- 6 Enter any amount that you reported on Line 4 of the Deductions Worksheet for federal Form W-4 plus any additional Illinois subtractions or deductions. 6 _____
- 7 Divide Line 6 by 1,000. Round to the nearest whole number. Enter the result on Line 7. 7 _____
- 8 Add Lines 5 and 7. Enter the result. This is the total number of additional allowances to which you are **entitled**. You are not required to claim these allowances. The number of additional allowances that you choose to claim will determine how much money is withheld from your pay. 8 _____
- 9 Enter the total number of additional allowances you elect to claim on Line 2 of Form IL-W-4, below. This number may not exceed the amount on Line 8 above, however you can claim as few as zero. Entering lower numbers here will result in more money being withheld(deducted) from your pay. 9 _____

IMPORTANT: If you want to have additional amounts withheld from your pay, you may enter a dollar amount on Line 3 of Form IL-W-4 below. This amount will be deducted from your pay in addition to the amounts that are withheld as a result of the allowances you have claimed.

----- Cut here and give the certificate to your employer. Keep the top portion for your records. -----

Illinois Department of Revenue IL-W-4 Employee's Illinois Withholding Allowance Certificate

_____-_____-_____
Social Security number

Name

Street address

_____-_____-_____
City State ZIP

Check the box if you are exempt from federal and Illinois Income Tax withholding and sign and date the certificate.

Printed by the authority of the State of Illinois - web only, 1 copy IL-W-4 (R-12/19)

This form is authorized under the Illinois Income Tax Act. Disclosure of this information is required. Failure to provide information may result in this form not being processed and may result in a penalty.

- 1 Enter the total number of basic allowances that you are claiming (Step 1, Line 4, of the worksheet). 1 _____
- 2 Enter the total number of additional allowances that you are claiming (Step 2, Line 9, of the worksheet). 2 _____
- 3 Enter the additional amount you want withheld (deducted) from each pay. 3 _____

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Your signature

Date

Employer: Keep this certificate with your records. If you have referred the employee's federal certificate to the IRS and the IRS has notified you to disregard it, you may also be required to disregard this certificate. Even if you are not required to refer the employee's federal certificate to the IRS, you still may be required to refer this certificate to the Illinois Department of Revenue for inspection. See Illinois Income Tax Regulations 86 Ill. Adm. Code 100.7110.



INDIVIDUAL PROVIDER STANDARDS

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 <input type="checkbox"/> Male <input type="checkbox"/> 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)

<input type="checkbox"/>	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
<input type="checkbox"/>	16 to 18 years of age and enrolled in school (must not be employed during school hours)
<input type="checkbox"/>	17 to 18 years of age and not enrolled in school
<input type="checkbox"/>	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:

Task	Experience/Training
------	---------------------

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

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.



HOME SERVICES PROGRAM - HSP PROVIDER AGREEMENT

**HOME SERVICES PROGRAM PROVIDER AGREEMENT (HSP 1413)
 FOR PARTICIPATION IN THE ILLINOIS MEDICAL ASSISTANCE PROGRAM**

As an Individual Provider for the Illinois Department of Human Services Home Services Program, I agree to enroll as a Medicaid Waiver Program Provider to be compensated for services and to comply with all conditions as contained within this agreement.

As a Medicaid Waiver Program Provider, I agree to:

- comply with all requirements set forth in the Individual Provider Payment Policies (IL488-2252), the Waiver Program Provider Agreement (IL488-2262 IMPACT waiver), and the IMPACT Individual Provider Enrollment Form (IL488-2263);
- not discriminate in the provision of services based on the grounds of sex, race, color, national origin or disability;
- comply with Personal Assistant (PA), Certified Nursing Assistant (CNA), Registered Nurse (RN), and/or Licensed Practical Nurse (LPN) requirements as set forth in 89 Ill. Adm. Code 686.10, and/or the 77 Ill. Adm. Code 395;
- comply with HSP's Electronic Visit Verification and Timekeeping System (EVV) as mandated by the SMART Act 97-0689, Section 5.5(f) & (g);
- be accurate, complete and truthful in completion of the HOME SERVICES TIME SHEET (IL488-2251), and by signing the IL488-2251, I agree to be fully liable for the information the form contains (Any submission of false or fraudulent billing, or any concealment of information relevant to payment of these bills may be prosecuted under applicable Federal and State laws);
- maintain a copy of the completed HOME SERVICES TIME SHEET (IL488-2251) and any other records related to the billing services paid by the Division of Rehabilitation Services (These records must be maintained for at least three (3) years from the date the service was billed.);
- notify IDHS-DRS if there is an overpayment for any service provided and return any overpayment to the State of Illinois.

I agree that should the information provided be incomplete, inaccurate, or falsified, it may be cause for my termination as an IDHS-DRS Provider under the Home Services Program.

To be completed by the Individual Provider

All fields are required and **must be complete**. Please print clearly to avoid delays.

Please select service type provided: (select all that apply)

(PA)

(CNA)

(RN)

(LPN)

Personal Assistant

Certified Nursing Assistant

Registered Nurse

Licensed Practical Nurse

Full Printed Name:
 (As shown on ID) _____

SSN: _____ DOB: _____

Individual Provider Signature: _____ Date: _____

HSP Customer Full Name: _____

To be completed by the HSP Field Office

All fields are required and **must be complete**. Please print clearly to avoid delays.

HSP Customer District Number: _____ HSP Customer Case Number: _____

HSP Office Location Name: _____

HSP Staff Printed Name: _____

HSP Staff Job Title: _____

HSP Staff Signature: _____ Date: _____



INDIVIDUAL PROVIDER PAYMENT POLICIES

Home Services Program (HSP) customers and Individual Providers are responsible for accurately completing and signing all Individual Provider time sheets. Completion of the time sheet will require both parties to sign and verify the information contained on it is correct. Fraudulently completing these documents will result in a formal investigation by the Medicaid Task Force, with possible criminal prosecution by the Illinois State Police (ISP). This document provides critical information for completing a time sheet.

Every Individual Provider is required to have an employment packet on file for each customer that employs him/her for services required in the home.

Individual Provider Social Security numbers will be verified. Those having unverified Social Security numbers will be informed of their inability to begin employment or to continue working as an Individual Provider.

Individual Providers can only be paid for the hours they worked for the customer per the HSP Service Plan. Billing for hours not worked constitutes Medicaid fraud. Individual Providers are required to use HSP's Electronic Visit Verification and Timekeeping System (EVV) as mandated by the SMART Act 97-0689, Section 5.5(f) & (g).

The services provided in the home are for the customer(s) having a HSP Service Plan. Services for family members, guests, animals, etc. will not be reimbursed.

The Service Plan indicates how many days per month specific tasks are required by the customer. Work schedules are directed by the customer and, though flexible, should generally follow the Service Plan; this may include hours for such daily tasks as personal care, toileting, meal preparation, etc.

- An example of an inappropriate time sheet would be the Individual Provider billing the total hours that are available during only one pay period of the month.

Hours worked in excess of the HSP Service Plan will not be authorized without prior approval from the customer's counselor. Individual Providers are required to perform only those tasks outlined on the Service Plan and within the time frames approved.

Individual Providers can only be paid for hours and tasks performed in the customer's home.

- Task outside the home will only be approved if the customer does not have adequate facilities.

Examples include: Individual Provider using a laundry facility if the Customer does not have a washer and dryer, banking and grocery shopping.

- In no instance may the Individual Provider be authorized for hours and tasks that were performed in the Individual Provider's home. Examples of tasks prohibited inside the Individual Provider's home include: doing the customer's laundry, meal preparation or supervising the customer.

Hours worked in excess of sixteen hours in a twenty-four hour period will not be authorized without approval from the customer's counselor. This sixteen hour limitation does not apply to Individual Providers providing respite services.

Individual Providers are not authorized to work for a HSP customer if that customer is out of the home, i.e. in a nursing facility, hospitalized, on vacation, etc. However, there are some exceptions that are allowable, such as the counselor gives prior approval and the request meets the policy guidelines. Please contact the counselor to address any questions before risking non-payment of services provided.

It is strictly prohibited to transport a customer in the Individual Provider's automobile or other mode of transport **WHILE PERFORMING ANY DUTY AS AN INDIVIDUAL PROVIDER**. Customers must seek and secure alternative means of transportation, such as use of family resources or public transportation. Any driving by an Individual Provider is at his/her own risk.

Individual Providers are not allowed to subcontract. Subcontracting is the practice of letting someone else work in your place, putting the time on your time sheet and then paying them yourself. This is not only an illegal practice but also causes problems with Social Security withholding. Each Individual Provider will only be paid for services which he or she provided directly to the customer.



INDIVIDUAL PROVIDER PAYMENT POLICIES

It is against administrative rules for legally responsible relatives to serve as the Individual Provider for HSP customers. This includes a spouse working for his/her disabled spouse; children under the age of 18 working for their disabled parent; or a parent, step-parent, or foster parent working as an Individual Provider for his/her disabled child under the age of 18. Individual Providers and customers can request clarification at anytime there may be a question or concern about this issue.

Individual Providers cannot charge HSP for the same hours worked when working another job. This includes working for other HSP customers or as a childcare provider paid through the Department of Human Services. This constitutes fraud and will be prosecuted as such.

Customers should never pre-sign time sheets and they are expected to review the accuracy of dates and times worked prior to submitting the time sheet on the last day of the payroll window. Time sheets submitted with hours not yet worked will be returned to the customer and could delay Individual Provider payments.

Individual Providers are never required to have their payroll check co-signed by the customer even if the check is mailed to the customer's address.

Individual Providers shall not sign the time sheets on behalf of the customer unless they are Power of Attorney, or Legal Guardian. Customers are never to sign the time sheet on behalf of the Individual Provider.

Individual Providers and customers must submit timely billing in order to assure payment. Timesheets received five (5) business days after the end date of service will likely delay payment. The repeated failure of the Individual Provider to comply with this requirement shall be considered as evidence of the customer's failure to cooperate with HSP due to the failure to adequately supervise the Individual Provider.

Individual Providers may obtain employment verifications from the State of Illinois. The information is limited but includes: the gross earnings for each pay period for the requested time frame, the hourly rate of pay, total wages earned for the past twelve months, social security number, address, city, state, and the zip code. All requests for employment verifications must be requested in writing. The local office will provide direction where the request may be faxed or mailed.

Individual Providers should utilize the toll free Provider Information Line at 1-800-804-3833 whenever information concerning checks might be needed. This system can verify that billing information was received and processed for payment, including the expected arrival date of the checks. Phone calls to the local offices during payment cycles can potentially delay payments to Individual Providers because of the volume of data entry required of the field staff.

Personal Assistants are covered for collective bargaining purposes by the Service Employee International Union (SEIU) Health Care Illinois/Indiana (as mandated by the SEIU Collective Bargaining Agreement with the State of Illinois). Each pay period, a deduction will be taken from an PA's wages to cover one of the following:(1) membership costs to join SEIU, or (2) a "fair share deduction" if a PA does not join SEIU. The rates for membership, fair share and maximum monthly dues are posted on the Rehabilitation Services Provider Information section "for Providers" page at www.dhs.state.il.us. If you have a question about union membership dues please contact SEIU at 1-866-933-7348.

Customers and Individual Providers are encouraged to contact the HSP local office to address any billing questions or concerns prior to submitting time sheets for payments. This one additional step will promote accurate and timely payments to the Individual Provider.

I acknowledge that the above information has been reviewed and is understood.

Customer Printed Name and Signature

Date

Individual Provider Printed Name and Signature

Date



Notice of Enrollment of Medicaid Waiver Providers in the IMPACT System

Illinois implemented a new electronic provider enrollment system in July 2015. The new web-based system is known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT). IMPACT will be used by all Medicaid and Waiver Program providers doing business with Illinois. All Individual Providers seeking to provide services with the DHS Division of Rehabilitation Services (DHS-DRS) Medicaid Waiver Program will be required to be enrolled in IMPACT. DHS will be enrolling Individual Providers in the IMPACT system. In order to complete enrollment DHS will obtain the necessary information from the Individual Provider. The Individual Provider by signing the Waiver Program Provider Agreement agrees to the terms and conditions of the Trading Partner agreement in the IMPACT Provider Enrollment System. The full version of the IMPACT Provider Enrollment Terms and Conditions can be found at http://www.illinois.gov/hfs/impact/Documents/PE_Terms_Conditions.pdf

WAIVER PROGRAM PROVIDER AGREEMENT

WHEREAS, _____, hereinafter referred to as "the Provider", is enrolled with the Illinois Department of Healthcare and Family Services, hereinafter referred to as "HFS", as an eligible provider in the Medical Assistance Program; and

(Print Full Legal Name)

Department of Healthcare and Family Services, hereinafter referred to as "HFS", as an eligible provider in the Medical Assistance Program; and

WHEREAS, the Provider is enrolling with the Department of Human Services, Division of Rehabilitation Services (DHS-DRS) (hereinafter referred to as "Waiver Agency") as a provider in the Persons with Disabilities, Persons with Brain Injuries, and/or Persons with HIV/AIDS Wavers.

WHEREAS, the Provider wishes to submit claims for services rendered to eligible Healthcare and Family Services clients via the the Waiver Agency. The Provider is agreeing to permit the Waiver Agency to act on their behalf in enrolling the Provider as an Illinois Medical Assistance Program Provider. Under penalties of perjury, the Provider certifies that the information given to complete the enrollment is correct. The Waiver Agency will have authority to complete the electronic application using the Illinois Medical Assistance Program Advanced Cloud Technology (IMPACT) provider enrollment system. The Waiver Agency will maintain the provider's enrollment records in IMPACT including, but not limited to, updating information, making changes to the provider's enrollment status and revalidating enrollment information. The Waiver Agency will have legal authority to execute the terms and conditions of the Trading Partner agreement in the IMPACT Provider Enrollment System.

NOW THEREFORE, the Provider agrees as follows to the provisions:

1. The Provider shall, on a continuing basis, comply with all current and future program policy provisions as set forth in any applicable Program handbooks/agreements with the appropriate administering Waiver Agency, Illinois Medical Assistance or Waiver Agency, as appropriate, shall notify the Provider of changes in policy 30 days before the effective date of the change unless there is an emergency, as defined in the Administrative Procedure Act, or the change is to comply with State or Federal law or regulation.
2. The Provider shall, on a continuing basis, comply with applicable licensing or certification standards as contained in State laws or regulations.
3. The Provider shall comply with Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and regulations promulgated thereunder which prohibit discrimination on the grounds of sex, race, color, national origin or disability.
4. The Provider shall, on a continuing basis, comply with Federal standards specified in Title XIX on the Social Security Act, and also with all applicable Federal and State laws and regulations.
5. The Provider shall invoice Waiver Agency for Medical Assistance covered services; Waiver Agency will arrange payment for covered services from Illinois Medical Assistance, as is outlined in the Social Security Act, Section 1902 (a)(27) and (a)(32).
6. Payment to the Provider under this Agreement shall constitute payment in full. Any payments received by the Provider from other sources shall be shown as a credit and deducted from the Provider's charges.
7. The Provider shall be fully liable for the truth, accuracy, and completeness of all claims for payment submitted electronically or in hard copy. Furthermore, the Provider agrees to review, affix an original signature on, and retain in their files the billing certification. Any false or fraudulent claim or claims or any concealment of a material fact may be prosecuted under applicable Federal and State laws.
8. The Provider shall maintain all records necessary to fully disclose the nature and extent of services provided to individuals under Articles V, VI, and VII of the Public Aid Code. The Provider shall maintain said records for not less than six (6) years from date of service or as required by applicable Federal and State laws, whichever is longer, and shall furnish these records upon demand when so requested by Illinois Medical Assistance, the Waiver Agency or their designees. If an Illinois medical Assistance or a Waiver Agency audit is initiated, the Provider shall retain all original records until the audit is completed and every audit issue has been resolved, even it the retention period extends beyond the required period.

(Continued on next page)



State of Illinois
 Department of Human Services
 Division of Rehabilitation Services - Home Services Program
WAIVER PROGRAM PROVIDER AGREEMENT

(Waiver Program Provider Agreement - Continued)

9. If not a practitioner, the Provider shall comply with the Federal regulations requiring ownership and control disclosure found at 42 CFR part 455, Subpart B.
10. The Provider shall exhaust all other sources of reimbursement as required by medical Assistance Program policy prior to seeking reimbursement from Illinois Medical Assistance.
11. The Provider shall be fully liable to Illinois Medical Assistance and the Waiver Agency for any overpayments which may result from the Provider's billings to Illinois medical Assistance and the Waiver Agency. The Provider shall be responsible for promptly notifying Illinois Medical Assistance and the Waiver Agency of any overpayments of which the Provider becomes aware. Illinois Medical Assistance and the Waiver Agency shall recover any overpayments by setoff, crediting against future billings or by requiring direct repayment to Illinois Medical Assistance and the Waiver Agency.
12. There has not been a prohibitive transfer of ownership interest to or in the provider by a relative who is terminated or bared from participation in the Program pursuant to 305 ILCS 5/124.25.
13. The Provider shall furnish to Illinois Medical Assistance or the U.S. Department of Health and Human Services (Hereinafter referred to as "HHS") on request, information related to business transactions in accordance with 42CFR 455.105 paragraph (b). The Provider agrees to submit, within 35 days after the date of such information related to business transactions in accordance with 42 CFR 455.105 paragraph (b). The Provider agrees to submit, within 35 days after the date of such request by Illinois Medical Assistance or HHS, complete information about: (1) the ownership of any subcontractor with whom the Provider has had business transactions totaling more the \$25,000 during the 12 month period ending on the date of the request; and (2) any significant business transactions between the provider and any wholly owned supplier, or significant between the Provider and any subcontractor, during the 5 year period ending on the date of the request.
14. Knowingly falsifying or willfully withholding information on the Provider Enrollment Application and/or the Agreement for Participation may be cause for termination of participation in the Illinois Medical Assistance Program.
15. The Provider, if a Home Services Program provider per the definitions and requirements of 89 Ill. Administrative Code Part 686, shall maintain compliance with applicable parts of the most recently updated Attachment D to the Department of Human Services grant agreement - (available via <http://www.dhs.state.il.us/page.aspx?item=29741>).
16. The Provider (if a hospital, nursing facility, hospice, home health care provider, or personal care services provider) shall comply with Federal requirements, found at 42 CFR Part 489, Subpart I, related to maintaining written policies and providing written information to patients regarding advance directives.

The signature below certifies that the Provider agrees to all of the provisions as stated in the Waiver Program Provider Agreement for Participation in the Illinois Medical Assistance program.

Provider Name (Print Full Legal Name): _____

Last 4 digits of Social Security Number: _____

National Provider Identifier (NPI): _____
 (Applies only for CNA, LPN, and RN)

Provider Signature: _____

Date: _____

Note: This Form is applicable only to Individual Providers providing services under the Division of Rehabilitation Services, Home Services Program.



State of Illinois
 Department of Human Services
 Division of Rehabilitation Services - Home Services Program
IMPACT INDIVIDUAL PROVIDER ENROLLMENT FORM

DRS PROVIDER:
**THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND SIGNED
 OR IT MAY BE RETURNED. IF YOU ARE UNSURE OF HOW TO
 RESPOND, PLEASE WRITE N/A IN THE COMMENTS SECTION.**

A: Individual Provider Information (Please print clearly)		(For Office Use Only) Application ID:	
First Name:		Last Name:	
SSN:		Date of Birth:	
Street Address:		E-mail:	
City:		State:	
Zip Code:		County:	
Provider Type: PA <input type="checkbox"/> CNA <input type="checkbox"/> LPN <input type="checkbox"/> RN <input type="checkbox"/>	License Number (LPN/RN only):	NPI (CNA/LPN/RN only):	

B: Provider Questionnaire for PA

#	Questions	Yes	No	Comments
1.	Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the Requested Date in the comment field to be considered.	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Do you wish to end date your enrollment? If Yes, what date?	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Are you currently excluded from any Illinois or other state program? If Yes, provide state of exclusion and program.	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Are you currently excluded from any federal program? If Yes, provide the program and date.	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Have you ever had a criminal or healthcare program-related conviction? If Yes, provide type of conviction and date.	<input type="checkbox"/>	<input type="checkbox"/>	
6.	Have you ever had a judgment under any false claims act? If Yes, list judgment and date.	<input type="checkbox"/>	<input type="checkbox"/>	
7.	Have you been certified or recertified by Medicare within the last year? If Yes, provide date.	<input type="checkbox"/>	<input type="checkbox"/>	
8.	Have you been certified by another State's Medicaid Program? If Yes, provide each state and effective date of certification.	<input type="checkbox"/>	<input type="checkbox"/>	
9.	Have you ever had a program exclusion/debarment? If Yes, provide program and date.	<input type="checkbox"/>	<input type="checkbox"/>	
10.	Have you ever had civil monetary penalty? If Yes, provide penalty type and date.	<input type="checkbox"/>	<input type="checkbox"/>	
11.	Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	<input type="checkbox"/>	<input type="checkbox"/>	
12.	Are you a Home Health Agency, DME, Medigar, Taxi, Service Car or Ambulance providing non-emergency services and have you had the required fingerprinting completed? If Yes, with what vendor and date?	<input type="checkbox"/>	<input type="checkbox"/>	
13.	Are you a Medigar, Service Car or Taxi/Livery Company that is not registered with the Secretary of State? If Yes, provide the county clerk registration number.	<input type="checkbox"/>	<input type="checkbox"/>	
14.	Have you signed an agreement authorizing you or your organization to participate as an All Kids Application Agent? If Yes, enter the effective date of your participation.	<input type="checkbox"/>	<input type="checkbox"/>	
15.	Are you planning to provide services reimbursable through DoA, DCFS, DSCC, DHS/DASA, DHS/DRS, DHS/DMH, DHS/EI, DHS/DDD? If Yes, complete "Associate MCO Plan" step in Business Process Wizard.	<input type="checkbox"/>	<input type="checkbox"/>	
16.	Is your organization a health plan, LTC facility or other provider approved for an ABE provider portal account to assist individuals with eligibility for medical benefits? If yes, enter effective date of participation.	<input type="checkbox"/>	<input type="checkbox"/>	



State of Illinois
 Department of Human Services
 Division of Rehabilitation Services - Home Services Program
IMPACT INDIVIDUAL PROVIDER ENROLLMENT FORM

C: Provider Questionnaire for CNA/LPN/RN

	Questions	Yes	No	Comments
1.	Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the Requested Date in the comment field to be considered.	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Do you wish to end date your enrollment? If Yes, what date?	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Are you currently excluded from any Illinois or other state program? If Yes, provide state of exclusion and program.	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Are you currently excluded from any federal program? If Yes, provide the program and date.	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Have you ever had a criminal or healthcare program-related conviction? If Yes, provide type of conviction and date.	<input type="checkbox"/>	<input type="checkbox"/>	
6.	Have you ever had a judgment under any false claims act? If Yes, list judgment and date.	<input type="checkbox"/>	<input type="checkbox"/>	
7.	Have you been certified or recertified by Medicare within the last year? If Yes, provide date.	<input type="checkbox"/>	<input type="checkbox"/>	
8.	Have you been certified by another State's Medicaid Program? If Yes, provide each state and effective date of certification.	<input type="checkbox"/>	<input type="checkbox"/>	
9.	Have you ever had a program exclusion/debarment? If Yes, provide program and date.	<input type="checkbox"/>	<input type="checkbox"/>	
10.	Have you ever had civil monetary penalty? If Yes, provide penalty type and date.	<input type="checkbox"/>	<input type="checkbox"/>	
11.	Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	<input type="checkbox"/>	<input type="checkbox"/>	
12.	Have you had any malpractice settlement, judgment, or agreement? If Yes, provide dollar amounts and dates.	<input type="checkbox"/>	<input type="checkbox"/>	
13.	Are you a Home Health Agency, DME, Medica, Taxi, Service Car or Ambulance providing non-emergency services and have you had the required fingerprinting completed? If Yes, with what vendor and date?	<input type="checkbox"/>	<input type="checkbox"/>	
14.	Are you planning to provide services reimbursable through DoA, DCFS, DSCC, DHS/DASA, DHS/DRS, DHS/DMH, DHS/EI, DHS/DDD? If Yes, complete "Associate MCO Plan" step in Business Process Wizard.	<input type="checkbox"/>	<input type="checkbox"/>	
15.	Are you an APN (Certified RN Anesthetist, Nurse Midwife, Clinical Nurse Special, Nurse Practitioner) or Physician Assistant, and do you have a Collaborative Agreement? If Yes, provide NPI(s) of collaborating provider.	<input type="checkbox"/>	<input type="checkbox"/>	
16.	Are you a Nurse Midwife, with hospital admitting and/or delivery privileges? If Yes, list name and address of all facilities.	<input type="checkbox"/>	<input type="checkbox"/>	
17.	Are you a Certified Registered Nurse Anesthetist without a collaborative agreement? If Yes, list names and addresses of all facilities where you practice.	<input type="checkbox"/>	<input type="checkbox"/>	
18.	Is Child/Adolescent Psychiatry Residency or General Psychiatry Residency your subspecialty? If Yes, enter the place of your psychiatric residency and type(s).	<input type="checkbox"/>	<input type="checkbox"/>	
19.	Are you a radiologist, hospital (outpatient), Imaging Center or Independent Diagnostic Testing Facility, and are participating or wish to participate in the Breast Cancer Quality Screening Program?	<input type="checkbox"/>	<input type="checkbox"/>	
20.	Are you a Physician, Hospital, FQHC, ERC, Medichex Clinic, RHC, Home Health Agency, Community Health Agency, Certified Health Dept. or School Based/Linked Clinic, and are participating or wish to participate in the MPE Program?	<input type="checkbox"/>	<input type="checkbox"/>	
21.	Is your organization a health plan, LTC facility or other provider approved for an ABE provider portal account to assist individuals with eligibility for medical benefits? If yes, enter effective date of participation.	<input type="checkbox"/>	<input type="checkbox"/>	
22.	Are you enrolled in the Designated Family Planning Provider/Clinic Program? If Yes, provide enrollment date and approving agency.	<input type="checkbox"/>	<input type="checkbox"/>	
23.	Are you enrolled in the Vaccines for Children Program (VFC) and have a specialty/subspecialty other than OB, GYN, OB/GYN? If Yes, provide enrollment date.	<input type="checkbox"/>	<input type="checkbox"/>	



Do not return following documentation to the local DRS office! The forms below are to be kept for informational and future purposes.

- ! IMPACT IP Form Instructional Sheet
- ! IL488-2399 – Report of Injury to a Provider
- ! Timesheet Instructions
- ! Understanding Work Week vs Pay Period
- ! HSP Provider Payroll Schedule
- ! Santrax (EVV) Call Reference Guide
- ! C-95A – Direct Deposit Form
- ! IL444-0800 – Debit Card Application
- ! CDC Clean Hands Count Flyer
- ! Official SEIU Healthcare Brochure

IMPACT INDIVIDUAL PROVIDER ENROLLMENT FORM INSTRUCTIONS FOR COMPLETION

The following is a guide to assist Individual Providers to correctly complete the IMPACT Individual Provider Enrollment Form and the Notice of Waiver Program Provider Agreement.

IMPACT INDIVIDUAL PROVIDER ENROLLMENT FORM (IL488-2263)

- **ALL** Individual Providers are required to complete Section A of the IMPACT Individual Provider Enrollment Form
- **Personal Assistants** are required to complete Section A & B of the IMPACT Individual Provider Enrollment Form
- **CNAs, LPNs and RNs** are required to complete Section A & C of the IMPACT Individual Provider Enrollment Form
- If you are an Individual Provider who provides more than one service type, please select your highest discipline.
Ex: You are a PA and a CNA, please follow the requirements and complete the form based on the highest discipline selected.
- LPNs and RNs must provide a valid License Number to show they are certified.
- NPI (National Provider Identifier) is required for all CNA*, LPN and RNs to be enrolled in the IMPACT System. ***NOTE:** A NPI for CNA's is optional at this time and only required if you currently have one.
- If you do not have an NPI< please obtain one at <https://nppes.cms.hhs.gov> or visit <http://drs.illinois.gov/hsp/impact> to find out how to obtain an NPI.

IMPACT WAIVER PROGRAM PROVIDER AGREEMENT (IL488-2262)

- **ALL** Individual Providers must print full legal name, last 4 digits of SSN, sign and date IL488-2262.
- CNAs*, LPNs, and RNs must also include their NPI number.

Personal Assistant (PA):

A: Individual Provider Information

Please complete all of your basic information in Section A.

Personal Assistants can leave the following blank:

- a. Application ID *(For Office Use Only)*
- b. License Number *(For LPN/RN Only)*
- c. NPI *(For CNA*/LPN/RN Only)*

B: Provider Questionnaire for PA

Please respond to all 16 questions in Section B.

If you are unsure of how to answer any of the questions, please respond with N/A under Comments.

C: Provider Questionnaire for CNA/LPN/RN

Skip Section C.

IMPACT INDIVIDUAL PROVIDER ENROLLMENT FORM

INSTRUCTIONS FOR COMPLETION

CNA:

A: Individual Provider Information

Please complete all of your basic information in Section A.

CNAs can leave the following blank:

- a. Application ID *(For Office Use Only)*
- b. License Number *(For LPN/RN Only)*

B: Provider Questionnaire for PA

Skip Section B.

C: Provider Questionnaire for CNA/LPN/RN

Please respond to all 23 questions in Section C.

If you are unsure of how to answer any of the questions, please respond with N/A under Comments.

LPN/RN:

A: Individual Provide Information

Please complete all of your basin information in Section A.

LPN/RN can leave the following blank:

- a. Application ID *(For Office Use Only)*

B: Provider Questionnaire for PA

Skip Section B.

C: Provider Questionnaire for CNA/LPN/RN

Please respond to all 23 questions in Section C.

If you are unsure of how to answer any of the questions, please respond with N/A under Comments.

PLEASE NOTE:

National Provider Identifier (NPI):

If you are a CNA*/LPN/RN applying for a NPI number, the online application at <https://nppes.cms.hhs.gov> will require the entry of Taxonomy Code to process your request. The following Taxonomy Codes are recommended based on your Provider Type:

CNA: 376K00000X
LPN: 164W00000X
RN: 163W00000X

***NOTE:** A NPI is optional for CNA's at this time and only required if you currently have one.



REPORT OF INJURY TO AN INDIVIDUAL PROVIDER

A report of a work-related injury must be completed within 24 hours of the event. Please call the HSP representative to report the incident, then complete the following questions and fax or mail immediately to IDHS-DRS, HSP Labor Relations, 100 South Grand Ave. E., P.O. Box 19429, Springfield, IL 62794-9429, or 217/557-9434 (Fax).

Individual Providers who are injured in the home and work for an agency should report the injury to their employer.

This form covers only Personal Assistants, Private Duty Certified Nurse Aides, Private Duty Licensed Practical Nurses, Private Duty Registered Nurses, Private Duty Physical Therapists, Private Duty Occupational Therapists, and Private Duty Speech Therapists who are paid through the Home Services Program.

(YOU MUST COMPLETE ALL QUESTIONS)

1. Name of the Individual Provider who was injured: _____

2. Address of the Individual Provider: _____

3. Date of birth: _____ Social Security Number: _____

4. Phone Number of Individual Provider: _____

5. Location and address where the injury occurred: _____

6. Describe how the injury occurred:

7. Explain the type of injury sustained:

8. Was there any lost work time? Yes No If so, when did they resume work? _____

9. Date of the injury: _____

10. Time of the injury: _____

11. Name and HSP case number of customer served at time of incident: _____

Printed Name of Person Reporting the Injury

Signature of Person Reporting the Injury

Date

Time Sheet Instructions

Note: Individual Providers must call in and out using the EVV System and record the times accurately.

All fields required to be completed in order for timesheet to be processed.

State of Illinois
Department of Human Services - Division of Rehabilitation Services
Home Services Program Time Sheet

District: 344 **1**

Case Number: 04928401 Worker SSN: 123-45-6789
Customer Name: John Smith Worker Name: MARY JONES
Address: 123 Main St. Apt. #: 4 Home Address: 1 W. Capitol Apt. #: _____
City/Zip Code: Bloomington, IL 61701 City/Zip Code: MOLTA, IL 61759 **3**
Phone: 309 782-2722 Phone: 309 449-0300
 Information has changed since last time sheet was submitted. Information has changed since last time sheet was submitted.
NOTE: Check will be mailed to individual Provider's home address

Month: July Year: 2014 **4**
Dates: (check box) _____ Indicate AM or PM with each start and stop time

	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Start	Stop	Start	Stop	Start	Stop	Daily Total
5 X Personal Assistant	1st	16th	9:02am	11:30am					
<input type="checkbox"/> Certified Nurse Assistant	2nd	17th	9:00am	11:31am					
	3rd	18th							
	4th	19th							
Rate: _____	5th	20th							
<input type="checkbox"/> Licensed Practical Nurse	6th	21st							
Rate: _____	7th	22nd	8:30am	11:35am					
<input type="checkbox"/> Registered Nurse	8th	23rd	8:45am	11:49am					
	9th	24th	8:49am	11:16am					
Rate: _____	10th	25th							
<input type="checkbox"/> Physical or Occupational Therapist	11th	26th							
	12th	27th							
Rate: _____	13th	28th	8:31am	11:33am					
<input type="checkbox"/> Speech Therapist	14th	29th	8:30am	11:31am					
	15th	30th							
Rate: _____	31st								
									Pay Period Total

6

CUSTOMER/INDIVIDUAL PROVIDER CERTIFICATION FOR SERVICES RENDERED
I certify that the above information is true and in accordance with the Individual Provider Payment Policies (IL488-2252). I understand falsification of any information submitted on this form could lead to criminal prosecution.
Worker Signature: Mary Jones Date: July 18, 2014
I certify that the above information is true and that services were received as stated. I understand falsification of any information submitted on this form could lead to criminal prosecution.
Customer Signature: John Smith Date: July 18, 2014
8 ----- FOR OFFICE USE ONLY -----
DHS Payment Approval: _____ Date: _____ Gross: _____ Auth: _____

IL488-2251 (R-7-12) - Home Services Program Time Sheet
Printed by the Authority of the State of Illinois P.O. #13-0094 350,000 Copies Page 1 of 1

- 1** Enter the three digit district number
- 2** Enter Case Number, Customer Name, Address, Zip Code, and current Phone Number. Mark the box if this information has changed.
- 3** Enter Worker SSN, Worker Name, Address, Zip Code and current Phone. Mark the box if the information has changed
- 4** Enter the month and the year that the service was provided.
- 5** If you are working as something other than a P.A., please check the box.
- 6** List the exact time provided to you via the EVV system. Do NOT round!
- 7** Worker Signature and Date
- 8** Customer Signature and Date

Helpful Hints

- Write the exact time as provided by the EVV system.
- Consider using a highlighter to note changes in address or rate of pay.
- Use black or blue ink.
- Complete the timesheet in full; failure to do so may delay payment.

EVV Phone Numbers

English	Spanish	Multiple Customers in Home
1-855-347-1770	1-855-347-0771	1-844-604-7391
1-855-573-0726	1-855-573-1726	1-844-786-7495

PROVIDER HOTLINE

Call this number
FIRST for information
about your checks.

1-800-804-3833

Understanding a Work Week vs. a Payroll Period

HSP Calendar						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
The Work Week - Sunday at 12:00am through Saturday at 11:59pm						
13	14	15	16	17	18	19
20	21	22	23	24	25	26
The Payroll Period - the 1st - 15th and the 16th - last day of the month.						
27	28	29	30	The payroll period and the work week sometimes overlap.		

What is a Work Week?

A week that begins Sunday at 12:00 a.m. (midnight) and ends each Saturday at 11:59 p.m.

What is a Payroll Period?

A payroll period is the 1st of the month through the 15th of the month and the 16th of the month through the last day of the month. A payroll period and work week will sometimes overlap.

How do I know if I am complying with the service plan hours?

You and your Customer may wish to plan your service hours on a calendar. Remember: a calendar week is a work week.



Home Services Program Individual Provider Payroll Schedule 2020

Pay Period	Time Sheets Due	PA Hotline	Pay Date
December 16-31, 2019	January 1 - 8	January 15	January 28
January 1-15	January 16 - 23	January 30	February 13
January 16-31	February 1 - 7	February 14	February 28
February 1-15	February 16 - 25	February 28	March 13
February 16-28	March 1- 7 *	March 13	March 27
March 1-15	March 16 - 22	March 31	April 13
March 16-31	April 1 - 7	April 15	April 28
April 1-15	April 16 - 22	April 30	May 13
April 16-30	May 1 - 7	May 14	May 28
May 1-15	May 16 - 22	May 29	June 12
May 16-31	June 1 - 7 *	June 15	June 26
June 1-15	June 16 - 22	June 29	July 13
June 16-30	July 1 - 8	July 15	July 28
July 1-15	July 16 - 22	July 31	August 13
July 16-31	August 1 - 7	August 14	August 28
August 1-15	August 16 - 22 *	August 28	September 11
August 16-31	September 1 - 9	September 15	September 28
September 1-15	September 16 - 22	September 30	October 13
September 16-30	October 1 - 7	October 15	October 28
October 1-15	October 16 - 22	October 29	November 13
October 16-31	November 1 - 7 *	November 12	November 25
November 1-15	November 16 - 22 *	November 30	December 11
November 16-30	December 1 - 7	December 10	December 23
December 1-15	December 16 - 22	December 30	January 13
December 16-31	January 1 - 8, 2021	January 14	January 28

**Timesheet due date falls on a weekend. Please ensure timesheets are signed and delivered prior to the stated deadline to guarantee timely payment.*

Provider Assistance Hotline:
1-800-804-3833 or
1-877-434-1082 (TTY)

Useful Tips:

To ensure successful speaker verification, follow these useful tips:

- ⚡ Speak Normally
 - Don't change the normal rhythm or volume of your voice.
- ⚡ Speak Clearly
 - Don't whisper or chew during the Santrax call.
- ⚡ Use Your Phone's Handset
 - Avoid using speakerphone, cordless or wireless phones.
- ⚡ Avoid Noisy Environments
 - Eliminate all background noise by staying away from TV, Radios or other sources of noise.

What to do if there is a

Problem:

These are some possible problems you may experience when using the telephone.

- ⚡ Busy Signal
- ⚡ No Answer

1. Check the number to make sure you have the right phone number.
2. Try calling again.
3. Try calling the second toll-free number provided of the front page of this guide.
4. If you still cannot complete the call, Please call the DHS EVV Help Line at 1-888-713-5139.

⚡ If the system says: “**Sorry, Invalid Number**”

See if the phone has a **T-P** (Tone-to-pulse) switch; make sure the switch is on **T**. If there is no switch, you must say your ID number one digit at a time, into the phone after the tone.

Call Reference Guide

Write your Santrax ID number above for easy reference.

Dial:

1-855-347-1770

or

1-855-573-0726

Calling Instructions

Calling Santrax: When arriving at, or leaving the customer's home, make sure you have the following information:

Calling IN:

- Your Santrax ID.

Calling OUT:

- Your Santrax ID.



- Dial any of the toll-free numbers located on the front page of this guide.**



Santrax will say: "Welcome, please enter your Santrax ID."

If you are experiencing difficulties with the first toll-free number, please use the second toll-free number.



- Press the numbers of your Santrax ID on the touch tone phone.**



Santrax will say: "To verify your identity, please repeat: At Santrax, my voice is my password."

NOTE: *If you have not been enrolled in Speaker Verification, Santrax will skip this prompt. If this is the case, skip step 3, and then continue with the next prompt.*



- Say "At Santrax, my voice is my password"**

The Santrax system may ask you to repeat the phrase several times before verifying your identity.

Calling Instructions

Santrax will say: "If this is a Fixed Visit Verification visit using the FVV device, press the star (*) key to enter the visit verification numbers. Otherwise, press the pound (#) key to continue."



If this is an FVV Call, press the star () key and refer to the FVV Call Reference Guide for detailed instruction for the FVV call process. If this is not an FVV call, press pound (#) and continue.*



- Press the pound (#) key to continue.**



Santrax will say: "Please select "1" to call in or "2" to call out."



- Press the one (1) key to "Call In".**

Or



Press the two (2) key to "Call Out".



Santrax will say: "Received at (TIME). Enter number of tasks."

NOTE: *If you are placing the in call, HANG UP NOW.*

Tasks are only entered on the out call.

Calling Instructions



- Press one (1) to indicate you will be entering one task.**



Santrax will say, "Enter task ID"



- Press the Task Number you performed.**

NOTES:

- Refer to your **Task Reference Chart** below.
- If you made a mistake entering the task, press "00", the system will confirm by saying: "Starting Over, Enter number of tasks".*



Santrax will say: "You entered one task."



- Hang up.**

Task Reference Chart

Task ID	Description
11	CNA
12	LPN
13	Personal Assistant
14	RN

STATE OF ILLINOIS

IMPORTANT NOTICE: This form is to be used only for State of Illinois Recurring Payments.

If you wish your payments sent to your financial institution for deposit into your savings or checking account, you must complete this form to authorize this action. Some agencies may require your financial institution to verify routing and account information. The State Comptroller will forward your recurring payments to the destination you authorize. The financial institution may be any bank, savings bank, savings and loan association or similar institution, or Federal- or state-chartered credit union that is a member of the Automated Clearing House Access Program. If you do not have an account at such a facility, you must contact a qualifying financial institution and establish an account prior to enrolling for direct deposit.

INSTRUCTIONS

Please type or print in ink all information requested.

1. Type or print the payee's Social Security Number. Do not include dashes.
2. Type or print the name of the person to whom the payment is made. This is the Payee Name except where a representative payee has been appointed or a guardian or conservator has been appointed by a Court.
3. Type or print the Name of Program Agency.
4. Type/Print Payee Name in the space provided, sign where indicated (Signature of Payee) and print Date.
5. Type or print the Work Area Code and Telephone Number of the payee or a number where the payee can be reached during the day.
6. Type or print the Name of Financial Institution in which the payee's account resides.
7. Type or print the Financial Institution Area Code and Telephone Number.
8. Type or print the financial institution Branch Address, City, State, Zip Code where the payee's account resides.
9. Type or print the 9-digit Financial Institution Routing Number that appears at the bottom of the payee's printed checks. (The program agency may require the payee to have this information verified by the financial institution prior to submitting the authorization form.)
10. Type or print the Payee Account Number that also appears at the bottom of the payee's printed checks. The number of digits varies among institutions.
11. You must select one account type to receive recurring payments (**Checking or Savings**). Payee must indicate which one of his accounts (Savings or Checking) should receive the recurring direct deposits.
12. Attach a voided check before submitting this completed form to your agency's payroll clerk. Do not substitute a deposit slip for the voided check. Financial institutions may alter numbers that appear on deposit slips for internal purposes.

CANCELLATION INSTRUCTIONS

When entered in the payee's record with the program agency, this authorization will remain in effect until canceled by notice to the program agency by the payee or in the event of death of the payee or the beneficiary of this payment. The financial institution should also be notified if the payee cancels this agreement. The financial institution may cancel their agreement by providing the payee with a written notice 30 days in advance of the cancellation date. The payee must advise the program agency immediately if this authorization is cancelled. The financial institution cannot cancel this authorization by advice to the program agency.

Privacy Act Notice:

You previously provided your Taxpayer Identification Number (TIN), i.e. your social security number or your employer identification number, to the State of Illinois upon becoming a State of Illinois payee. Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons, such as the State of Illinois Office of the Comptroller, who must file documents with the Internal Revenue Service to report income paid to you, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA. The Illinois Office of the Comptroller, as administrator of the direct deposit program, requests verification of your TIN on the Authorization for Deposit of Recurring Payments. Your TIN verification enables proper payee identification and corresponding direction of payments as specified on your completed Authorization for Deposit of Recurring Payments. While not mandatory, failure to provide your TIN on the Authorization precludes your participation in the direct deposit program.



Illinois Debit MasterCard Payment Option Form

If you chose the Illinois Debit MasterCard[®] Card, we will update our records and you will receive your Illinois Debit MasterCard in the mail. Activate your card immediately by calling the toll free number (1-866-338-2944) and follow the instruction on the materials enclosed with your card. Make sure we have your correct address. Your card will not be forwarded.

In order to get a Illinois Debit MasterCard:

- * **Attach a copy of your current Driver's License or State I.D. card**
- * You MUST fill in all the blanks in the section you are completing (Section 1 to start card use, section 2 to stop card use.)
- * All information must be clear and readable
- * Once you choose the Illinois Debit MasterCard your payments will continue on the card until a written cancellation Payment Option Form is received and processed at DHS.
- * You MUST send the form to:

Department of Human Services
Bureau of Expenditure Accounting Debit Card Project
100 South Grand Ave. East, 1st Floor
Springfield, Illinois 62762

COMPLETE ONLY ONE SECTION BELOW: If you want to **START** using the Illinois Debit MasterCard, complete section 1. If you have a card now and wish to **STOP** using it, complete Section 2.

SECTION 1 (To request a new Illinois Debit MasterCard)

Illinois Debit MasterCard[®] Card Payment Option - All blanks in this section below MUST be completed

(Choose your Provider type) **Child Care Provider** **PA - DRS Personal Assistant**

Social Security Number: _____ Daytime Phone: _____ *Enter "N/A" if you do not have a phone*
(Include area code)

Enter your name below as it appears on your Social Security Card or on your current IDHS payment checks:

Last Name: _____ First Name: _____ Middle Initial: _____

Doing Business As Name: _____ (Use this line for your DBA, if licensed with one)

Mailing Address: (Indicate Street, Apartment Number, Floor)

_____ (Street # and Name: with St. Ave, Ct, Apt. #, Floor)

City: _____ State: _____ Zip Code: _____

I authorize the State of Illinois Office of the Comptroller to direct payment for deposit to the Illinois Debit MasterCard card account as directed by the paying State agency. I understand the card will be sent to me by mail and my payments will be held by the bank until I withdraw them using my Illinois Debit MasterCard card. I further authorize the Comptroller to initiate, if necessary, debit entries and adjustments for any credit entries in error. This authorization is applicable to all Child Care and Personal Assistants payments issued by the Comptroller to the below named payee as identified by its designated payee identification number.

I understand the Illinois Debit MasterCard is issued by Comerica Bank, pursuant to a license by MasterCard International Incorporated. I further certify that I am at least 18 years of age.

Signature: _____ Date: _____

With this signature, I certify that the information provided above is accurate.

All blanks above MUST be completed in order to request a Illinois Debit MasterCard.

SECTION 2 (To cancel your Illinois Debit MasterCard)

I would like to CANCEL use of my Illinois Debit MasterCard and receive my payments the way I did before requesting the Debit card (either paper check or Direct Deposit).

If you were using Direct Deposit, and that bank account is now closed, your next payment may be delayed and possibly will come in the mail. Child Care providers must contact The Office of the Comptroller Direct Deposit Unit at (217) 557-0930 if the account has changed or closed. Personal Assistants must contact the DRS Local Office if there have been any changes to your bank account since the last time you received Direct Deposit in order to avoid delays.

Reason for Card Cancellation _____

Print Your Name: _____ Social Security Number: _____

Signature: _____ Date: _____

Please retain your Illinois Debit MasterCard until you receive your next payment by check or direct deposit.

CLEAN HANDS COUNT

FOR HEALTHCARE PROVIDERS

KNOW THE **TRUTH** TO PROTECT YOURSELF AND PROTECT YOUR PATIENTS

TRUTH:

Alcohol-based hand sanitizer is more effective and less drying than using soap and water.

THE NITTY GRITTY:

Compared to soap and water, alcohol-based hand sanitizers are better at reducing bacterial counts on hands and are effective against multidrug-resistant organisms (e.g., MRSA). Additionally, alcohol-based hand sanitizers cause less skin irritation than frequent use of soap and water.



TRUTH:

Using alcohol-based hand sanitizer does NOT cause antibiotic resistance.

THE NITTY GRITTY:

Alcohol-based hand sanitizers kill germs quickly and in a different way than antibiotics. There is no chance for the germs to adapt or develop resistance.

TRUTH:

Alcohol-based hand sanitizer does not kill *C. difficile*, but it is still the overall recommended method for hand hygiene practice.

THE NITTY GRITTY:

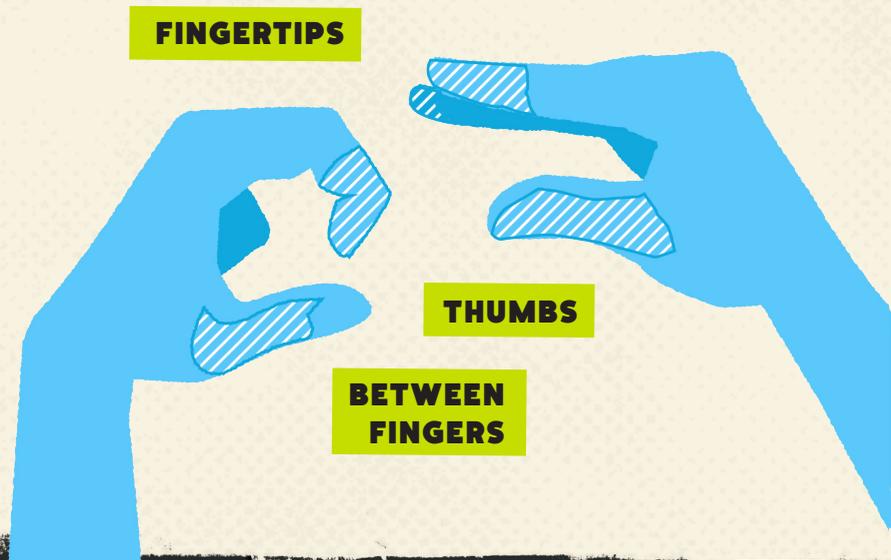
Always use gloves when caring for patients with *C. difficile*. In addition, when there is an outbreak of *C. difficile* in your facility, wash your hands with soap and water after removing your gloves.

TRUTH:

Some healthcare providers miss certain areas when cleaning their hands.

THE NITTY GRITTY:

Using alcohol-based hand sanitizer becomes a habit and sometimes healthcare providers miss certain areas:



Clean Hands Count 100% of the Time

PROTECT YOURSELF AND PROTECT YOUR PATIENTS FROM POTENTIALLY DEADLY GERMS

TRUTH:

The amount of product you use matters.

THE NITTY GRITTY :

Use enough alcohol-based hand sanitizer to cover all surfaces of your hands. Rub your hands together until they are dry. Your hands should stay wet for around 20 seconds if you used the right amount.

TRUTH:

Glove use is not a substitute for cleaning your hands. Dirty gloves can soil your hands.

THE NITTY GRITTY :

Clean your hands after removing gloves to protect yourself and your patients from infection.

TRUTH:

On average, healthcare providers perform hand hygiene less than half of the times they should.

THE NITTY GRITTY :

When healthcare providers do not perform hand hygiene 100% of the times they should, they put themselves and their patients at risk for serious infections.



www.cdc.gov/HandHygiene

