IMPACT Revalidation Packet

Mandatory Revalidation Documentation	Who Signs It?
IL488-1413: HSP Provider Agreement	**Provider**
IL488-2262: Waiver Program Provider Agreement	**Provider**
IL488-2263: IMPACT IP Enrollment Form	**Provider**
IL488-2252: Individual Provider Payment Policies	**Provider & Customer**
Valid Government Issued Photo ID – E.g., Driving License	**Provider**
Social Security Verification proof – E.g., SSN	**Provider**

Instructions

1. Sign and date all documents.
2. Return completed documents to your local field office before the revalidation due date.
3. All documents are required for Revalidation.
4. IL488-2252 form must be completed for each customer the IP is working for.

State of Illinois
Department of Human Services - Division of Rehabilitation Services

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)

☐ Personal Assistant (PA) ☐ Certified Nursing Assistant (CNA) ☐ Registered Nurse (RN) ☐ Licensed Practical Nurse (LPN)

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: _____

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

WAIVER PROGRAM PROVIDER AGREEMENT

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
(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

(For Office Use Only)

Instructions for Completing this Form

Personal Assistants, CNA, LPN, RN are required to:

1. Section A: Answer all questions.
2. Section B: Answer all questions.
3. Section C: Answer all questions if you are an LPN or RN.
   - Must provide a valid License Number to show they are certified.
   - NPI (National Provider Identifier) is required to be enrolled in the IMPACT System.

   If you do not have an NPI, please obtain one at https://nppes.cms.hhs.gov
   - Use below Taxonomy Codes are based on your specialty.
     - **LPN :** 164W00000X **RN :** 163W00000X
4. Section D**:** Answer all questions.
   - If you are unsure of how to answer any of the questions, please respond with **N/A under Comments**.
5. **Sign bottom of all pages.**

A: Individual Provider Information (Print Clearly)

First Name:	Last Name:	
Last Four of SSN:	Date of Birth:	
Street Address:	E-mail:	
City:	State:	Zip Code:
Home Phone:	Cell Phone:	

B. Provider Information

Provider Type: PA ☐ CNA ☐ LPN ☐ RN ☐	**Gender at Birth:** Male ☐ Female ☐	**Gender Identity:** Man ☐ Woman ☐ Non-binary ☐ Gender Non-Conforming ☐ Other ☐ Prefer Not to Answer ☐	
Communication Preference: Cell Phone ☐ Home Phone ☐ Email ☐ Text ☐ TTY ☐ Video Phone ☐	**Preferred Pronoun:** He/His ☐ She/Her ☐ They/Their ☐ Other ☐ Prefer not to answer ☐	**Language Preferences:** English ☐ Spanish ☐ Other ☐	Mailing Preferences: Braille ☐ Large Print ☐

C: LPN/RN Information

License Number (LPN/RN only):	NPI (LPN/RN only):	Additional Notes:(if any)

Sign Below

Provider Signature: _____ Date: _____

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

IMPACT INDIVIDUAL PROVIDER ENROLLMENT FORM

D: Questionnaire for PA/CNA/LPN/RN (If you're unsure of how to respond, please comment N/A)

	QUESTIONS	YES	NO	COMMENTS
1.	If you are an out of state provider that provided emergent care to an Illinois Medicaid participant, you can request a retroactive enrollment back to the date the services were provided. If yes, enter the requested date to be considered in the comment field. Enrollment applications must be submitted within 45 days of the date of service to be considered for a retroactive enrollment date.	☐	☐	
2.	Do you wish to end date your enrollment? If yes, what date?	☐	☐	
3.	Are you currently excluded from any Illinois or other state program? If yes, provide state of exclusion and program.	☐	☐	
4.	Are you currently excluded from any federal program? If yes, provide the program and date.	☐	☐	
5.	Have you ever had a criminal conviction? If yes, provide type of conviction and date.	☐	☐	
6.	Have you ever had a judgment under any false claims act? If yes, list judgment and date.	☐	☐	
7.	Have you been certified or re-certified by Medicare within the last year? If yes, provide date.	☐	☐	
8.	Have you been certified by another State's Medicaid Program? If yes, provide each state and effective date of certification.	☐	☐	
9.	Have you ever had a program exclusion/debarment? If yes, provide program and date.	☐	☐	
10.	Have you ever had civil monetary penalty? If yes, provide penalty type and date.	☐	☐	
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.	☐	☐	
12.	Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates.	☐	☐	
13.	Are you an APN (Certified RN Anesth., Nurse Midwife, Clinical Nurse Special, NP) or a Board-Certified Behavior Analyst or Registered Behavior Technician employed outside of a BHC and you have a Collaborative Agreement? If yes, provide NPI(s) of collaborating provider.	☐	☐	
14.	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.	☐	☐	
15.	Do you carry professional liability insurance? If yes, please provide the name of your carrier and the policy coverage limit per occurrence and in aggregate.	☐	☐	
16.	If enrolling as a Pharmacist, have you completed ACPE accredited training program related to the initiation, dispensing, or administration of drugs, laboratory tests, assessments, referrals, and consultations for HIV? If yes, enter the date you completed the training	☐	☐	
17.	If enrolling as a Pharmacist, have you completed an ACPE accredited training program related to patient self-screening risk assessment, patient assessment contraceptive counseling and education, and dispensation of hormonal contraceptives? If yes, enter the date you completed the training.	☐	☐	

Provider Signature: _____ Date: _____

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

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 _____