



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.
 - o Must provide a valid License Number to show they are certified.
 - o 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>

- o Use below Taxonomy Codes are based on your specialty.
 - **LPN** : 164W00000X **RN** : 163W00000X
- 4. Section D: Answer all questions.
 - o 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 <input type="checkbox"/> CNA <input type="checkbox"/> LPN <input type="checkbox"/> RN <input type="checkbox"/>	Gender at Birth: Male <input type="checkbox"/> Female <input type="checkbox"/>	Gender Identity: Man <input type="checkbox"/> Woman <input type="checkbox"/> Non-binary <input type="checkbox"/> Gender Non-Conforming <input type="checkbox"/> Other <input type="checkbox"/> Prefer Not to Answer <input type="checkbox"/>	
Communication Preference: Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Email <input type="checkbox"/> Text <input type="checkbox"/> TTY <input type="checkbox"/> Video Phone <input type="checkbox"/>	Preferred Pronoun: He/His <input type="checkbox"/> She/Her <input type="checkbox"/> They/Their <input type="checkbox"/> Other <input type="checkbox"/> <input style="width: 100px; height: 20px;" type="text"/> Prefer not to answer	Language Preferences: English <input type="checkbox"/> Spanish <input type="checkbox"/> Other <input type="checkbox"/> <input style="width: 100px; height: 20px;" type="text"/>	Mailing Preferences: Braille Large Print

C: LPN/RN Information

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

Provider Signature: _____ Date: _____



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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.	<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 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 re-certified 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 amount and dates.	<input type="checkbox"/>	<input type="checkbox"/>	
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.	<input type="checkbox"/>	<input type="checkbox"/>	
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.	<input type="checkbox"/>	<input type="checkbox"/>	
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.	<input type="checkbox"/>	<input type="checkbox"/>	
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	<input type="checkbox"/>	<input type="checkbox"/>	
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.	<input type="checkbox"/>	<input type="checkbox"/>	

Provider Signature: _____

Date: _____