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

PROVIDER BACKGROUND SCREENING WAIVABLE CONVICTIONS - CONSENT FORM

Dear Customer:

A prospective Individual Provider (IP) must enroll and be approved in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system to work for you. The IMPACT system has a criminal background screening procedure. Your prospective IP

____ most recently completed the IMPACT background screening on, _______________

and it returned crime(s) that can be "waived" by the Customer.

The background screening results have been verified as accurate by direct confirmation from the IP, or through a second background screening verification.

The crime(s) reported for the provider are:

☐ **I CONSENT** • I elect **TO** hire an IP. • IP **can be paid** by HSP after approval notification to the Customer.	• I have reviewed the information provided to me regarding the enrollment. • I have received and reviewed the Waivable Convictions notification letter that lists the crime(s). • I have received and reviewed the completed IL488-2540, the Dispute form. • I have received and reviewed all additional information requested by, and/or provided to me, from HSP or the IP. • I have enough information to make an informed choice.
☐ **I DO NOT CONSENT** • **I elect NOT to hire this IP** and will find another IP. • **IP will not be able to be paid** by HSP. • No Response will be considered "I Do Not Consent"	• I have reviewed the information provided to me regarding the enrollment. • I have received and reviewed the Waivable Convictions notification letter that lists the crime(s). • I have received and reviewed the completed IL488-2540, the Dispute form. • I have received and reviewed all additional information requested by, and/or provided to me, from HSP or the IP. • I have enough information to make an informed choice.
☐ **NEW SCREENING REQUEST** • **I elect to get an updated screening** results for this IP.	• I request HSP to run a new screening for this provider. • I understand that new screening results may not have any changes.

____
Individual provider Name:

______________________________ ______________________________ ______________________________
Customer Name: Customer Signature: Customer Signature Date:

Please complete and return this form to your local DRS office or to:

HSP IMPACT UNIT
Provider Background Screening
100 S Grand Ave E, 1st FL
Springfield, IL 62762