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

PROVIDER BACKGROUND SCREENING (REVALIDATION) NON-WAIVABLE CONVICTIONS - CONSENT FORM

Date:_____

Dear Customer:

You were previously notified of Individual provider (IP)_____ having non-waivable crimes. These crimes were reviewed by Healthcare and Family Services (HFS) Office of the Inspector General (OIG).

OIG advised that they will not prevent the provider from working. You have a **choice to retain or discontinue this provider**. If you choose to retain this provider with crimes as listed below you must complete this consent form and return within 20 business days from the date of this form.

The crime(s) reported for the provider are:

☐ **I CONSENT** • I elect **to retain this IP.** • **IP can continue to be paid by HSP.**	• I have reviewed the information provided to me regarding the revalidation. • I have received and reviewed the Non-Waivable convictions Notification letter (Revalidation) that lists the crime(s). • I have received and reviewed the completed IL488-2540R, the Revalidation - 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 retain this IP** and will find another IP. • **IP will no longer 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 revalidation. • I have received and reviewed the Revalidation - Non-Waivable Convictions Notification Letter that lists the crime(s). • I have received and reviewed the completed IL488-2540R, the Revalidation - 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.

Individual Provider Name

Customer Name | 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 Floor
Springfield IL 62762