State of Illinois
Department of Human Services - Division of Developmental Disabilities

HOME-BASED SUPPORT SERVICES (HBS) SERVICE AGREEMENT

Instructions:

A. Each service provider must have a completed Service Agreement.
B. Services and their amounts will be in accordance with the individual's personal plan.
C. Providers may not exceed Monthly Service Amount(s).
D. All parties signing the service agreement should retain their own copies for a minimum of **three** years.

1. **Individual Information:**
List the Individual's name, social security number, phone number, and email (if applicable). If someone other than the individual completes this form, list the Preparer's name, phone number, relationship to the Individual and email.

2. **Service Agreement:**
Please check off only one box:
Type of Submission: ☐ Initial/New Services ☐ Change to Services ☐ Termination of Services

Initial/New Services - defined as new to Home-Based Services or adding new services.
Changes to Services - defined as going from children to adult, service rate change or monthly service amount changes.
Termination of Services - defined as ending services with a Service Provider.
Start Date of Services - enter the date the Individual started services.
End Date of Services - enter in the date the Individual stopped services. (write N/A if end date is unknown)

- Service provider: list the name of the provider agency or individual provider.
- Service Codes:IDHS-DDD Service Codes & Rates are available at: http://www.dhs.state.il.us/page.aspx?item=38992
- Service Type: describe the service being provided
- Monthly Service Amount: list the maximum amount per month that can be provided
- Non-agency Personal Support Worker rates must be determined using the applicable Fiscal/Employer Agent's rate table.
- Non-agency Personal Support Workers must also complete a Service Authorization with their Fiscal/ Employer Agent
- The total dollar amount of services received in a given month shall **not** exceed the maximum HBS amount.

3. **Service Provider Information**:
List the Service Provider name, FEIN Number, Social Security Number, phone number, email address (if applicable). Each service provider **must** complete and sign a service agreement.

4. **Note and observe General Provisioning:**
- A. The individual or designated representative is responsible for notifying each service provider when the monthly maximum changes.
- B. The individual or designated representative is responsible for notifying all providers when the individual is no longer Medicaid eligible or no longer enrolled in the Home-Based Services Program.
- C. The Service Provider may not exceed the monthly Home-Based Service amount as listed in Service Agreement.

5. **Signatures:**
- The Service Provider or Representative will sign and date.
- The Individual/Guardian will sign and date.
- The Employer of Record, will sign date (if applicable).
- The Self-Direction Assistant will sign and date (if applicable).

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1. **Individual Information:**

Individual Name: _____ SSN: _____

Phone Number: _____ Email: _____

(List preparer's information if someone other than the Individual completes this form, such as a designated representative or self-direction assistant.)

Preparer Name: _____ Phone Number: _____

Relationship to Individual: _____ Email: _____

2. **Service Agreement:**

Type of Submission: ☐ Initial/New Services ☐ Changes to Services ☐ Termination of Services

This Service Agreement shall be effective for the period listed below.

Start Date of Services: _____ End Date of Services: _____

SERVICE PROVIDER	SERVICE CODE	SERVICE TYPE	SERVICE RATE	MONTHLY SERVICE AMOUNT
			***TOTAL MONTHLY SERVICE AMOUNT:**	

**The total dollar amount of services received in a given month may not exceed the maximum HBS amount.*

3. **Service Provider Information:**

Name: _____

FEIN/SSN: _____

Address:(City, State, & Zip Code): _____

Phone Number: _____ Email: _____

4. **General Provisions:**

A. The individual or designated representative is responsible for notifying each service provider when the monthly maximum changes.
B. The individual or designated representative is responsible for notifying all providers when the individual is no longer Medicaid eligible or no longer enrolled in the Home-based Services Program.
C. The Service Provide may not exceed the monthly Home-Based Service amount as listed in Service Agreement.

5. **Signatures:**

The signatures below certify that the Individual and the Service Provider named above agree to all of the provisions as stated in this agreement, are consistent with the Personal Plan, and are consistent with the budgeted monthly allotment. For self-directed personal support workers, by signing this form all parties understand that failure to comply with the service agreement could result in the interruption of payroll until any and all issues are resolved.

_____ _____
Service Provider Signature Date

_____ _____
Individual/Guardian Printed Name and Signature Date

_____ _____
Employer of Record Signature (if applicable) Date

_____ _____
Self-Direction Assistance Provider Printed Name and Signature (If applicable) Date