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)

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

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: _____