



## INDIVIDUAL PROVIDER STANDARDS

Dear Customer,

During the eligibility determination process, it was determined you are capable of supervising an Individual Provider to assist you in your home. Individual Providers are defined as a Personal Assistant, Registered Nurse, Licensed Practical Nurse, Certified Nurse Assistant, Occupational Therapist, Physical Therapist and Speech Therapist. Your Service Plan identifies which types of Individual Providers will be used to meet your needs.

When customers use Individual Provider services, they are required to collect and certify the following information for each Individual Provider used. If you do not complete the information on this form and submit it before the Individual Provider begins employment, it may result in non-payment to the Individual Provider and ineligibility for further services for you.

**Please complete a separate form for each Individual Provider you use and submit with other required paperwork to your Home Services Program Office.**

### Individual Provider Information:

1. Name: _____	2. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
3. Birthdate (MM/DD/YYYY): _____	4. Phone Number (include area code): _____
5. Legal Address (Where the Individual Provider actually lives)	6. Mailing Address (Where the Individual Provider will receive his/her check)
_____	_____
_____	_____
_____	_____

7. Individual Provider email address, if applicable, (for electronic correspondence such as timesheets and announcements):

\_\_\_\_\_

8. The Individual Provider is: (please check appropriate category)

<input type="checkbox"/>	14 or 15 years of age and not employed during school hours, has an employment certificate and meets all other requirements of the Child Labor Law, and will be supervised by an adult 21 years or older
<input type="checkbox"/>	16 to 18 years of age and enrolled in school (must not be employed during school hours)
<input type="checkbox"/>	17 to 18 years of age and not enrolled in school
<input type="checkbox"/>	an adult, 18 years of age or older

9. The Individual Provider's relationship to the Customer?

Family    Please specify: \_\_\_\_\_   
  Friend     Referral



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**Individual Provider Information: (continued)**

10. The Individual Provider's previous experience and/or training are adequate and consistent with the specific tasks performed for me in my home as identified below:

Task	Experience/Training

11. If the Individual Provider will perform incidental health care tasks, written permission has been obtained from my physician or another appropriate medical professional as approved by the Home Services Program.

- Not applicable       Yes       No

12. The Individual Provider has demonstrated a satisfactory understanding of Universal Precautions that will meet my needs.

- Yes       No

13. The Individual Provider has provided the Home Services Program with a copy of his/her Social Security card or other documentation verifying this information.

- Yes       No

14. The Individual Provider has provided the Home Services Program with a completed Employment Eligibility Verification form (I-9, U.S. Department of Justice) along with the required information that accompanies it.

- Yes       No

15. The Individual Provider has received, completed and signed the Waiver Program Provider Agreement for Participation in the Illinois Medical Assistance Program form and will submit it to the Home Services Program office.

- Yes       No

I hereby certify the above information is true and accurate to the best of my knowledge. I further certify the Individual Provider named above has satisfactory communication skills and the physical capacity to meet my needs and he/she can satisfactorily follow directions in the completion of tasks performed.

I understand falsification of the above information by me may jeopardize payment to the Individual Provider and my receiving services through the Home Services Program.

\_\_\_\_\_  
 Signature of Customer Date

\_\_\_\_\_  
 Printed Name Parent, Guardian or Representative

\_\_\_\_\_  
 Signature of Parent, Guardian or Representative Date

NAMES OF INDIVIDUAL PROVIDERS REFERRED TO CUSTOMERS BY THE DEPARTMENT OF HUMAN SERVICES - DIVISION OF REHABILITATION SERVICES SHOULD BE CONSIDERED AS POTENTIAL WORKERS AND NOT RECOMMENDATIONS TO USE THAT INDIVIDUAL. CUSTOMERS MAKE THE INDIVIDUAL PROVIDER(S) SELECTION AND SHOULD CHECK ALL REFERENCES/RECOMMENDATIONS PRIOR TO USING AN INDIVIDUAL.