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

IMPACT INDIVIDUAL PROVIDER ENROLLMENT FORM

(For Office Use Only)
Application ID:

A: Individual Provider Information (Print Clearly)

First Name:	Last Name:	
Last Four of SSN:	Date of Birth:	
Street Address:	E-mail:	
City:	State:	
Zip Code:	Home Phone:	Cell Phone:

B. Provider Information

Provider Type:	**Gender at Birth:**	**Gender Identity:**
PA ☐ CNA ☐ LPN ☐ RN ☐	Male ☐ Female ☐	Man ☐ Woman ☐ Non-binary ☐ Gender Non-Conforming ☐ Other ☐ Prefer Not to Answer ☐

Communication Preference:	**Preferred Pronoun:**	**Language Preferences:**
Cell Phone ☐ Home Phone ☐ Email ☐	He/His ☐ She/Her ☐	English ☐ Spanish ☐
Text ☐ TTY ☐ Video Phone ☐	They/Their ☐	Other ☐

C: LPN/RN Information

License Number (LPN/RN only):	NPI (LPN/RN only):	Additional Notes:(if any)

D: Questionnaire for PA/CNA/LPN/RN (If you're unsure of how to respond, please comment N/A)

	QUESTIONS	YES	NO	COMMENTS
1.	If you are an out of state provider that provided emergent care to an Illinois Medicaid participant, you can request a retroactive enrollment back to the date the services were provided. If yes, enter the requested date to be considered in the comment field. Enrollment applications must be submitted within 45 days of the date of service to be considered for a retroactive enrollment date.	☐	☐	
2.	Do you wish to end date your enrollment? If yes, what date?	☐	☐	
3.	Are you currently excluded from any Illinois or other state program? If yes, provide state of exclusion and program.	☐	☐	
4.	Are you currently excluded from any federal program? If yes, provide the program and date.	☐	☐	
5.	Have you ever had a criminal conviction? If yes, provide type of conviction and date.	☐	☐	
6.	Have you ever had a judgment under any false claims act? If yes, list judgment and date.	☐	☐	

Provider Signature: _____ Date: _____

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D: Questionnaire for PA/CNA/LPN/RN (If you're unsure of how to respond, please comment N/A) (continued)

	Questions	Yes	No	Comments
7.	Have you been certified or re-certified by Medicare within the last year? If yes, provide date.	☐	☐	
8.	Have you been certified by another State's Medicaid Program? If yes, provide each state and effective date of certification.	☐	☐	
9.	Have you ever had a program exclusion/debarment? If yes, provide program and date.	☐	☐	
10.	Have you ever had civil monetary penalty? If yes, provide penalty type and date.	☐	☐	
11.	Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	☐	☐	
12.	Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates.	☐	☐	
13.	Are you an APN (Certified RN Anesth., Nurse Midwife, Clinical Nurse Special, NP) or a Board-Certified Behavior Analyst or Registered Behavior Technician employed outside of a BHC and you have a Collaborative Agreement? If yes, provide NPI(s) of collaborating provider.	☐	☐	
14.	Are you enrolled in the Vaccines for Children Program (VFC) and have a specialty/subspecialty other than OB, GYN, OB/GYN? If yes, provide enrollment date.	☐	☐	
15.	Do you carry professional liability insurance? If yes, please provide the name of your carrier and the policy coverage limit per occurrence and in aggregate.	☐	☐	
16.	If enrolling as a Pharmacist, have you completed ACPE accredited training program related to the initiation, dispensing, or administration of drugs, laboratory tests, assessments, referrals, and consultations for HIV? If yes, enter the date you completed the training	☐	☐	
17.	If enrolling as a Pharmacist, have you completed an ACPE accredited training program related to patient self-screening risk assessment, patient assessment contraceptive counseling and education, and dispensation of hormonal contraceptives? If yes, enter the date you completed the training.	☐	☐	

E: Instructions for completing this form

Personal Assistants, CNA, LPN, RN are required to:

- **Section A:** Answer all questions**.**
- **Section B:** Answer all questions.
- **Section C:** Answer all questions if you are an **LPN or RN.**
  - Must provide a valid License Number to show they are certified.
  - NPI (National Provider Identifier) is required to be enrolled in the IMPACT System.
  - If you do not have an NPI, please obtain one at https://nppes.cms.hhs.gov.
  - Use below Taxonomy Codes are based on your specialty.
    - **LPN : 164W00000X**
    - **RN : 163W00000X**
- **Section D:** Answer all questions.
  - If you are unsure of how to answer any of the questions, please respond with **N/A under Comments**.
- **Sign the bottom of all pages.**

Provider Signature: _____ Date: _____