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
(Please print clearly)

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

Provider Type: PA ☐ CNA ☐ LPN ☐ RN ☐	License Number (LPN/RN only):	NPI (LPN/RN only):

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

	Questions	Yes	No	Comments
1.	Are you ONLY enrolling to provide services related to COVID-19 emergency response? Answering Yes to this question will create a temporary enrollment that will end within six months from the termination of the public health emergency. If you want to enroll to provide ongoing services to Illinois Medicaid participants, you should answer No to this question.	☐	☐	
2.	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.	☐	☐	
3.	Do you wish to end date your enrollment? If yes, what date?	☐	☐	
4.	Are you currently excluded from any Illinois or other state program? If yes, provide state of exclusion and program.	☐	☐	
5.	Are you currently excluded from any federal program? If yes, provide the program and date.	☐	☐	
6.	Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date.	☐	☐	
7.	Have you ever had a judgment under any false claims act? If yes, list judgment and date.	☐	☐	
8.	Have you been certified or recertified by Medicare within the last year? If yes, provide date.	☐	☐	
9.	Have you been certified by another State's Medicaid Program? If yes, provide each state and effective date of certification.	☐	☐	
10.	Have you ever had a program exclusion/debarment? If yes, provide program and date.	☐	☐	
11.	Have you ever had civil monetary penalty? If yes, provide penalty type and date.	☐	☐	
12.	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.	☐	☐	
13.	Are you a Home Health Agency, DME, Medicar, Taxi, Serv Car or Ambulance providing non-emergency Serv, have you had the required fingerprinting completed? If yes, with what vendor and date?	☐	☐	
14.	Are you a Medicar, Service Car or Taxi/Livery Company that is not registered with the Secretary of State? If yes, provide the county clerk registration number.	☐	☐	
15.	Have you signed an agreement authorizing you or your organization to participate as an All Kids Application Agent? If yes, enter the effective date of your participation.	☐	☐	
16.	Are you planning to provide services reimbursable through DoA, DCFS, DSCC, DHS/DASA, DHS/DRS, DHS/DMH, DHS/EI, DHS/DDD? If yes, complete "Associate MCO Plan" step in Business Process Wizard.	☐	☐	

Provider Signature: _____ Date: _____

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

	Questions	Yes	No	Comments
1.	Are you ONLY enrolling to provide services related to COVID-19 emergency response? Answering Yes to this question will create a temporary enrollment that will end within six months from the termination of the public health emergency. If you want to enroll to provide ongoing services to Illinois Medicaid participants, you should answer No to this question.	☐	☐	
2.	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.	☐	☐	
3.	Do you wish to end date your enrollment? If yes, what date?	☐	☐	
4.	Are you currently excluded from any Illinois or other state program? If yes, provide state of exclusion and program.	☐	☐	
5.	Are you currently excluded from any federal program? If yes, provide the program and date.	☐	☐	
6.	Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date.	☐	☐	
7.	Have you ever had a judgment under any false claims act? If yes, list judgment and date.	☐	☐	
8.	Have you been certified or recertified by Medicare within the last year? If yes, provide date.	☐	☐	
9.	Have you been certified by another State's Medicaid Program? If yes, provide each state and effective date of certification.	☐	☐	
10.	Have you ever had a program exclusion/debarment? If yes, provide program and date.	☐	☐	
11.	Have you ever had civil monetary penalty? If yes, provide penalty type and date.	☐	☐	
12.	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.	☐	☐	
13.	Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates.	☐	☐	
14.	Are you a Home Health Agency, DME, Medicar, Taxi, Serv Car or Ambulance providing non-emergency Serv, have you had the required fingerprinting completed? If yes, with what vendor and date?	☐	☐	
15.	Are you planning to provide services reimbursable through DoA, DCFS, DSCC, DHS/DASA, DHS/DRS, DHS/DMH, DHS/EI, DHS/DDD. If yes, complete "Associate MCO Plan" step in Business Process Wizard.	☐	☐	
16.	Are you an APN (Certified RN Anesth, Nurse Midwife, Clinical Nurse Special, NP) or a Registered Behavior Technician and you have a Collaborative Agreement? If yes, provide NPI(s) of collaborating provider.	☐	☐	
17.	Are you a Nurse Midwife, with hospital admitting and/or delivery privileges? If yes, list name and address of all facilities.	☐	☐	
18.	Are you a Certified Registered Nurse Anesthetist without a collaborative agreement? If yes, list the names and addresses of all facilities where you practice.	☐	☐	
19.	Is Child/Adolescent Psychiatry Residency or General Psychiatry Residency your subspecialty? If yes, enter the place of your psychiatric residency and type(s).	☐	☐	
20.	Are you a radiologist, hospital (outpatient), Imaging Center or Independent Diagnostic Testing Facility, and are participating or wish to participate in the Breast Cancer Quality Screening Program?	☐	☐	
21	Are you enrolled in the Designated Family Planning Provider/Clinic Program? If yes, provide enrollment date and approving agency.	☐	☐	
22.	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.	☐	☐	
23.	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.	☐	☐	

Provider Signature: _____ Date: _____