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

IMPACT INDIVIDUAL PROVIDER ENROLLMENT FORM

DRS PROVIDER:
THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND SIGNED OR IT MAY BE RETURNED. IF YOU ARE UNSURE OF HOW TO RESPOND, PLEASE WRITE N/A IN THE COMMENTS SECTION.

A: Individual Provider Information (Please print clearly)	(For Office Use Only) Application ID:
First Name:	Last Name:
SSN:	Date of Birth:
Street Address:	E-mail:
City:	State:
Zip Code:	County:

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

B: Provider Questionnaire for PA

	Questions	Yes	No	Comments
1.	Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the Requested Date in the comment field to be considered.	☐	☐	
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 or healthcare program-related 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.	☐	☐	
7.	Have you been certified or recertified 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.	Are you a Home Health Agency, DME, Medicar, Taxi, Service Car or Ambulance providing non-emergency services and have you had the required fingerprinting completed? If Yes, with what vendor and date?	☐	☐	
13.	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.	☐	☐	
14.	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.	☐	☐	
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.	Is your organization a health plan, LTC facility or other provider approved for an ABE provider portal account to assist individuals with eligibility for medical benefits? If yes, enter effective date of participation.	☐	☐	

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C: Provider Questionnaire for CNA/LPN/RN

	Questions	Yes	No	Comments
1.	Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the Requested Date in the comment field to be considered.	☐	☐	
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 or healthcare program-related 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.	☐	☐	
7.	Have you been certified or recertified 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 amounts and dates.	☐	☐	
13.	Are you a Home Health Agency, DME, Medicar, Taxi, Service Car or Ambulance providing non-emergency services and have you had the required fingerprinting completed? If Yes, with what vendor and date?	☐	☐	
14.	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.	☐	☐	
15.	Are you an APN (Certified RN Anesthetist, Nurse Midwife, Clinical Nurse Special, Nurse Practitioner) or Physician Assistant, and do you have a Collaborative Agreement? If Yes, provide NPI(s) of collaborating provider.	☐	☐	
16.	Are you a Nurse Midwife, with hospital admitting and/or delivery privileges? If Yes, list name and address of all facilities.	☐	☐	
17.	Are you a Certified Registered Nurse Anesthetist without a collaborative agreement? If Yes, list names and addresses of all facilities where you practice.	☐	☐	
18.	Is Child/Adolescent Psychiatry Residency or General Psychiatry Residency your subspecialty? If Yes, enter the place of your psychiatric residency and type(s).	☐	☐	
19.	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?	☐	☐	
20.	Are you a Physician, Hospital, FQHC, ERC, Medichek Clinic, RHC, Home Health Agency, Community Health Agency, Certified Health Dept. or School Based/Linked Clinic, and are participating or wish to participate in the MPE Program?	☐	☐	
21	Is your organization a health plan, LTC facility or other provider approved for an ABE provider portal account to assist individuals with eligibility for medical benefits? If yes, enter effective date of participation.	☐	☐	
22.	Are you enrolled in the Designated Family Planning Provider/Clinic Program? If Yes, provide enrollment date and approving agency.	☐	☐	
23.	Are you enrolled in the Vaccines for Children Program (VFC) and have a specialty/ subspecialty other then OB, GYN, OB/GYN? If Yes, provide enrollment date.	☐	☐	