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

PROVIDER BACKGROUND SCREENING DISPUTE FORM

As an Individual Provider, you enrolled in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system to work as an Individual Provider for a Customer of the Home Services Program (HSP). The IMPACT background screening returned waivable and/or non-waivable conviction(s) matching the personal information you provided in the enrollment application.

- A waivable conviction is a criminal conviction that will allow an HSP Customer the choice to hire you after being made aware of the conviction.
- A non-waivable conviction is a criminal conviction that, if verified, may prohibit you from proceeding with enrollment or receiving payment for services provided to an HSP Customer.

Please choose one of the options below. You must provide documentation to substantiate any claims made on this form.

☐ **Option 1** - I dispute the findings or accuracy of the background screening and request a secondary background screening.

If you are disputing the background screening results, please provide additional information to support your claim. Attach additional page(s) if necessary. Additional information may include evidence that the background screening is inaccurate (e.g., not convicted of the crimes, wrong person, or SSN).

If you dispute the results of the background screening, the Home Services Program (HSP) will proceed with a secondary background screening. HSP will provide the results of the secondary background screening, along with the information you provided above, to you and your Customer for review, if necessary.

☐ **Option 2** - I do not dispute the background screening and find the results returned as accurate, and/or I do not think I present a danger to the safety or wellbeing of the Customer, my quality of care will not be affected.

Have you received any type of pardon to the offense(s) listed on the background screening? ☐ Yes ☐ No
(Attach supporting documentation to your claim and additional pages if necessary)

Pardoning Authority: _____ County: _____ State: _____

Convicted Offense: _____ Date of Pardon: _____

Terms of Pardon: _____

Please list any post-conviction community service, charitable activity, and/or evidence regarding your rehabilitation.

Please provide details on your claim below or on additional pages. Evidence must be provided if warranted by the claim (e.g., length of time since conviction, rehabilitation, community service, stable employment, long-term relationships)

Individual Provider Printed Name: _____

Individual Provider Signature: _____ Date: _____

Please complete and return this form to your local DRS office or to:

HSP IMPACT UNIT
Provider Background Screening
100 S Grand Ave E, 1st FL
Springfield, IL 62762