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

PROVIDER BACKGROUND SCREENING CONSENT FORM

Dear Customer:

A prospective Individual Provider (IP) must enroll and be approved in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system to work for you. The IMPACT system has a criminal background screening procedure. Your prospective IP most recently completed the IMPACT background screening on _____ and it returned criminal convictions(s) that can be "waived" by the Customer.

The background screening results have been verified as accurate by direct confirmation from the IP, or through a second background screening verification. Based on the level of the criminal conviction(s), you have a choice to proceed with the IP's enrollment, request a new background screening if the screening date above is more than 1 year old, or discontinue the IP's enrollment.

Any additional information relevant to the IP's background screening has been included with this form. Please review the additional information provided. By providing your consent on this form, you agree to hire an IP with criminal conviction(s).

The potential conviction(s) reported for _____ were:

_____ _____ _____

_____ _____ _____

I CONSENT: I have reviewed the information provided to me regarding the enrollment for the IP named below. I have received and reviewed the Provider Background Screening Notification letter that lists the criminal conviction(s) associated with the IP named below. I have received and reviewed the completed **IL488-2540,** the Provider Background Screening Dispute form, for the IP named below. I have received and reviewed any and all additional information requested by, and/or provided to me, from the Home Services Program or the IP named below. I have sufficient information under which to make an informed choice. I elect TO hire an IP with criminal conviction(s).

☐ I **CONSENT** to hiring Individual Provider: _____

Customer Printed Name: _____

Customer Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

I DO NOT CONSENT: I have reviewed the information provided to me regarding the enrollment for the IP name below. I have received and reviewed the *Provider Background Screening Notification* letter that lists the criminal conviction(s) associated with the IP named below. I have received and reviewed the completed **IL488-2540**, the Provider Background Screening Dispute form, for the IP named below. I have received and reviewed any and all additional information requested by, and/or provided to me, from the Home Services Program or the IP named below. I have sufficient information to make an informed choice. I elect NOT to hire an IP with a history of criminal conviction(s) and have decided to seek assistance with another IP.

☐ I **DO NOT CONSENT** to hiring Individual Provider: _____

Customer Printed Name: _____

Customer Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

☐ I request updated background screening results for this provider.

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