State of Illinois
Illinois Department on Aging

Community Care Program

PROVIDER APPLICATION FOR EMERGENCY HOME RESPONSE SERVICE

INSTRUCTIONS:
PLEASE PRINT OR TYPE (NO PENCIL).

PART A: APPLICANT INFORMATION

Administrative Office Contact Information:		
1. LEGAL NAME OF AGENCY →		
Address →	Street:	
→	City:	
→	State:	Zip Code:
Contact Person at Administrative Office →	Name:	
→	Title:	
→	Phone: ( )	Ext:
→	Fax: ( )	
E-mail Address for Contact Person →	E-mail:	
Business Hours of Administrative Office →		
Is your Emergency Home Response agency a subsidiary of a parent organization?	❑ Yes ❑ No	
If yes, Name and Address of parent organization.		
Name of Parent Organization: →		
Address of Parent Organization: →	Street:	
→	City:	
→	State:	Zip Code:

PART B: PROPOSED SERVICE AREA

❑ **STATEWIDE**

❑ **COUNTY / COUNTIES SERVED (SPECIFY BELOW)**

❑ Adams	❑ Crawford	❑ Grundy	❑ Kendall	❑ Massac	❑ Pike	❑ Stephenson
❑ Alexander	❑ Cumberland	❑ Hamilton	❑ Knox	❑ McDonough	❑ Pope	❑ Tazewell
❑ Bond	❑ DeKalb	❑ Hancock	❑ Lake	❑ McHenry	❑ Pulaski	❑ Union
❑ Boone	❑ DeWitt	❑ Hardin	❑ LaSalle	❑ McLean	❑ Putnam	❑ Vermilion
❑ Brown	❑ Douglas	❑ Henderson	❑ Lawrence	❑ Menard	❑ Randolph	❑ Wabash
❑ Bureau	❑ DuPage	❑ Henry	❑ Lee	❑ Mercer	❑ Richland	❑ Warren
❑ Calhoun	❑ Edgar	❑ Iroquois	❑ Livingston	❑ Monroe	❑ Rock Island	❑ Washington
❑ Carroll	❑ Edwards	❑ Jackson	❑ Logan	❑ Montgomery	❑ Saline	❑ Wayne
❑ Cass	❑ Effingham	❑ Jasper	❑ Macon	❑ Morgan	❑ Sangamon	❑ White
❑ Champaign	❑ Fayette	❑ Jefferson	❑ Macoupin	❑ Moultrie	❑ Schuyler	❑ Whiteside
❑ Christian	❑ Ford	❑ Jersey	❑ Madison	❑ Ogle	❑ Scott	❑ Will
❑ Clark	❑ Franklin	❑ JoDaviess	❑ Marion	❑ Peoria	❑ Shelby	❑ Williamson
❑ Clay	❑ Fulton	❑ Johnson	❑ Marshall	❑ Perry	❑ Stark	❑ Winnebago
❑ Clinton	❑ Gallatin	❑ Kane	❑ Mason	❑ Piatt	❑ St. Clair	❑ Woodford
❑ Coles	❑ Greene	❑ Kankakee				

COOK COUNTY:

- ❑ Sub-area 01: 60626, 60640, 60645, 60659, 60660
- ❑ Sub-area 02: 60625, 60630, 60631, 60646, 60656
- ❑ Sub-area 03: 60634, 60635, 60639, 60641, 60666
- ❑ Sub-area 04: 60613, 60614, 60618, 60647, 60657
- ❑ Sub-area 05: 60601, 60602, 60603, 60604, 60605, 60606, 60607, 60610, 60611, 60622, 60661
- ❑ Sub-area 06: 60615, 60616, 60637, 60649, 60653
- ❑ Sub-area 07: 60609, 60623, 60629, 60632, 60638
- ❑ Sub-area 08: 60617, 60619, 60627, 60628, 60633, 60827
- ❑ Sub-area 09: 60620, 60621, 60636, 60643, 60652, 60655
- ❑ Sub-area 10: 60608, 60612, 60624, 60644, 60651

SUBURBAN COOK COUNTY:

❑ Barrington	❑ Cicero	❑ Leyden	❑ North Proviso	❑ Palatine	❑ Riverside	❑ Thornton
❑ Berwyn	❑ Elk Grove	❑ Lyons	❑ Northfield	❑ Palos	❑ Schaumburg	❑ Wheeling
❑ Bloom	❑ Evanston	❑ Maine	❑ Norwood Park	❑ Rich	❑ South Proviso	❑ Worth
❑ Bremen	❑ Hanover	❑ New Trier	❑ Oak Park	❑ River Forest	❑ Stickney	
❑ Calumet	❑ Lemont	❑ Niles	❑ Orland			

If the geographic area is smaller than a county or township, identify municipalities or relevant portions of the county(ies), township(s) and/or sub-area(s)/zip code(s):

PART C: EMERGENCY HOME RESPONSE EQUIPMENT INFORMATION

(For questions 1–8 refer to the EHRS unit. Please specify which unit you are applying for certification and attach required documentation for **each** unit).

_____

Unit Name

❑ UL1637 (Attached) or ❑ UL1635 (Attached)

1. As stated in Section 240.1541(a), all Emergency Home Response Service equipment must be tested, approved and listed to meet Underwriters Laboratories safety standards for home health care signaling equipment and digital alarm communicator systems units.

❑ **Yes** ❑ **No**

2. As stated in Section 240.1541(b), all home units must be capable of signaling from both the activation device remote and the base unit. ❑ **Yes** ❑ **No**

3. As stated in Section 240.1541(c)(1), the activation device must be a portable and waterproof type of wireless remote configured with the following:

a. a crystal or Surface Acoustic Wave (SAW) resonator controlled transmitter frequency for long-term reliability, ❑ **Yes** ❑ **No**

b. digital encoding capability for at least 10 combinations sufficient for high density situations, ❑ **Yes** ❑ **No**

c. a minimum transmission range of 300 feet, ❑ **Yes** ❑ **No**

d. an internal battery capable of operating as a power source for a minimum 5 years, ❑ **Yes** ❑ **No**

e. a low battery charge signal; and, ❑ **Yes** ❑ **No**

f. components certified as appropriate by the Federal Communications Commission under 47 CFR 15. ❑ **Yes** ❑ **No**

(Attach: Descriptive brochure showing the above specifications)

4. As stated in Section 240.1541(c)(2), the activation device must be capable of conducting automatic battery testing and transmitting the results through the base unit to the support center on a regular basis. ❑ **Yes** ❑ **No**

5. As stated in Section 240.1541(c)(3), that the adaptive version of the activation device must be available that can be used by hearing, mobility and visually-impaired clients.

❑ **Yes** ❑ **No**

(Attach: Policy or picture of device)

6. As stated in Section 240.1541(d)(1), the EHRS base unit must have the following specifications:

a. an integrated unit that connects to either a rotary dial or touchtone telephone via a modular jack that does not interfere with the normal use of the telephone, ❑ **Yes** ❑ **No**

b. an Underwriters Laboratory (UL) approved plug as the connector to a standard residential electrical outlet for its power supply, ❑ **Yes** ❑ **No**

c. an appropriate connection for a seizure line jack so the support center can be signaled even in the event the telephone receiver is off its hook, ❑ **Yes** ❑ **No**

d. an easily identifiable “ready” light to verify whether the batteries on the activation device and base unit are charged, ❑ **Yes** ❑ **No**

Unit Name

e. an easily identifiable "confirmation" light that indicates when the support center has received a signal, ❑ **Yes** ❑ **No**

f. a battery that automatically charges whenever the base unit is powered and that maintains a charge for at least 12 hours when the electric power to the base unit is interrupted, ❑ **Yes** ❑ **No**

g. transmission capability to signal the support center if the base unit battery fails or has a low charge, or electric power to the base unit is interrupted, ❑ **Yes** ❑ **No**

h. a configuration that allows signaling service through one base unit for up to 2 clients in a home, ❑ **Yes** ❑ **No**

i. microphone and speaker to enable 2-way voice communication between the client's home and the support center. The support center must be able to control both the microphone sensitivity and speaker volume; and, ❑ **Yes** ❑ **No**

(Attach: Descriptive brochure showing the above specifications)

j. appropriate certification by the Federal Communications Commission under 47 CFR 15 and 47 CFR 68. ❑ **Yes** ❑ **No**

(Attach: Supporting documentation if appropriate or state why not appropriate)

7. As stated in Section 240.1541(d)(2), the base unit must give both audible and visual confirmation of the signal status using digitized voice technology and lighting cues to help the client stay calm while waiting on his or her designated emergency responder or other appropriate response to the situation directed by the support center. ❑ **Yes** ❑ **No**

8. As stated in Section 240.1541(d)(3), the base unit must re-attempt signaling on a regular basis until the support center confirms its receipt. ❑ **Yes** ❑ **No**

PART D: SUPPORT CENTER INFORMATION

1. I have read and understand as stated in Section 240.1541(e)(1), the EHRS support center must have back-up monitoring capacity to take over all monitoring functions and handle all incoming emergency signals. The back-up monitoring center must be at a location different from the primary center, on a different power grid system and on a different telephone trunk line. It must have a back-up battery and electrical generating capacity, as well as telephone line monitoring abilities. ❑ **Yes** ❑ **No**

2. I have read and understand as stated in Section 240.1541(e)(2) that the EHRS support center and back-up center equipment, at a minimum, must:

a. monitor the EHRS system for the receipt of incoming signals from connected base units in clients' homes, including test transmissions and fault conditions, on a continuous basis, ❑ **Yes** ❑ **No**

b. have an audible and visual alarm for the notification of all incoming signals, including test transmissions and fault conditions, ❑ **Yes** ❑ **No**

c. direct an appropriate response within a minute of the receipt of a signal as an operational average without disrupting or terminating the connection to the base unit in the client's home, 24-hours-a-day, 365 days-a-year, including interpretation services and communication facilitated by a teletypewriter (TTY) communication device for the deaf, ❑ **Yes** ❑ **No**

d. provide technical support as required, 24-hours-a-day, 365 days-a-year, ❑ **Yes** ❑ **No**

e. identify each client and simultaneously record all communication among the client, support center and responder, as applicable, for all signals, including test transmissions and fault conditions, ❑ **Yes** ❑ **No**

f. display, print and archive the client identifier, date, time, communication and response period for each incoming signal, which must be maintained for at least a 3-year period for quality control and liability purposes, ❑ **Yes** ❑ **No**

g. have an uninterruptible power supply (UPS) back-up that will automatically take over system operation in the event electric power to the support center is interrupted, other type of malfunction occurs, or repairs are needed. The back-up power supply must be sufficient to operate the entire system for a minimum of 12 hours, ❑ **Yes** ❑ **No**

h. have separate and independent primary and back-up receivers, computer servers, databases, and other components to provide an uninterruptible monitoring system in the event of equipment malfunction, ❑ **Yes** ❑ **No**

i. perform self-diagnostic testing for malfunctions in equipment in client homes and at the support center, and for fault conditions in the primary and back-up operating systems and power supply at the support center, that could interfere with receiving and responding to signals, such as non-operational receivers and transmitters, signals received with no communications, telephone line outages, power loss, etc.; and, ❑ **Yes** ❑ **No**

j. maintain appropriate certification by the Federal Communications Commission under 46 CFR 15 (2008) and 46 CFR 68 (2008). ❑ **Yes** ❑ **No**

Primary Call Center		
Address →	Street:	
→	City:	
→	State:	Zip Code:
Contact Person at Call Service →	Name:	
→	Title:	
→	Phone: ( )	Ext:
→	Fax: ( )	
E-mail Address for Contact Person →	E-mail:	
Back-up Center(s)		
Address →	Street:	
→	City:	
→	State:	Zip Code:
Contact Person at Back-up Center →	Name:	
→	Title:	
→	Phone: ( )	Ext:
→	Fax: ( )	
E-mail Address for Contact Person →	E-mail:	
Back-up Center(s)		
Address →	Street:	
→	City:	
→	State:	Zip Code:
Contact Person at Back-up Center →	Name:	
→	Title:	
→	Phone: ( )	Ext:
→	Fax: ( )	
E-mail Address for Contact Person →	E-mail:	

(Attach additional sheet(s) if necessary)

Installation, Training and Repair Technicians Who Serve Illinois		
Address →	Street:	
→	City:	
→	State:	Zip Code:
Name of Installer →	Name:	
→	Geographic Area(s) Served:	
→		
→		
→		
Address →	Street:	
→	City:	
→	State:	Zip Code:
Name of Installer →	Name:	
→	Geographic Area(s) Served:	
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→		
Address →	Street:	
→	City:	
→	State:	Zip Code:
Name of Installer →	Name:	
→	Geographic Area(s) Served:	
→		
→		
→		

(Attach additional sheet(s) if necessary)

PART E: SERVICE SPECIFICATIONS

1. I have read and understand **all** applicable Community Care Program rules set forth in 89 Illinois Administrative Code Part 240. ❑ **Yes** ❑ **No**

2. I have read and understand the definition of Emergency Home Response Service as stated in Section 240.235. ❑ **Yes** ❑ **No**

3. I have read and understand as stated in Section 240.235 that my agency must provide the following specific service components:

a. provide a base unit, adaptive activation devices with all connectors, parts and equipment necessary for installation, ❑ **Yes** ❑ **No**

b. wireless adaptive activation devices, ❑ **Yes** ❑ **No**

c. visual and audible indications of alarm activation, ❑ **Yes** ❑ **No**

d. adaptive activation devices shall be provided at no extra cost to the client, ❑ **Yes** ❑ **No**

e. deliver the activation device to the client and install the base unit within 15 calendar days from the date of referral ❑ **Yes** ❑ **No**

f. train the client and his or her designated emergency responder on the proper use of the base unit and activation device at the time of installation, ❑ **Yes** ❑ **No** **(Attach: Copy of training material)**

g. assist the client in selecting and designating up to 3 local emergency responders, ❑ **Yes** ❑ **No**

h. obtain client's/representative's signature to document that the EHRS unit was delivered and installed and that instructions and demonstration were given and understood, ❑ **Yes** ❑ **No**

i. own and operate a support center, ❑ **Yes** ❑ **No**

j. own and operate a back-up support center, ❑ **Yes** ❑ **No**

k. maintain adequate local staffing levels of qualified personnel, ❑ **Yes** ❑ **No**

l. repair or replace the base unit or activation device within 24 hours of receiving malfunction report, ❑ **Yes** ❑ **No**

m. alert the client when electric power to the base unit has been interrupted, ❑ **Yes** ❑ **No**

n. notify the CCU within one business day after activation of the base unit, ❑ **Yes** ❑ **No**

o. notify the CCU immediately if EHRS services cannot be initiated or must be terminated, and, ❑ **Yes** ❑ **No**

p. maintain records in accordance with Section 240.1542. ❑ **Yes** ❑ **No**

4. I will comply with all Administrative Requirements for Certification specified in CCP Rule Section 240.1505. ❑ **Yes** ❑ **No**

5. I will comply with all Applicable Responsibilities imposed on provider agencies under the Community Care Program specified in CCP Rule Section 240.1520. ❑ **Yes** ❑ **No**

6. I have read and understand as stated in Section 240.1542 that in order for my agency to qualify for certification my agency must:

a. meet the administrative requirements and minimum administrative standards under Section 240.1505, ❑ **Yes** ❑ **No**

b. meet the certification requirements under Sections 240.1600 or 240.1605, ❑ **Yes** ❑ **No**

c. provide assurance that its equipment and support center are in continual compliance with the technology requirements imposed on provider agencies under Section 240.1541, ❑ **Yes** ❑ **No**

d. maintain adequate records for administration, audit, budgeting, evaluation, operation and planning, ❑ **Yes** ❑ **No**

e. comply with the Underwriters Laboratories safety standards for home health care signaling equipment, UL 1637, and, ❑ **Yes** ❑ **No**

f. comply with the Underwriters Laboratories safety standards for digital alarm communicator systems units, UL 1635. ❑ **Yes** ❑ **No**

7. I have read and understand as stated in Section 240.1542(b) that if an EHRS provider is not able to meet these administrative requirements, then the Department shall deny its request for a certification of qualifications under Section 240.1600. ❑ **Yes** ❑ **No**

PART F: APPLICANT CERTIFICATIONS

By my **notarized** signature below,

I certify that information in this Emergency Home Response Service for Provider Certification is true, accurate, and complete to the best of my knowledge as of the time of signing; that the agency is fiscally sound; that the service proposed herein complies with all Rules of the Community Care Program and will be available on an equal basis in a nondiscriminatory manner without reprisal or retaliation to all eligible participants regardless of age; ancestry; arrest or conviction record; citizenship; color; creed or religion; familial status; gender, sex or sexual orientation; genetic information; marital status; military status or unfavorable discharge from military service; national origin or race; order of protection status; parental status; physical or mental disability; political beliefs; pregnancy; legal source of income; or any other protected classification under applicable civil rights laws; that the agency is in compliance with all applicable Federal, State, and local laws, regulations, and ordinances; and that the agency will cooperate with Department officials in verifying information and hereby authorizes any third party with relevant information bearing on the certification decision to release such information to the Department upon request.

I understand that knowingly providing false information or omitting information may result in denial of certification, decertification or debarment as a service provider under the Community Care Program, termination of any provider agreement and/or other enforcement under federal and state law.

I also agree to update this information as necessary so that it remains true, accurate, and complete while this application is being processed.

_____ _____

Signature of Authorized Representation Date

_____

Name/Title **(Type or Print)**

NOTARY CERTIFICATE

STATE OF _____)
) SS:
COUNTY OF _____)

Subscribed and sworn to before me this _____ day of _____, 20_____.

_____ _____

Signature of Notary Public Printed or typed name of Notary Public

_____ _____

County of residence Date commission expires

Return original and 2 copies of form to: **REMEMBER TO KEEP A COPY FOR YOUR RECORDS**

Illinois Department on Aging
ATTN: Office of Service Development and Procurement
One Natural Resources Way, #100
Springfield, IL 62702-1271

This application is authorized as outlined by the Illinois Act on the Aging. Disclosure of this information is REQUIRED. Failure to provide information could result in denial of certification as a service provider under the Community Care Program.

The Illinois Department on Aging does not discriminate in admission to programs or treatment of employment in government-funded programs, services, or activities in compliance with applicable civil rights laws, policies, and procedures. If you feel you have been discriminated against, you have a right to file a complaint with the Illinois Department on Aging. For information, call the Senior HelpLine: 1-800-252-8966 (Voice); 1-888-206-1327 (TTY).