State of Illinois
Illinois Department on Aging

Community Care Program Provider Application for ADULT DAY SERVICE

INSTRUCTIONS: Please print or type (no pencil). Write "N/A" if question is not applicable.

APPLICANT:

PART A. PROPOSED SERVICE AREA

1. Planning and Service Area (PSA) in which Adult Day Service Site is located: _____

PSA NUMBER:

Indicate below the geographic area which you propose to serve from the adult day service site.

Attach a map of the proposed area.

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2. Mark ALL exceptions which apply to your agency:

☐ a. Serving limited or non-English speaking participants
Identify language group(s) served:

☐ b. Unit of local government
Provide details:

☐ c. Benevolent, charitable, social or religious organization providing services under organization charter to a specific population or in an area smaller than a county, sub-area or township.
Provide details:

3. Can transportation to/from your facility be completed in a reasonable period of time?

☐ **Yes** ☐ **No**

PART B. APPLICANT INFORMATION

1. Legal Name of Agency

2. Address of Administrative Office

Street: _____

City: _____ State: _____ Zip Code: _____

Telephone: ( )_____ Ext. _____ Fax: ( ) _____

3. Contact person at Administrative Office

Name: _____

Title:_____

Email: _____

4. Business Hours of Administration Office: _____a.m. to _____p.m.

5. Adult Day Service Site

a. **Name** *(if different from Administrative Office)*: _____

b. **Address** *(if different from Administrative Office)*:

Street: _____

City: _____ State: _____ Zip Code: _____

Telephone: ( )_____ Ext. _____ Fax: ( ) _____

c. **Contact Person**

Name: _____

Title: _____

Email: _____

d. Is your ADS site located on the grounds of or adjacent to a nursing facility, an institution for mental diseases, intermediate care facility for individuals with intellectual disabilities, a hospital or any other institutional setting?

☐ **Yes** (By checking yes, you are not eligible to apply based on the federal HCBS Waiver regulation "integrated sitting" requirement see NOTE below)

☐ **No**

NOTE: Per federal HCBS Waiver regulations, (CFR, 441.301(5)), settings that are not Home and Community-Based include nursing facilities, an institution for mental diseases; and intermediate care facility for individuals with intellectual disabilities; a hospital, and any other settings that have qualities of an institutional setting. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution.

PART C. OPERATION INFORMATION

1. **Service Hours of site:** _____a.m. to _____p.m.
2. **Days of Operation?**

   ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

3. **Days/Dates when service will not be provided:**

4. **Attach Admission Policy**
5. **Attach Discharge Policy**
6. **What is the total square feet of activity area per participant?** _____
7. **What is the maximum number of CCP participants that will be served at this site?** _____
8. **Indicate below the number of required Adult Day Service staff at the site:**

	None	Employ		Subcontract		Other
		Full-Time	Part-Time	Full-Time	Part-Time	
Program Administrator						
Program Coordinator/Director						
Program Nurse						
Certified Nutrition Staff						
Nutrition Consultant/ Dietitian						
Transportation Driver/Escort						

If "none" or "other" is marked, explain:

PART D. SERVICE INFORMATION

Check Yes or No for questions 1 – 10

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

2. I have read and understand the definition of Adult Day Service and all applicable rules as stated in Section 240.230. ☐ **Yes** ☐ **No**

3. I have read and understand that I must provide the specific service components of Adult Day Service as stated in Section 240.230 of the CCP rules, when required by the Plan of Care, including:

a. assessment of the participant's strengths and needs, and development of an individual written person-centered plan of care and ADS Addendum for each participant that establishes specific participant goals for all service components to be provided or arranged for by the service provider; ☐ **Yes** ☐ **No**

b. a balance of purposeful activities to meet the participant's interrelated needs and interests (social, intellectual, cultural, economic, emotional, physical and spiritual) designed to improve or maintain the optimal functioning of the participant; ☐ **Yes** ☐ **No**

c. opportunities to participate in other activities outside of the ADS are provided; ☐ **Yes** ☐ **No**

d. assistance with or supervision of activities of daily living (i.e., walking, eating, toileting and personal care), as needed; ☐ **Yes** ☐ **No**

e. provision of health-related services appropriate to the participant's needs as identified in the provider's assessment and/or physician's orders, including health monitoring, nursing intervention on a moderate or intermittent basis for medical conditions and functional limitations, medication monitoring, medication administration or supervision or self-administration, and coordination of health services; ☐ **Yes** ☐ **No**

f. a nutritious daily meal, supplementary snacks, and special diets as directed by the participant's physician; ☐ **Yes** ☐ **No**

g. agency provision or arrangement for transportation, with at least one vehicle physically accessible, to enable participants to receive adult day service at the adult day service provider's site and participate in sponsored outings; and ☐ **Yes** ☐ **No**

h. provision of emergency care as appropriate in accordance with established adult day service provider policies and Section 240.1510 of this Part. ☐ **Yes** ☐ **No**

4. I will comply with all aspects of the Person-Centered Plan of Care and ADS Addendum specified in CCP rule Sections 240.230 and 240.730. ☐ **Yes** ☐ **No**

5. I will comply with all Administrative Requirements for Certification specified in CCP rule Section 240.1505. ☐ **Yes** ☐ **No**

6. I have read and understand that my agency must establish and comply with all written policies and procedures specified in CCP rule Section 240.1510. ☐ **Yes** ☐ **No**

7. I will be accountable for all Provider Responsibilities specified in CCP rule Section 240.1520, including not deviating from:

a. I have read and understand that I must comply with the insurance requirements specified in CCP rule Section 240.1520. ☐ **Yes** ☐ **No**

b. I have read and understand that my agency must accept all CCP participant referrals except under the conditions specified in CCP rule Section 240.1520(f). ☐ **Yes** ☐ **No**

c. I have read and understand that my agency shall not deviate from a CCP participant's person-centered plan of care and ADS Addendum without specific direction from the Department or the Care Coordination Unit except under the conditions specified in CCP rule Section 240.1520 (g). ☐ **Yes** ☐ **No**

d. I have read and understand that my agency must advise the CCU of any changes in the participant's physical, mental or environmental needs when the changes would affect the participant's eligibility or service level or would require a change in the plan of care, as specified in CCP rule Section 240.1520(h). ☐ **Yes** ☐ **No**

e. I have read and understand that my agency must respond to all participant requests within 15 calendar days from the date of the request, as specified in CCP rule Section 240.1520(i). ☐ **Yes** ☐ **No**

f. I have read and understand that my agency must bill the Department electronically as specified in CCP rule Section 240.1520(j). ☐ **Yes** ☐ **No**

g. I have read and understand that my agency will provide an annual audit report to the Department within six (6) months after the date of the close of the provider's business fiscal year as specified in CCP rule Section 240.1520(k). ☐ **Yes** ☐ **No**

8. I will comply with all Standards Requirements for Adult Day Service Providers specified in CCP rule Section 240.1550. ☐ **Yes** ☐ **No**

9. I will comply with all General Adult Day Service Staffing Requirements specified in CCP rule Section 240.1555. ☐ **Yes** ☐ **No**

10. I will comply with all standards for Adult Day Service Staff specified in CCP rule Section 240.1560. ☐ **Yes** ☐ **No**

PART E. SUBCONTRACTS

1. How will transportation be provided to CCP participants?

☐ Participant transportation will be provided in a vehicle(s) owned or leased by this agency.

☐ Participant transportation will be provided by a subcontractor. "Part F., Request for Approval to Subcontract" form, must be submitted before an agreement can be executed.

2. How will meals be provided to CCP participants?

☐ Meals will be provided by the adult day service.

☐ Meals will be provided by a subcontractor. "Part F., Request for Approval to Subcontract" form, must be submitted before an agreement can be executed.

PART F. ILLINOIS DEPARTMENT ON AGING REQUEST FOR APPROVAL TO SUBCONTRACT

MAKE COPIES AS NEEDED

1. REQUESTING AGENCY
Name:

SITE ADDRESS

Street: _____

City: _____ State: _____ Zip Code: _____

CONTACT PERSON

Name: _____

Title: _____

Telephone: ( )_____ Ext. _____ Fax: ( ) _____

2. SUBCONTRACTOR
Name:

ADDRESS

Street: _____

City: _____ State: _____ Zip Code: _____

AUTHORIZED SUBCONTRACTOR REPRESENTATIVE

Name: _____

Title: _____

Telephone: ( )_____ Fax: ( ) _____

3. PURPOSE OF SUBCONTRACT

_____ _____

Signature (Authorized Representative/Requesting Agency) **Date**

PART G. APPLICANT SIGNATURE PAGE

By my **notarized** signature below,

I certify that information in this Adult Day Service Application 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

NOTARY CERTIFICATE

State of _____

County of _____ SS:

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:

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

Remember to keep a copy for your records

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).

IL-402-1126 (8/19; 3/15; 8/14; 3/09)