Illinois Department on Aging

Community Care Program

LEGAL ENTITY APPLICATION FOR PROVIDER CERTIFICATION

PART A: APPLICANT INFORMATION

1. LEGAL NAME OF APPLICANT AGENCY		
a. D/B/A (if applicable)		
b. Commonly used name (if different from Line 1a.)		
c. Web site address of applicant agency		
ATTACHMENT: Organization chart _____		
2. ADMINISTRATIVE OFFICE		
a. Address	Street:	
	City:	
	State:	Zip Code:
b. Business Hours/Days of Week		
c. Contact Person at Administrative Office	Name:	
	Title:	
	Phone: ( )	Ext:
	Fax: ( )	
	E-mail:	
3. APPLICANT'S AUTHORIZED REPRESENTATIVE		
Name:		
Title:		
Phone: ( )	Ext.	
Fax: ( )		
E-mail:		
4. ILLINOIS DEPARTMENT OF HUMAN RIGHTS (IDHR) NUMBER:		
IDHR #:		
LETTER FROM ILLINOIS DEPARTMENT OF HUMAN RIGHTS: _____		

PART B: ORGANIZATIONAL INFORMATION

1. LEGAL STRUCTURE – MARK THE TYPE OF LEGAL STRUCTURE OF THE APPLICANT AGENCY **AND** ATTACH LEGAL STRUCTURE DOCUMENTATION.

❑ Individual/Sole Proprietorship

_____"Certificate of Ownership of Business" issued by the county clerk for each county in which the provider is proposing to provide CCP service

❑ Partnership

_____"Certificate of Ownership of Business" issued by the county clerk for each county in which the provider is proposing to provide CCP service

❑ Not-for-Profit Corporation

_____"Certificate of Good Standing" from the Office of the Illinois Secretary of State certifying that the corporation has complied with the requirement to file an annual report,

AND

_____A current letter from the Office of the Illinois Attorney General certifying that the corporation is in full compliance with **OR** is exempt from the charitable trust laws of the State of Illinois

❑ Limited Liability Company

_____"Certificate of Good Standing" from the Office of the Illinois Secretary of State certifying that the corporation has complied with the requirement to file an annual report and has paid required franchise taxes

_____ First page (not the cover page) and the signature pages of operating agreement.

❑ Corporation

_____"Certificate of Good Standing" from the Office of the Illinois Secretary of State certifying that the corporation has complied with the requirement to file an annual report and has paid required franchise taxes

❑ Unit of State Government

_____Letter from the Director or head of the agency citing statutory authority for the agency to enter into a Provider Agreement to provide the proposed CCP service

❑ Unit of Local Government

_____Copy of a resolution or ordinance, passed by the governing body, authorizing application for certification and execution of the Provider Agreement. List designated individual for signature.

❑ Other (specify) _____

2. AUTHORIZED REPRESENTATIVES OF THE APPLICANT AGENCY	
List ALL individuals who have been designated as an Authorized Representative of the applicant agency. Attach page, if needed. _____ **Only those listed below may sign a contract.**	
Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:

1. **(1-4 are optional) Used for aggregate data collection only. Does your entity's ownership/operation meet any of the following criteria as defined in the Business Enterprise for Minorities, Women, and Persons with Disabilities Act (30 ILCS 575) (https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=550&ChapterID=7)**

- ☐ **Minority** -- Please Specify _____
  Percentage (total) _____
- ☐ **Women** (Female Gender)
  Percentage (total) _____
- ☐ **Persons with disabilities**
  Percentage (total) _____

1. **Is your entity veteran owned or operated?** ☐ Yes ☐ No
   Percentage (total) _____
2. **Serving limited or non-English speaking participants**
   Identify language group(s) served:
   _____

PART C: FINANCIAL INFORMATION

1. FISCAL YEAR OF APPLICANT AGENCY:	*Month/Date through Month/Date*
2. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN) OR SOCIAL SECURITY NUMBER (individuals or sole proprietorships only)	FEIN #: **OR** Soc. Sec. #:
3. EIN Assignment Letter (IRS Issued)	Letter **must** include: Legal name, legal status, and complete EIN number. _____
4. W-9 REQUEST FOR TAXPAYER ID NUMBER AND CERTIFICATION	a. Attach a completed W-9 for your agency. A form download is available at www.irs.gov/pub/irs-pdf/fw9.pdf _____

REQUIRED FINANCIAL ATTACHMENTS:

☐ _____Audited financial report with a balance sheet, income statement, statement of cash flow, and all applicable notes for last complete fiscal year.

Auditor's license number _____.

OR

☐ **NEW BUSINESSES ONLY** – Review documentation per rule 89 Illinois Administrative Code 240.1505 (a10) and attach documents accordingly.

☐ **For Profit Business**

Submit proof that employee tax accounts are reestablished with the State of Illinois and the U.S. Treasury _____

Also, submit either:

a bank approved business plan with approved financial backing; **or** if financial resources are from individuals, the most recent 2 years of tax returns, as well as any bank approved individual financial backing for use in the business. _____

☐ **Not-For-Profit Business**

Bank approved business plan with approved financial backing or a signed financial statement illustrating restricted and nonrestricted funding; **and** Proof that employee tax accounts are established with the State of Illinois and the U.S. Treasury.

_____ _____

☐ _____Agency business plan.

☐ _____ Bank reference for each account maintained by your agency that indicates accounts are in good standing. **MUST** be on bank letterhead.

☐ _____ Budget narrative which discusses plans to monitor/analyze the budget and to cover potential cash flow problems and year-end deficits.

5. INSURANCE

Indicate below the applicant agency insurance coverage:

a. General liability ($1,000,000 per occurrence, $3,000,000 in the aggregate) ❑ **Yes**

b. Worker's compensation ❑ **Yes**

c. Volunteer protection (If applicable) ❑ **Yes** ❑ **No**

ATTACHMENT: Insurance Certificate _____

PART D: BUSINESS PRACTICE HISTORY

1. PAST BUSINESS PRACTICES

Mark all applicable items relevant to the service for which certification is sought regarding past business practices by the applicant agency and its affiliates (including the managers, directors, or owners) for the 10-year period preceding the date of this application. **For any items checked (except for "none"), attach narrative and copy of determination issued by the applicable licensing body, business issuer, court or federal/state agency.**

- ❑ _____denial, suspension, revocation, or termination for cause of a license or contract, or any other enforcement action, such as court civil or criminal action
- ❑ _____termination of a contract or surrender of a license before expiration or allowing a contract/license to expire in lieu of enforcement action
- ❑ _____any federal or state Medicaid or Medicare sanctions or penalties relating to the operation of the agency including, but not limited to, Medicaid abuse or fraud
- ❑ _____any federal or state civil and/or criminal felony convictions
- ❑ _____operation of an agency that has been decertified in any state under Medicare or Medicaid
- ❑ _____citations for client abuse, neglect, injury, financial exploitation, or inadequate care in any state
- ❑ None

Additional Information:

1. Is your agency affiliated with another CCP agency? ❑Yes ❑No

   If so, with whom? (INH, ADS, other) _____

2. Does your agency have contracts with other state agencies? ❑Yes ❑No

   If so, with whom? (DHS, HFS, other) _____

Provide a minimum of five references from individuals and/or businesses which can attest to your agency's qualifications relevant to providing CCP services. Do not include any relatives.

Name/Contact Number	Relationship with Agency/How long/Reference Letter
1.	1. _____
2.	2. _____
3.	3. _____
4.	4. _____
5.	5. _____

PART E: SERVICE INFORMATION

1. SERVICE FOR CERTIFICATION: ❑ **EHRS** ❑ **AMD**

2. EXPERIENCE

a. Emergency Home Response Providers:

A **minimum of <u>five</u> years'** experience in business operations providing Emergency Home Response Service is required. Does your agency meet this requirement?

1. My agency has been providing <u>Emergency Home Response Service</u> for a minimum of five years. ❑ **Yes** ❑ **No**

2. ❑ Other adjustment to the experience requirement (i.e., substituting management team experience for agency experience).

Attachment: Experience Documentation for **Emergency Home Response Service Providers**

Attach documentation of experience or exception for Emergency Home Response Service applicants.

_____

b. Automated Medication Dispenser Providers:

A **minimum of <u>five</u> years'** experience in business operations providing Automated Medication Dispenser Service is required. Does your agency meet this requirement?

1. My agency has been providing <u>Automated Medication Dispenser Service</u> for a minimum of five years. ❑ **Yes** ❑ **No**

2. ❑ Other adjustment to the experience requirement (i.e., substituting management team experience for agency experience).

Attachment: Experience Documentation for **Automated Medication Dispenser Service Providers**

Attach documentation of experience or exception for Automated Medication Dispenser Service applicants.

_____

PART F: PERSONNEL

Will your agency employ Family Home Care Aides? ❑Yes ❑No

Attachments: Policies and Procedures for:

- _____job descriptions
- _____wage ranges
- _____employee benefits
- _____promotion and evaluation criteria
- _____grievance procedures

PART G: APPLICANT CERTIFICATIONS

By my signature below,

I certify that information in this Legal Entity 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

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); 711 (TRS)