



Agency Name _____ Telephone # _____

Address _____ FAX Number _____

_____ FEIN # _____

_____ NPI# _____

1. Is the agency licensed as a Home Nursing Agency with the Illinois Department of Public Health (IDPH)?

Yes No

1a. If Yes, provide the license number: _____

1b. If Yes, provide a copy of the license with submission of this document.

1c. If Yes, what **counties** are you approved for through IDPH? _____

2. Please provide the age range of clients served: _____

What were their specific technology, equipment, and skilled care needs? _____

3. Is the agency a certified vendor with the Illinois State Comptroller? Yes No

3a. If yes, provide a copy of your W-9.

3b. If no, please provide a copy of your IRS EIN Assignment Letter and a copy of your W-9.

4. Is the agency an enrolled Medicaid provider in the IMPACT system with an:

Enrollment Type **Facility/Agency/Organization (FAO)**, Provider Type **Home Health Agency, Specialty Home Nursing Agency** with the subspecialty of **Nursing Services**? Yes No

If Yes, provide the assigned IMPACT number: _____

5. Please provide the full name of your Director of Nursing and their nursing license number:

Director of Nursing name

Nursing License Number

Administrative Representative/Title

Date

Email Address