DIVISION OF SPECIALIZED CARE FOR CHILDREN

# INITIAL NURSING AGENCY INFORMATION SHEET

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?

   ☐ 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. The agency meets the minimal requirement of being in business for 1 year providing home-based shift nursing (RN/LPN) care to individuals with complex care needs? ☐ Yes ☐ No

   If Yes, provide the start date of business (Date taken from IDPH License): _____

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

   What were their specific technology and skilled care needs? _____

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

   4a. If yes, provide a copy of your W-9.
   4b. If no, please provide a copy of your IRS EIN Assignment Letter and a copy of your W-9.

5. 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: _____

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

   _____ _____

_____ _____

*Administrative Representative/Title* *Date*

_____

*Email Address*