

Agency Name _____ Telephone # _____

Address _____ FAX Number _____

_____ FEIN # _____

_____ NPI# _____

1. Are you licensed as a Home Nursing Agency through the Illinois Department of Public Health?

If so, provide the license number:

2. Has the agency been in business for 1 year providing home-based shift nursing (RN/LPN) care to individuals with complex care needs? _____

If so, provide the start date of business: _____

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

What were their specific technology and skilled care needs? _____

4. Are you a certified vendor with the Illinois State Comptroller? _____

5. Are you an enrolled Medicaid provider in the IMPACT system as a Home Nursing Agency with the subspecialty of Nursing Services? _____

If so, provide the assigned IMPACT number: _____

6. What Counties are you approved for through IDPH? _____

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

_____ Administrative Representative/Title

_____ Date

_____ Email Address