State of Illinois
Department of Healthcare and Family Services

WAIVER PROGRAM PROVIDER AGREEMENT FOR PARTICIPATION IN THE ILLINOIS MEDICAL ASSISTANCE PROGRAM

As a Personal Assistant or private duty Certified Nurse Aide (CNA) for the Department of Human Services' Home Services Program, I agree to enroll as a Medicaid Waiver Program provider to be compensated for services and to comply with all conditions as contained within this agreement.

As a Medicaid Waiver Program Provider, I agree to:

- comply with all requirements set forth in the Home Services Customer/Provider Agreement (IL488-1947);
- not discriminate in the provision of services based on the grounds of sex, race, color, national origin or disability;
- comply with the Personal Assistant requirements as set forth in 89 Ill. Adm. Code 686.10, or the Certified Nurse Aide requirements as set forth in 77 Ill. Adm. Code 395:
- voluntarily assign the responsibility for payment to me for the services I provide to customers of the Department of Human Services Division of Rehabilitation Services (DHS-DRS);
- accept payment from the State of Illinois for services provided, as payment in full;
- be accurate, complete and truthful in the completion of the HOME SERVICES TIME SHEET (L488-2251), and by signing the IL488-2251, I agree to be fully liable for the information the form contains (Any submission of false or fraudulent billing, or any concealment of information relevant to the payment of these bills may be prosecuted under applicable Federal and State laws.);
- maintain a copy of the completed IL488-2251 and any other records related to the billing for services paid by the Division of Rehabilitation Services (These records must be maintained for at least three years from the date the service was billed.);
- notify DHS-DRS if there is an overpayment for any service provided and return any overpayment to the State of Illinois.

I agree that should the information provided be incomplete, inaccurate or falsified, it may be cause for my termination as a DHS-DRS provider under the Home Services Program.

Provider must complete the following:

Personal Assistant or CNA signature: _____

Personal Assistant or CNA **printed** name: _____

Personal Assistant or CNA Social Security number: _____

Personal Assistant or CNA Date of Birth: _____

HSP Customer Name: _____

To Be Completed by Field Office

HSP Customer district number: _____

HSP Office: _____

Address _____

City _____

State _____ Zip Code _____

_____ _____ _____

(Signature of HSP staff) (Job Title) (Date)

For State Use Only
Illinois Department of Healthcare and Family Services

_____ _____

Administrator, Division of Medical Programs Date

Print Form