NEW PROVIDER CHECK LIST

Home Health Providers

DATE: Click here to enter text.
PROVIDER NAME: Click here to enter text.
IMPACT APP ID: Click here to enter text.
NPI: Click here to enter text.

Our records show you are obligated to undergo a screening evaluation through the Illinois IMPACT system for enrollment as an Illinois Medicaid Provider. To continue your enrollment as a Home Health provider, any checked items below must be returned within thirty (30) business days. FAILURE TO FOLLOW ALL INSTRUCTIONS AND TO SUBMIT ALL REQUIRED DOCUMENTS WITHIN THE STATED TIME MAY RESULT IN THE DENIAL OF YOUR APPLICATION, AS PROVIDED IN 89 IL 140.28 AND IN 305 ILCS 5/12-4.25.

All checked items listed below must be submitted in one complete package within thirty (30) business days to the following email address: Impact.Pesdocs@illinois.gov. This email is ONLY for submitting documentation to the Department. Do not reply or send multiple inquiries to this email address. All electronic documents must be in one of the following formats: PDF, JPG, DOC, or DOCX. In the subject line of your email, you must include both your IMPACT Application Identification number and your official provider name. To send your information securely, we strongly recommend password protecting and using the following link to file transfer utility https://filet.illinois.gov/filet/PIMupload.asp. Send your password in a separate email.

☒Name, address and location of the agency.
☒A current organizational chart identifying business ownership, including name and percentage of ownership.
☒Proof of current good standing and registration with the IL Secretary of State only if you are registered as a corporation to operate under an assumed name. *You are not required to be registered as a corporation to be an IL Medicaid provider, unless you are located OUT OF STATE.
☒Copy of current Workers' Compensation insurance; or explanation of why you do not have insurance.
☒Copy of telephone bill dated within 30 days of submission of application.
☒Fingerprints submitted via LIVESCAN – See below for instruction.

Business location documentation (all are required)
☒Proof of current building ownership, or current valid lease agreement.
☒A Certificate of Insurance documenting minimum professional liability coverage of $1 Million per occurrence and $3 Million in the aggregate.
☒Proof of building insurance

For general questions about becoming a provider in the Illinois Medical Assistance Program or for assistance in IMPACT Provider Enrollment, please contact the Provider Enrollment helpdesk at 1-877-782-5565 or by email IMPACT.Help@illinois.gov.

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Fingerprints

Fingerprints must be submitted for each of the following:

- **each owner, direct or indirect, that owns 5% or more of the business**
- **each managing officer/employee**

Fingerprints must be submitted via LIVESCAN. Please submit proof of fingerprinting in the form of a copy of the electronic fingerprint receipt from the authorized fingerprint vendor. Please use this link for approved LIVESCAN vendors capable of completing the fingerprint process: https://www.idfpr.com/licenselookup/fingerprintlist.asp

You must provide the ORI number and the purpose code to the fingerprint vendor. The ORI number for the Illinois Department of Healthcare and Family Services is IL920600Z and the purpose code is MMV (Medicare Medicaid Vendors).

In accordance with 305 ILCS 5/12-4.25 (G)(2) *Medical Assistance Program; Vendor Participation* Title 89 Illinois Administrative Code Section 140.498 (a)(1) *Fingerprint-Based Criminal Background Checks* "Vendors shall be responsible for the payment of costs of fingerprint-based criminal background checks."

If you have submitted fingerprints under the ORI number assigned to the Illinois Department of Healthcare and Family Services within the preceding year, you do not need to obtain new fingerprints. You may submit a copy of the receipt from the authorized fingerprint vendor as proof.

If you are an **out-of-state** applicant, you must contact the OIG to obtain a fingerprint card and Form IL486-2222 OOS-FP Identity Verification Certifying Statement for obtaining and submitting inked fingerprints via a LIVESCAN vendor capable of processing inked fingerprints cards. Please look for this capability on the list of approved vendors identified in the link at the end of this email. Please email your request for a fingerprint card to HFS.OIG.LiveScan@illinois.gov; **the subject line must contain the IMPACT application ID number and the official provider name.** Your email request must identify the number of cards necessary and ONE address to which the cards will be mailed. THIS MAILBOX WILL NOT BE UTILIZED FOR ANY COMMUNICATION OTHER THAN REQUESTING FINGERPRINT CARDS FOR OUT-OF-STATE APPLICANTS.

FBI NOTICE: Under provisions set forth in Title 28, Code of Federal Regulations (CFR), Section 50.12, you are hereby notified that all fingerprints submitted will be used to check the Criminal History Records of the FBI. Identification records obtained from the FBI will be used solely for the purpose requested cannot be disseminated outside of the HFS Office of the Inspector General. If the information contained in a Criminal History Record disqualifies an applicant, the OIG official making the determination of suitability for employment, in the State's Medicaid Program, shall provide an applicant the opportunity to complete, or challenge the accuracy of the information contained in the FBI Identification Record, and afford an applicant a reasonable time to correct or complete the information, or decline to do so. The Procedures to change, correct, or update a criminal history record are set forth in Title 28, CFR, Section 16.34.