COMMUNITY CARE PROGRAM PROVIDER APPLICATION FOR
ADULT DAY SERVICE

INSTRUCTIONS: Please print or type (no pencil). Write “N/A” if question is not applicable.

Applicant:

PART A. PROPOSED SERVICE AREA

1. PLANNING AND SERVICE AREA (PSA) IN WHICH ADULT DAY SERVICE SITE IS LOCATED:
   PSA NUMBER: ____________

   Indicate below the geographic area which you propose to serve from the adult day service site.

   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

   Attach a map of the proposed area.

2. MARK ALL EXCEPTIONS WHICH APPLY TO YOUR AGENCY:

   □ a. Serving limited or non-English speaking clients
       Identify language group(s) served: __________________________________

   □ b. Unit of local government
       Provide details: __________________________________

   □ c. Benevolent, charitable, social or religious organization providing services under organization charter to a specific population or in an area smaller than a county, sub-area or township.
       Provide details: __________________________________

3. CAN TRANSPORTATION TO/FROM YOUR FACILITY BE COMPLETED IN A REASONABLE PERIOD OF TIME?
   □ Yes    □ No
PART B. APPLICANT INFORMATION

1. LEGAL NAME OF AGENCY __________________________________________________________

2. ADDRESS OF ADMINISTRATIVE OFFICE

   Street: ____________________________________________________________
   City: __________________________ State: _______ Zip Code: __________
   Telephone: (      ) __________ Ext. _____ Fax: (      ) __________

3. CONTACT PERSON AT ADMINISTRATIVE OFFICE

   Name: ____________________________________________________________
   Title: ____________________________________________________________
   E-Mail: __________________________________________________________

4. BUSINESS HOURS OF ADMINISTRATIVE OFFICE: ________ A.M. TO ________ P.M.

5. ADULT DAY SERVICE SITE

   A. NAME (if different from Administrative Office):

   _________________________________________________________________

   B. ADDRESS (if different from Administrative Office)

   Street: __________________________________________________________
   City: __________________________ State: _______ Zip Code: __________
   Telephone: (      ) __________ Ext. _____ Fax: (      ) __________

   C. CONTACT PERSON

   Name: __________________________________________________________
   Title: __________________________________________________________
   E-Mail: ________________________________________________________
**PART C. OPERATION INFORMATION**

1. **SERVICE HOURS OF SITE:** ________ A.M. TO ________ P.M.

2. **DAYS OF OPERATION?**
   - [ ] Monday    [ ] Tuesday    [ ] Wednesday    [ ] Thursday    [ ] Friday    [ ] Saturday    [ ] Sunday

3. **DAYS/DATES WHEN SERVICE WILL NOT BE PROVIDED:**
   - __________________________________________________________
   - __________________________________________________________
   - __________________________________________________________

4. **ATTACH ADMISSION POLICY**

5. **ATTACH DISCHARGE POLICY**

6. **WHAT IS THE TOTAL SQUARE FEET OF ACTIVITY AREA PER CLIENT?** __________

7. **WHAT IS THE MAXIMUM NUMBER OF CCP CLIENTS THAT WILL BE SERVED AT THIS SITE?** __________

8. **INDICATE BELOW THE NUMBER OF REQUIRED ADULT DAY SERVICE STAFF AT THE SITE:**

<table>
<thead>
<tr>
<th>Role</th>
<th>None</th>
<th>Employ</th>
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<th>Other</th>
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<td>Full Time</td>
<td>Part Time</td>
<td>Full Time</td>
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<td>Program Administrator</td>
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<td>Program Coordinator/Director</td>
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<td>Program Nurse</td>
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<td>Certified Nutrition Staff</td>
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<tr>
<td>Nutrition Consultant/Dietitian</td>
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<td>Transportation Driver/Escort</td>
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</table>

**If “NONE” OR “OTHER” IS MARKED, EXPLAIN:** ________________________________
PART D. SERVICE INFORMATION

Check (X) Yes or No for questions 1 – 10

1. I have read and understand all applicable Community Care Program (CCP) rules set forth in 89 Illinois Administrative Code Part 240. ☐ Yes ☐ No

2. I have read and understand the definition of Adult Day Service as stated in Section 240.230. ☐ Yes ☐ No

3. I have read and understand that I must provide the specific service components of Adult Day Service as stated in Section 240.230 of the CCP rules, when required by the Plan of Care, including:
   a. assessment of the client’s strengths and needs, and development of an individual written plan of care for each client that establishes specific client goals for all service components to be provided or arranged for by the service provider; ☐ Yes ☐ No
   b. a balance of purposeful activities to meet the client’s interrelated needs and interests (social, intellectual, cultural, economic, emotional, physical and spiritual) designed to improve or maintain the optimal functioning of the client; ☐ Yes ☐ No
   c. assistance with or supervision of activities of daily living (e.g., walking, eating, toileting and personal care), as needed; ☐ Yes ☐ No
   d. provision of health-related services appropriate to the client’s needs as identified in the provider’s assessment and/or physician’s orders, including health monitoring, nursing intervention on a moderate or intermittent basis for medical conditions and functional limitations, medication monitoring, medication administration or supervision or self-administration, and coordination of health services; ☐ Yes ☐ No
   e. a nutritious daily meal, supplementary snacks, and special diets as directed by the client’s physician; ☐ Yes ☐ No
   f. agency provision or arrangement for transportation, with at least one vehicle physically accessible, to enable clients to receive adult day service at the adult day service provider’s site and participate in sponsored outings; and ☐ Yes ☐ No
   g. provision of emergency care as appropriate in accordance with established adult day service provider policies and Section 240.1510 of this Part. ☐ Yes ☐ No

4. I will comply with all aspects of the Plan of Care specified in CCP rule Section 240.730. ☐ Yes ☐ No

5. I will comply with all Administrative Requirements for Certification specified in CCP rule Section 240.1505. ☐ Yes ☐ No

6. I have read and understand that my agency must establish and comply with all written policies and procedures specified in CCP rule Section 240.1510. ☐ Yes ☐ No
7. I will be accountable for all Provider Responsibilities specified in CCP rule Section 240.1520, including not deviating from:
   a. I have read and understand that I must comply with the insurance requirements specified in CCP rule Section 240.1520. □ Yes □ No
   b. I have read and understand that my agency must accept all CCP client referrals except under the conditions specified in CCP rule Section 240.1520(f).
      □ Yes □ No
   c. I have read and understand that my agency shall not deviate from a CCP client’s plan of care without specific direction from the Department or the Case Coordination Unit except under the conditions specified in CCP rule Section 240.1520 (g). □ Yes □ No
   d. I have read and understand that my agency must advise the CCU of any changes in the client’s physical, mental or environmental needs when the changes would affect the client’s eligibility or service level or would require a change in the plan of care, as specified in CCP rule Section 240.1520(h).
      □ Yes □ No
   e. I have read and understand that my agency must respond to all client requests within 15 calendar days from the date of the request, as specified in CCP rule Section 240.1520(i). □ Yes □ No
   f. I have read and understand that my agency must bill the Department electronically as specified in CCP rule Section 240.1520(j). □ Yes □ No
   g. I have read and understand that my agency must bill a CCP client for any incurred expense for care in compliance with CCP rule Section 240.1520(k).
      □ Yes □ No

8. I will comply with all Standards Requirements for Adult Day Service Providers specified in CCP rule Section 240.1550. □ Yes □ No

9. I will comply with all General Adult Day Service Staffing Requirements specified in CCP rule Section 240.1555. □ Yes □ No

10. I will comply with all standards for Adult Day Service Staff specified in CCP rule Section 240.1560. □ Yes □ No

PART E. SUBCONTRACTS

1. How will transportation be provided to CCP clients?
   □ Client transportation will be provided in a vehicle(s) owned or leased by this agency.
   □ Client transportation will be provided by a subcontractor. “Part F., Request for Approval to Subcontract” form, must be submitted before an agreement can be executed.
   □ Arrangements have not yet been made for the provision of client transportation.

2. How will meals be provided to CCP clients?
   □ Meals will be provided by the adult day service.
   □ Meals will be provided by a subcontractor. “Part F., Request for Approval to Subcontract” form, must be submitted before an agreement can be executed.
   □ Arrangements have not yet been made for meal provision to clients.
PART F.  ILLINOIS DEPARTMENT ON AGING
REQUEST FOR APPROVAL TO SUBCONTRACT

MAKE COPIES AS NEEDED

A. REQUESTING AGENCY
   Name: ____________________________________________________________

SITE ADDRESS
   Street: ____________________________________________________________________
   City: __________________________ State: _______ Zip Code: __________

CONTACT PERSON
   Name: ____________________________________________________________
   Title: ___________________________________________________________________
   Telephone: (   ) ________________ Fax: (   ) ________________

B. SUBCONTRACTOR
   Name: ____________________________________________________________

ADDRESS
   Street: ____________________________________________________________________
   City: __________________________ State: _______ Zip Code: __________

Authorized Subcontractor Representative
   Name: ____________________________________________________________
   Title: ___________________________________________________________________
   Telephone: (   ) ________________ Fax: (   ) ________________

C. PURPOSE OF SUBCONTRACT
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

Signature (Authorized Representative/Requesting Agency) __________________________ Date __________________________

Type or Print Name/Title (Authorized Representative/Requesting Agency) __________________________
PART G. APPLICANT SIGNATURE PAGE

By my notarized signature below,

I certify that information in this Adult Day Service Provider Certification Application is true, accurate, and complete to the best of my knowledge as of the time of signing; that the agency is fiscally sound; that the service proposed herein complies with all Rules of the Community Care Program and will be provided to all eligible program participants in accordance with the Client Agreement–Plan of Care, regardless of race, color, national origin, religion, sex, sexual orientation, ancestry, marital status, physical or mental disability, unfavorable military discharge, or age; that the agency is in compliance with all applicable Federal, State, and local laws, regulations, and ordinances; and that the agency will cooperate with Department officials in verifying information and hereby authorizes any third party with relevant information bearing on the certification decision to release such information to the Department upon request.

I understand that knowingly providing false information or omitting information may result in denial of certification, decertification, or debarment as a service provider under the Community Care Program, termination of any Provider Agreement, and/or other enforcement action under federal and state law.

I also agree to update this information as necessary so that it remains true, accurate, and complete while this application is being processed.

____________________________________________
Signature of Authorized Representation

Date

Name/Title (Type or Print)

NOTARY CERTIFICATE

STATE OF _______________________

COUNTY OF _______________________

Subscribed and sworn to before me this ___ day of _________, 20____.

________________________
Signature of Notary Public

Printed or typed name of Notary Public

County of residence

Date commission expires

Return original and 2 copies of form to: REMEMBER TO KEEP A COPY FOR YOUR RECORDS

Illinois Department on Aging
Attn: Office of Service Development and Procurement
One Natural Resources Way, Suite 100
Springfield, IL 62702-1271

This application is authorized as outlined by the Illinois Act on the Aging. Disclosure of this information is REQUIRED. Failure to provide information could result in denial of certification as a service provider under the Community Care Program.

The Illinois Department on Aging does not discriminate in admission to programs or treatment of employment in government-funded programs, services, or activities in compliance with applicable civil rights laws, policies, and procedures. If you feel you have been discriminated against, you have a right to file a complaint with the Illinois Department on Aging. For information, call the Senior HelpLine: 1-800-252-8966 (Voice); 1-888-206-1327 (TTY).