INSTRUCTIONS

APPLICATION FOR HOME MEDICAL EQUIPMENT PROVIDER

In order for your application to be processed,
<u>ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED</u>
with the application and required fee unless otherwise directed in the instructions.

Purpose

The Home Medical Equipment and Services Provider Licensing Act of 1998 provides for the licensure of entities providing home medical equipment and its services.

Completing the Application

The application which you submit is valid for 3 years from date of receipt.

1) All information must be accurate and complete. Incomplete applications will not be processed and will be returned to you for completion.
2) Information should be typed or printed legibly with black ink.
3) **Initial Application for Licensure:** Complete questions 1-13 of the application including either Section I or II.
4) **Change of Ownership:** Complete questions 1-13 of the application and Section III.
5) **Re-Application:** (Change of address, change of name of facility or change of person responsible for day to day operations):
   (a) Complete questions 1-13 of the application.
   (b) Complete applicable portion of Sections I-VI.
   (c) Sign application.
6) **Out-of-State Applicants**
   (a) submit Certification of Licensure (CT-PH) completed by the principal state in which the facility is located, if applicable.
   (b) submit copy of last inspection report, if applicable.
7) **Corporations:**
   (a) attach a copy of the Articles of Incorporation
8) **Limited Liability Corporation:**
   (a) attach a copy of the Articles of Organization
9) **Certificate:** If certified by any recognized accreditation body, attach copy of certificate.

Certificate of Insurance

Supporting Document HME-INS must be properly completed and submitted. This is the only proof of commercial general liability insurance which will be accepted by this Department.

Fees

Initial licensure or change of ownership	$300
Change of address of facility	$150
Name change of facility	$150

Home Medical Equipment Providers

A separate license is required for each facility where business is conducted.

Mailing Address

Mail the completed application with the fee in the form of a check or money order to:

Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
320 W. Washington Street, 3rd Floor
Springfield, Illinois 62786

Telephone No.

For assistance in completing your application call:

1-800-560-6420 or TTY 1-866-325-4949

Internet Address

or visit our website at:

<u>www.idfpr.illinois.gov</u>

This page intentionally left blank for double-sided printing.

Illinois Department of Financial and Professional Regulation
320 West Washington, 3rd Floor, Springfield, Illinois 62786

License No.:_____

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 51/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

☐ **Illinois In-State Home Medical Equipment Provider License Application**
☐ **Illinois Out-of-State Home Medical Equipment Provider License Application**

☐ **Original Application** ☐ **Re-application**

Profession Code **203**

TO BE COMPLETED BY ALL APPLICANTS

1. TYPE OF APPLICATION
☐ New
☐ Change of Ownership
☐ Change of Name of Licensed Facility
☐ Change of Address

2. LEGAL NAME OF BUSINESS

3. ALL TRADE OR BUSINESS (DBA) NAMES USED BY CORPORATION OR LICENSEE

4. FEIN NUMBER

5. MEDICARE (NSC) ID NUMBER

6. NAME OF PERSON RESPONSIBLE FOR ON-SITE DAY TO DAY OPERATIONS

7. SSN OR ITIN

8. DATE OF BIRTH

9. PRINCIPAL ADDRESS OF FACILITY (Include Street, City, State and ZIP Code)

10. COUNTY

11. PHONE NO. (Include Area Code)

12. EMAIL ADDRESS (REQUIRED)

13. TYPE OF OWNERSHIP
☐ Individual ☐ Limited Liability Company
☐ Partnership ☐ Corporation
☐ Other

14. NUMBER OF OFF-SITE STORAGE FACILITIES OR WAREHOUSES UNDER OWNERSHIP OF ABOVE (Attach a separate sheet if needed.)

15.ACCREDITATION/CERTIFICATION NUMBER (If applicable)

16 SERVICES PROVIDED
☐ Oxygen and oxygen delivery systems ☐ Ventilators
☐ Respiratory disease management devices, excluding compressor driven nebulizers ☐ Apnea monitors
☐ Wheelchair seating systems
☐ Hospital beds and electronic computer driven wheelchairs excluding scooters
☐ Transcutaneous electrical nerve stimulator (TENS) units
☐ Low air-loss cutaneous pressure management devices
☐ Sequential compression devices
☐ Neonatal home phototherapy devices
☐ Enteral feeding pumps
☐ Other similar equipment

17 IF OXYGEN IS CHECKED ABOVE:
Do you transfill oxygen? ☐ Yes ☐ No
Do you carry over 1000 lbs ☐ Yes ☐ No

18 IF YES, PLEASE PROVIDE:
FDA# _____ DOT#_____

SECTION I

COMPLETE ONLY IF ILLINOIS IN-STATE FACILITY

APPROXIMATE DATE FACILITY WILL BE READY FOR OPERATION

SECTION II

COMPLETE ONLY IF OUT-OF-STATE APPLICANT
(Attach copy of HME and/or Pharmacy License, if applicable)

a. State(s) Currently Licensed In

b. License Number(s)

SECTION III

COMPLETE ONLY IF CHANGE OF OWNERSHIP

a. Previous Owner Information - Name, Address and FEIN No.

b. Previous Illinois HME License No.

c. Effective Date of Change

SECTION IV

COMPLETE ONLY IF CHANGE OF ADDRESS

a. Previous Address of Facility

b. Current Illinois HME License No.

c. Date of Proposed Opening

SECTION V

COMPLETE ONLY IF CHANGE OF NAME OF LICENSED FACILITY

a. Previous Legal Name of Facility

b. Is this a change of ownership? ☐ Yes ☐ No

c. Current Illinois License No.

d. Effective Date of Change

Legal Name of Business:

FEIN or SSN or ITIN:

Profession Name: HOME MEDICAL EQUIPMENT

TO BE COMPLETED BY ALL APPLICANTS

13. Has applicant, or any names therein listed, ever been convicted in a court of law, hearing, or other administrative procedure with any violation of the laws of the United States or of any individual state, relating to drugs, liquor, poisonous substance or any felony offense? ☐Yes ☐No *(If "Yes," state all particulars, dates, places, and present status on separate sheet.)*

I do solemnly swear or affirm that the answers appearing hereon are true and correct to the best of my knowledge and belief, that I am legally authorized to sign for this business, and complies with all applicable federal and State licensure and regulatory requirements; maintains a physical facility and medical equipment inventory (there shall only be one license permitted at each address); establishes proof of commercial general liability insurance, including but not limited to, coverage for products liability and professional liability; establishes and provides records of annual continuing education for personnel engaged in the delivery, maintenance, repair, cleaning, inventory control, and financial management of home medical equipment and services; maintains records on all patients to whom it provides home medical equipment and services; establishes equipment management and personnel policies; makes life sustaining home medical equipment and services available 24 hours per day and 7 days per week; and complies with any additional qualifications for licensure as determined by rule of the Department.

Type or Print Name of Person Responsible for Day to Day Operations	Signature of Person Responsible for Day to Day Operations	Date
Type or Print Name of Owner or Person Designated to Sign for Firm	Signature of Owner or Person Designated to Sign for Firm	Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

TO BE COMPLETED BY ALL APPLICANTS. List below the names and addresses of any other HME facilities in Illinois owned by the applicant.

	Name and Address of Each Facility: (Street Address, City, State, ZIP Code & County)	Area Code and Telephone Number of each facility: / License Number(s)	Full name, emergency telephone and social security number of the responsible person for each facility:	
1		Facility Phone No.	Full Name	
		License No.	Emergency Phone No.	
		Controlled Substance License No.	Social Security No.	Date of Birth
2		Facility Phone No.	Full Name	
		License No.	Emergency Phone No.	
		Controlled Substance License No.	Social Security No.	Date of Birth
3		Facility Phone No.	Full Name	
		License No	Emergency Phone No.	
		Controlled Substance License No.	Social Security No.	Date of Birth
4		Facility Phone No.	Full Name	
		License No	Emergency Phone No.	
		Controlled Substance License No.	Social Security No.	Date of Birth

TO BE COMPLETED BY ALL APPLICANTS

Legal Name of Business:

FEIN or SSN or ITIN:

Profession Name: HOME MEDICAL EQUIPMENT

SOLE PROPRIETORSHIP

Owner Name	Date of Birth	Social Security No.
Address (Street, City, State, ZIP Code)		

PARTNERSHIP (If additional space is required, list on a separate sheet.)

Partner Name	Date of Birth	Social Security No.
Address (Street, City, State, ZIP Code)		Percentage of Ownership
Partner Name	Date of Birth	Social Security No.
Address (Street, City, State, ZIP Code)		Percentage of Ownership
Partner Name	Date of Birth	Social Security No.
Address (Street, City, State, ZIP Code)		Percentage of Ownership

CORPORATION (List all officers, directors and shareholders owning 5% or more of outstanding shares.
If additional space is needed, use separate sheet.)

Name
Address (Street, City, State, ZIP Code)
Name
Address (Street, City, State, ZIP Code)
Name
Address (Street, City, State, ZIP Code)
Name
Address (Street, City, State, ZIP Code)

LIMITED LIABILITY COMPANY (List manager or members owning 5% or more of outstanding shares.
If additional space is needed, use separate sheet.)

Name
Address (Street, City, State, ZIP Code)
Name
Address (Street, City, State, ZIP Code)
Name
Address (Street, City, State, ZIP Code)
Name
Address (Street, City, State, ZIP Code)
Name
Address (Street, City, State, ZIP Code)

This page intentionally left blank for double-sided printing.

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Application Checklist for Home Medical Equipment Provider

In order for your application to be processed,
<u>ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED</u>
with the application and required fee unless otherwise directed in the instructions.

Before you mail your application, check the following items to make sure your application is complete!

THREE-PAGE APPLICATION REVIEW	**COMPLETED**
Page 1, Boxes 1-18	
Section I	
Section II	
Section III	
Section IV	
Section V	
Certifying Statement--Signed and Dated	
List of other facilities owned	
List of owners, officers, directors, shareholders	
SUPPORTING DOCUMENTS	**SUBMITTED**
HME-INS Form	
CT-PH Form (Facilities located outside of Illinois only)	

All supporting documents *<u>may not be required</u>*. Please refer to application instructions for your specific method of licensure.

This page intentionally left blank for double-sided printing.

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 120 (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

PHARMACY

CERTIFICATION BY LICENSING AGENCY / BOARD

SUPPORTING DOCUMENT

CT-PH

APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. You are authorized to photocopy this form as necessary.

1. NAME OF BUSINESS, CORPORATION, OR LLC			
2. DBA (ASSUMED NAME)			3. FEIN
4. FACILITY STREET ADDRESS		5. EMAIL ADDRESS (REQUIRED)	
6. FACILITY CITY	7. STATE	8. ZIP CODE	9. TELEPHONE NUMBER (include Area Code)

I hereby authorize _____ to furnish to the Illinois Department of
Other State Licensing Agency
Financial and Professional Regulation the information requested below.

Date _____ Signature of Applicant _____

DO NOT RETURN COMPLETED FORM TO APPLICANT

OTHER STATE LICENSING AGENCY: **The Illinois Department of Financial and Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the Certification. Please record N/A in areas which are not applicable.**

A. LICENSE NUMBER		F. TYPE OF LICENSE
B. LICENSE STATUS		☐ Pharmacy ☐ Wholesale Drug Distributor/Manufacturer ☐ Third Party Logistics (3PL) Provider ☐ Home Medical Equipment / Durable Medical Equipment ☐ Other _____
C. DATE ISSUED	D. DATE LICENSE EXPIRES	
E. HAS THIS LICENSE BEEN ENCUMBERED IN ANY WAY? _____ Yes _____ No **If "yes," please attach certified copies of all pertinent legal documents.**		G. TYPE OF ENCUMBERANCE ☐ Revoked ☐ Suspended / Restricted ☐ Surrendered ☐ Probation ☐ Limited

USE REVERSE SIDE OF THIS FORM FOR EXPLANATIONS.

1. Has the applicant been convicted under any federal, state, or local laws relating to drug samples, wholesale or retail drug distribution, or distribution of controlled substances, or the provision of home medical equipment and its services? ☐ Yes ☐ No
2. Has the applicant furnished any false or fraudulent material in any application made in connection with a pharmacy operation, drug manufacturing or distribution, or home medical equipment or its services? ☐ Yes ☐ No
3. Have any inspections resulted in deficiency ratings? (If yes, please explain.) ☐ Yes ☐ No
4. Has the applicant met all licensing requirements in your state? ☐ Yes ☐ No

BOARD SEAL AREA (affix official State Seal of licensing agency below) SEAL	**RETURN FORM TO:** Illinois Department of Financial and Professional Regulation Health Services Section 320 W. Washington Springfield, Illinois 62786
Signature	**Title**
State	**Date**

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

CERTIFICATION OF INSURANCE

SUPPORTING DOCUMENT

HME-INS

APPLICANT: ***Complete the applicant section of this form, then have your authorized insurance agent complete the remainder of the form. The completed form must be submitted WITH your application for licensure. This is the only form which you need to submit if you are certifying to current insurance coverage after the expiration of a previously held policy.***

1. NAME OF INSURED HOME MEDICAL EQUIPMENT & SERVICES PROVIDER BUSINESS (Must be exactly as it appears on application, renewal form or license.)

2. FEIN (If applicable)

3. SSN OR ITIN (If individual owner)
__ __ __ - __ __ - __ __ __ __

4. ADDRESS STREET, CITY, STATE, ZIP CODE (Specific Address of insured's location covered by insurance policy.)

5. NEW APPLICANTS ONLY

REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.

Home Medical Equipment & Services Provider — Profession Name

2 0 3 — Profession Code

6. TELEPHONE NUMBER (Where you can be reached during the day)

Area Code (__ __ __) __ __ __ - __ __ __ __

7. RENEWAL APPLICANTS AND PERSONS VERIFYING CURRENT INSURANCE ONLY.

INDIVIDUAL LICENSE NUMBER - RECORD THE LICENSE NUMBER YOU HOLD (IF APPLICABLE).

203 - _____

I hold commercial general liability insurance in at least the minimum amount of $1,000,000 including, but not limited to coverage for product liability and professional liability. Under penalties of perjury, I declare that I have examined this form, and to the best of my knowledge, it is true, correct, and complete.

Type or Print Name of Owner or Person Designated to Sign for Firm

Signature of Owner or Person Designated to Sign for Firm

Type or Print Title of Owner or Person Designated to Sign for Firm

Date

INSURANCE COMPANY: Complete the following information and return this form to the insured party.

A. NAME OF INSURANCE COMPANY

B. NAME OF AUTHORIZED AGENCY

C. INSURANCE COMPANY HOME ADDRESS: STREET, CITY, STATE, ZIP CODE

D. AGENT'S ADDRESS: STREET, CITY, STATE, ZIP CODE

E. INSURED'S POLICY NUMBER

F. AGENT'S BUSINESS TELEPHONE NUMBER

Area Code (__ __ __) __ __ __ - __ __ __ __

G. EFFECTIVE DATE OF POLICY

__ __ / __ __ / __ __
Month Day Year

H. EXPIRATION DATE OF POLICY

__ __ / __ __ / __ __
Month Day Year

If this Policy is terminated prior to its expiration, the Company agrees to give written notice to the Department of Financial and Professional Regulation, Division of Professional Regulation, at least thirty (30) days prior to the effective date of cancellation.

Signature of Authorized Agent

Date