State of Illinois
Illinois Department of Public Health

HHA Administrator Qualification Review Form

HOME HEALTH AGENCY ONLY
Attachment A - Administrator Qualification Review Form

Home Health Agency Name _____

Address _____

City _____ State _____ ZIP Code _____

Administrator Information

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ ZIP Code _____

Daytime Phone Number _____ Extension _____

Check one of the following categories. Section 245.20 "Home Health Agency Administrator" requires that the administrator must be one of the following:

○ Physician ○ Registered Nurse

○ Individual who meets the requirements for a public health administrator as defined in 77 IL Adm. Code 660.310

○ Individual with at least one year supervisory or administrative experience in home health care or in a related health program

Indicate the highest educational level obtained:

○ High School ○ ADN ○ Diploma R.N. ○ B.S.N.
○ B.A. ○ B.S. ○ Master's ○ Doctorate ○ M.D.

Please list the college(s) attended, the address, date of graduation, specialty and degree obtained.

Name of College _____

Address of College _____

City _____ State _____ ZIP Code _____

Date of Graduation _____ Specialty/Degree _____

Name of College _____

Address of College _____

City _____ State _____ ZIP Code _____

Date of Graduation _____ Specialty/Degree _____

Please list the high school attended, the address, and date of graduation.

Name of High School _____ Date of Graduation _____

Address of High School _____

City _____ State _____ ZIP Code _____

HHA Administrator Qualification Review Form

List applicable professional licenses, registrations and/or certifications currently held with the license number, date of expiration and state that issued the license, registration or certification. **ATTACH A COPY OF YOUR CURRENT ILLINOIS LICENSE IF APPLICABLE. YOUR CURRENT EMPLOYER MUST BE THE AGENCY IDENTIFIED IN THIS APPLICATION. Please also include a letter of intentions with this application (the applicant must write a letter stating that if he/she will be working part time elsewhere, as well as for this agency, both agencies are aware of the situation, and it presents no conflict of interest.**

_____

Describe your relevant work experience for the last five years.
(1) List your most recent position with **THIS AGENCY FIRST** and work backward.
(2) Give the starting and ending dates (month and year) for each employment and the weekly hours worked.
(3) Describe the administrative and financial functions performed for each position, with each agency, that qualify you to function as the administrator of a home health agency.
(4) Include the names, addresses and telephone numbers of organizations.

You may use an additional sheet of paper to complete this section. Resumes are not accepted in lieu of completion of this portion of the form.

Current Employer Name _____

Address of Current Employer _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total Hours Worked Weekly _____

Duties _____

_____

_____

Previous Employer Name _____

Address of Previous Employer _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total Hours Worked Weekly _____

Duties _____

_____

_____

State of Illinois
Illinois Department of Public Health

HHA Administrator Qualification Review Form

Previous Employer Name _____

Address of Previous Employer _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total Hours Worked Weekly _____

Duties _____

_____

_____

Have you ever been convicted of a criminal offense? ○ Yes ○ No

Are there any pending or administratively resolved issues concerning your professional license in Illinois or in another state? ○ Yes ○ No

If you answered "yes" to either or both of the above statements, please describe the criminal offense and/or the pending or administratively resolved licensure issues in detail, including the state of administrative action [Section 245.130 b) 2]. You may attach an additional sheet of paper if necessary for the explanation.

_____

_____

_____

_____

_____

I signify that the information contained in this form is true and correct to the best of my knowledge and belief. I realize that misrepresentation of this information at any time may be cause for denial of this application, or future revocation of a license.

_____ _____

Signature of Applicant (Original Only) Date Signed