State of Illinois
Healthcare and Family Services

Payment to Corporate Owners / Assurances

_____ located at,
FACILITY

_____
STREET

_____ _____ _____
CITY STATE ZIP CODE

wishes to have payments from the Illinois Department of Healthcare and Family Services sent directly to the address of the corporation or partnership business office. The facility and the owner must complete this form in order for the Department to send payments to an alternate payee address.

_____
NAME OF CORPORATION / PARTNERSHIP

_____ _____ _____ _____
CENTRAL BUSINESS OFFICE ADDRESS CITY STATE ZIP CODE

_____
FEDERAL EMPLOYEES IDENTIIFICATION NUMBER (FEIN)

_____
STATE OF INCORPORATION

CORPORATION / PARTNERSHIP OWNERS

BOARD OF DIRECTORS

1. The facility will maintain and make available to the Department, such records as are necessary to fully disclose the extent of the care or services rendered to Medicaid residents.

2. The facility will maintain and make available to the Department, such information regarding any payments claimed by the facility for providing care or services to residents as the Department may request. If such records are maintained at the central office location of the corporate or partnership owner, the corporate or partnership owner will make them available at the facility location at the request of the Department. Copies of the remittance advice will be maintained at the facility.

3. The facility and the corporate or partnership owner will maintain and make available all the financial records that may be requested by the Department, specifically including the records that set forth the terms of the relationship between the facility and its owner.

4. A facility shall manage a resident's personal funds only upon the written authorization from, in order of priority, the resident, the resident's guardian, the resident's representative, or the resident's immediate family member. Such authorization shall be attested to by a witness who has no pecuniary interest in the facility or its operations and who is not connected in any way to facility personnel or the administrator in any manner. If the facility manages the resident's personal funds, it must establish a separate, written record of each account. The facility will maintain the resident account records and resident room and board account records at the facility.

Payment to Corporate Owners / Assurances

5. The facility and the corporate or partnership owner will retain full responsibility for all payments made. This responsibility includes liability to repay any overpayments made by the Department.

6. In accepting Department payments, the facility warrants that it shall review all remittance advices that accompany payments and shall certify that all services specified therein are a true, accurate and complete record of services rendered by the facility. Furthermore, the facility agrees to review, affix an original signature, and retain in its files the Billing Certification which is the last page of the remittance advice.

7. The facility shall promptly notify the Department when it becomes aware of changes in services that may effect Department payment, provided that such notice shall in no event be made more than thirty days after the facility's receipt of any incorrect or incomplete remittance advice(s). The Department shall recover any overpayments that may occur as a result of the facility's failure to timely notify the Department of changes or corrections in services provided by setoff, crediting against future billings or by requiring direct repayment to the Department.

8. None of the officers, directors, or shareholders (of 5% or more of the shares of stock) of the corporate or partnership owner have been barred from participation in the Medical Assistance Program.

9. The facility and the corporate or partnership owner will notify the Department if ownership interest in the facility is transferred. Additionally, the facility and the corporate or partnership owner will notify the Department if any of the information on the Form HFS 2314 changes.

SIGNATURE OF FACILITY ADMINISTRATOR

DATE

PRINTED NAME OF ADMINISTRATOR

SIGNATURE OF CHIEF EXECUTIVE OFFICER OF THE CORPORATION / PARTNERSHIP

DATE

PRINTED NA,ME OF CHIEF EXECUTIVE OFFICER OF THE CORPORATION / PARTNERSHIP

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