DIRECT SUPPORT PERSON (DSP) TRAINING
ILLINOIS HEALTH CARE WORKER REGISTRY

INSTRUCTION MANUAL

JUNE
2012

THIS BOOKLET INCLUDES STEP-BY-STEP INSTRUCTIONS FOR SUBMITTING DSP TRAINING TO THE ILLINOIS HEALTH CARE WORKER REGISTRY

Illinois Department of Human Services
Division of Developmental Disabilities
319 E. Madison Street, Suite 4J
Springfield, IL 62701

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WHEN TO SUBMIT THE DSP TRAINING REGISTRY PACKET

A DSP Training record should be submitted to the Illinois Health Care Worker Registry when the DSP has successfully completed **120 hours of DSP training from a training program that has been approved by the Illinois Department of Human Services.** The Illinois Health Care Worker Registry Application Form, referred to in this Instruction Manual as the DSP Registry Form, must be **completed accurately and submitted online to SIU within 30 days of the DSP training completion date for each DSP.**

DSP Registry Forms completed after 30 days following the successful completion of the 120 hours of DSP training will not be accepted by the SIU online system **without a Waiver Letter** from the Department of Human Services (DHS) waiving this State of Illinois training requirement. More information about DSP Waivers for Delays in Meeting Training Requirements is available on the DHS website.

COMPLETING THE DSP REGISTRY FORM

The Illinois Health Care Worker Registry Application Form (DSP Registry Form) replaces the Scranton Form used previously to report DSP training completion. **Scranton forms are no longer accepted by SIU.**

Follow the completion directions on the Illinois Health Care Worker Registry Application Form before entering the information in the SIU online system. All required Applicant information **MUST** be provided on this form. The fields are identified below:

REQUIRED INFORMATION

Name

Enter the DSP's last name, first name, and middle name (if applicable). Please make sure the names entered here match the ones used by the trainee to request an Illinois State Police fingerprint criminal background check.

Date of Birth

Enter the month, the date, and the year the DSP was born.

Social Security Number

Enter the DSP's Social Security Number (SSN) in the spaces provided. This number is used as the unique identifier for person's reported on the Illinois Health Care Worker Registry. Please make sure the SSN is correct and matches the SSN used by the trainee to request an Illinois State Police fingerprint criminal background check.

COMPLETING THE DSP REGISTRY FORM (continued)

Address

Enter the DSP's complete street address, apartment number (if applicable), city, state, and 5- digit zip code where the DSP receives mail.

Telephone Number

Enter the telephone number where the DSP can be reached during the day.

Program Code

Enter the agency's 4–digit program code. If you do not know this code, please call 217-782-9438.

Program Completion Date

Enter the month, day, and year the **DSP successfully completed the 120 hours of DSP training**. The month, day and year must be the same as the date reported on the DSP Core Competency Area Checklist (IL 462-1286) or Direct Support Person Training Program: Core Competency Verification (IL 462-1290).

OPTIONAL INFORMATION

Race

Check the box that identifies the Race of the DSP.

Sex

Check the box that identifies the Sex of the DSP.

Eye Color

Check the box that identifies the eye color of the DSP.

Height

Enter the height of the DSP in feet and inches.

Consent to Place Information on Registry - Signature

The DSP's signature on this form certifies that the information provided by the DSP is accurate and grants permission to the State of Illinois and any affiliate on behalf of the State of Illinois to place information from the form onto the Illinois Health Care Worker Registry.

SUBMITTING THE DSP REGISTRY FORM ONLINE

All Illinois Department of Human Services (IDHS) provider agencies with a DSP training program **approved** by the IDHS are eligible to submit DSP Registry Forms (Illinois Health Care Worker Registry Application Form) for their DSPs online.

The DSP Online Registry Website:

https://dspr.dxrgroup.com

Request for login credentials

If you do not have your login credentials, please call 618-453-1962 or email dsp.email@siu.edu to request one.

Inquiry by Mail, Telephone, Fax, or Email

Illinois Nurse Assistant/Aide Training
Competency Evaluation Program
DSP Training Project
Southern Illinois University
Mail Code 4340
Carbondale, IL 62901

Tel: 618-453-1962
Fax: 618-453-4300
Email: dsp.email@siu.edu

NOTE: Southern Illinois University does not process reimbursements. DSP Training Reimbursement information may be found in the Bureau of Community Reimbursement's *Staff Training Reimbursement and Billing Manual* on the DHS website.

If you have questions regarding reimbursement, please call 217-557-7673. Requests for reimbursement should be mailed to the following address:

Illinois Department of Human Services
Bureau of Community Reimbursement Unit
319 E. Madison, Suite 2K
Springfield, IL 62701
Attn: Shaun Tobin

ILLINOIS HEALTH CARE WORKER REGISTRY FOLLOW UP CHECK

After submitting an online DSP Registry Forms to Southern Illinois University, allow 3 working days for processing, and then check the Health Care Worker Registry to ensure that the DSP's name appears on the Registry with the designation "DD Aide" under Programs. The Health Care Worker Registry is on the Illinois Department of Public Health website or providers can check by calling the Illinois Department of Public Health's Nurse Aide Registry at 217-785-5133.

NOTE: Section 350.683 c. of the Illinois Administrative Code requires that an individual shall notify the Health Care Worker Registry of CHANGES IN NAME OR ADDRESS WITHIN 30 DAYS and SUBMIT PROOF OF ANY NAME CHANGE TO THE DEPARTMENT. (Section 3-206.01 of the Act)

State of Illinois Department of Human Services
Division of Developmental Disabilities

ILLINOIS HEALTH CARE WORKER REGISTRY APPLICATION FORM

(Please type or print legibly)

Applicant Information

Name: ______________________ ______________________ __________
Last *First* *Middle*

Date of Birth: ______________
Month / Day / Year

Social Security Number: _____ - _____ - _____

Address: ______________________________________ __________
Street Address / P.O. Box / Rural Route *Apt.*

______________________________ __________ __________
City *State* *Zip Code*

Telephone Number: _____ - _____ - _____

Program Code: ______________

Program Completion Date: ______________
Month / Day / Year

Optional Information

Race
- ☐ Asian / Pacific Islander
- ☐ American Indian / Alaskan Native
- ☐ White
- ☐ Black
- ☐ Unknown

Sex
- ☐ Male
- ☐ Female

Eye Color
- ☐ Blue
- ☐ Green
- ☐ Brown
- ☐ Hazel

Height _____ (feet) _____ (inches)

Consent to Place Information on Registry

Your signature on this application certifies that the information provided is accurate and grants permission to the State of Illinois and any affiliate acting on the behalf of the State of Illinois to place information from this form on the Illinois Care Worker Registry.

____
Signature