

Completing your ACES\$ Service Authorization

Important:

- Below are instructions for completing your ACES\$ Service Authorization (SA). **The form is separate from this guide and can be found on login.mycil.org.**
- All sections must be filled out accurately. If the form is not filled out and signed completely and accurately, the SA form may not be processed. This could cause a delay in payroll for the Personal Support Worker (PSW) until the issues are resolved.
- Parents, Step-parents, guardians cannot work as a PSW for a consumer under the age of 18.
- Pay rate changes must be received by the 4th of the month to take effect for that month's payroll. Pay rate changes received after the 4th will take effect the following month.
- If the consumer has a legal guardian they cannot act as their own employer.
- **Sample SAs are available at the end of the guide for example purposes only.**

Consumer Information

- **Adult HCBS** or **Children and Young Adults HCBS** must be checked at the top.
- **Consumer Number** - This is the 4 digit Consumer code.
- Fill in all demographic and address information. We need the Consumer's **Full Name**; please do not write nicknames or abbreviated names.
- The **RIN Number** is the Consumer's 9 digit Medicaid ID#. This must be listed on all New Consumer authorizations.
- **Self-Directing Services**
 - Select **YES** if the Consumer is using the self-direction option and **NOT** using a Self-Directed Assistant. You can skip the Self-Directed Assistant Information section.
 - Select **NO** if the Consumer is using a Self-Directed Assistant. The Self-Directed Assistant Information section must be filled out.

Self-Directed Assistant Information

- If the Consumer is using a **Self-Directed Assistant** (formerly known as a Service Facilitator), please list the Self-Directed Assistant here. If the Consumer is choosing to use **Self-Direction**, please leave this section blank.

Employer Demographics

- If the Consumer is also the Employer, select **Consumer Employer**; no need to fill out the rest of the section.
- If someone else is the Employer for the account, select **Someone Else**. Then, complete all of the Employer information.
- Please use the Employer's **Full Name**; do not write nicknames or abbreviated names.

Service Authorization Information

- For new Consumers, select **New Consumer**. For other changes, select **Change to Services**.
- A **Monthly Service Start Date** must always be listed to update the budget.
- Budgets can be ongoing, an end date is not required.

- For Temporary budgets, fill in both the Monthly Service Start Date and Monthly Service End Date. Temporary budgets can span multiple months, but cannot end mid-month.
- Adding an end date to this section **DOES NOT** terminate services. Only entering a termination date will do so.
- For a **Termination of Services**, please write the last date of service and reason for termination.
- List all Active PSWs in this section who are to be working with the Consumer. **If a PSW is not listed, they will be terminated.** If there are more than 4 PSWs, please use multiple pages.

Fill in all PSW columns:

- **PSW Name** - full name must be listed; please do not write nicknames or abbreviated names.
- **Social Security #** -for activation and verification purposes, the last 4 digits of the PSW’s SSN is required.
- **Code** – for Regular Hours the code is 55D; for Crisis Hours the code is 53C.
- **Hourly Pay Rate** – list the PSW’s hourly pay rate. This is the rate the PSW will be paid.
- **Unit Rate** – this is calculated by multiplying the PSW’s hourly pay rate by 1.07. Standard rounding rules apply. (hourly pay rate x 1.07 = unit rate) The unit rate, NOT the pay rate, is used in the maximum monthly dollar amount calculation. A reference chart of common pay rate/unit rate calculations is on the last page.
- **Hours Approved per Month** - list the amount of hours the PSW is authorized. If there are multiple PSWs, shared is an acceptable amount of hours as long as the Total Monthly Amount is filled in.
- **Maximum Monthly** – this is calculated by multiplying the hours by the unit rate. (hours approved per month x unit rate = maximum monthly amount)
- **Total Monthly Amount** – this is the sum of the maximum monthly amounts listed for the PSWs above. This is the Consumer’s total budget amount. This number cannot be more than the DHS maximum budgets.

Budgeting Tips:

- Please consider all billings when setting the budget. The above DHS totals are for all Home-Based Services (i.e. PSW services, day programs, SDA fees, etc.).
- Hours must be listed in **15 minute increments**.
Note: .25 = 15 minutes | .50 = 30 minutes | .75 = 45 minutes
- If Crisis Funding (53C) is awarded, we also need a copy of the award letter to process timesheets.

DHS Budget Maximums

Waiver	2024 Total	2023 Total	Notes
Children and Young Adults HCBS	\$1886	\$1828	<i>Consumers on the Children and Young Adults HCBS can bill up to double the monthly allotment in one month, until they reach their yearly cap.</i>
Adult HCBS	\$1886	\$1828	<i>For consumers on the Adult HCBS still attending special education classes. On the Adult HCBS, double spending is not an option.</i>
	\$2829	\$2742	<i>For consumers no longer attending special education classes. DHS must be notified in writing with documentation from the special education district upon completion or discontinuation of classes.</i>
<i>*If you are unsure which waiver the consumer is in, please ask your ISC agency.</i>			

CURRENT Hourly Wage/ Unit Rate conversion chart 7.0%

Hourly Wage	Hourly Cost to You	Hourly Wage	Hourly Cost to You	Hourly Wage	Hourly Cost to You
14.00	14.98	17.75	18.99	21.50	23.01
14.25	15.25	18.00	19.26	21.75	23.27
14.50	15.52	18.25	19.53	22.00	23.54
14.75	15.78	18.50	19.80	22.25	23.81
15.00	16.05	18.75	20.06	22.50	24.08
15.25	16.32	19.00	20.33	22.75	24.34
15.50	16.59	19.25	20.60	23.00	24.61
15.75	16.85	19.50	20.87	23.25	24.88
16.00	17.12	19.75	21.13	23.50	25.15
16.25	17.39	20.00	21.40	23.75	25.41
16.50	17.66	20.25	21.67	24.00	25.68
16.75	17.92	20.50	21.94	24.25	25.95
17.00	18.19	20.75	22.20	24.50	26.22
17.25	18.46	21.00	22.47	24.75	26.48
17.50	18.73	21.25	22.74	25.00	26.75

Signatures

- The SA must be signed by the **Employer** and the **Self-Directed Assistant (SDA)**.
- If the Consumer is the Employer for the account, they must sign it.
 - If the consumer is their own employer, a Power of Attorney/parent cannot sign the SA for the consumer.
- If someone else is listed as the Employer on the account, that person must sign it.
- **PSWs cannot sign the authorization for any reason.**
- If Self-Directing services, an **SDA** signature is not needed.

After completing the separate ACES\$ Service Authorization form, please email directly to BudgetsIL@mycil.org or fax to 570-558-5570 or 217-528-9849 for processing.

Sample SAs are available on the following pages for example purposes.



SUBMIT SERVICE AUTHORIZATION:
 Fax: 217-528-9849 or 570-558-5570
 Email: budgetsIL@mycil.org

ACES\$ ILLINOIS
SERVICE AUTHORIZATION FORM

CONSUMER INFORMATION ** Children and Young Adults: Parents/Step-parents/Guardians cannot work as PSW for consumers under the age of 18.

Waiver Type*:(check one) Adult HCBS Children and Young Adults HCBS

Consumer Name : Sky Blue Consumer Number: A123
First Middle Last

Address: 123 Happy Road City Lincoln County Logan Zip 62656

Phone Number: 555-789-1234 Social Security Number 123-45-6789 RIN Number 987654321

Self Directing Services: Yes No *If no, please fill out the Self Directed Assistant Section Below*

Self-Directed Assistant Information

Self-Directed Assistant Name: Agency:
 Self-Directed Assistant Email: Phone Number:

Employer Information

Who is designated as the Employer?: Consumer Someone Else Relationship to Consumer: Guardian
List Employer Information Below

Employer Name: Mya Blue
First Middle Last

Address: 123 Happy Road City Lincoln County Logan ZIP 62656

Employer Phone Number : 555-789-1234 Employer Email : myablue@testemail.com

SERVICE AUTHORIZATION INFORMATION

Purpose for Authorization: New Consumer Change to Services*

Monthly Service Start Date: 01/01/2024 Monthly Service End Date:
 Termination of Service Effective Date: Reason for Termination:

PSW Name	Social Security #	CODE	Hourly Pay Rate	*Unit rate= Hourly Rate x 107.0% Unit Rate*	Hours Approved per Month	Maximum Monthly Dollar Amount
1. Happy Smith	567891234	55D	\$ 20.00	\$ 21.40	X 100	= \$ 2140.00
2.			\$	\$	X	= \$
3.			\$	\$	X	= \$
4.			\$	\$	X	= \$

* Pay rate changes must be received by the 4th of the month to take effect for that month's payroll. Pay rate changes received after the 4th will take effect the following month.

Total Monthly Amount = \$ 2140.00

I hereby authorize this service authorization and understand it is my responsibility to monitor and approve the provided budget for the individual consumer's service plan and monthly service maximum. I fully understand that failure to comply with the provided budget could result in the interruption of payroll for the direct support worker(s) until over budget issues are fully resolved.

Employer Signature Mya Blue Date 10/27/23

SDA Signature _____ Date _____

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Date Received: _____ Date Processed: _____ Staff Initials: _____



SUBMIT SERVICE AUTHORIZATION:
 Fax: 217-528-9849 or 570-558-5570
 Email: budgetsIL@mycil.org

**ACES\$ ILLINOIS
 SERVICE AUTHORIZATION FORM**

CONSUMER INFORMATION

*** Children and Young Adults: Parents/Step-parents/Guardians cannot work as PSW for consumers under the age of 18.*

Waiver Type*: (check one) Adult HCBS Children and Young Adults HCBS

Consumer Name: Consumer Number:

Address: City County Zip

Phone Number: Social Security Number RIN Number

Self Directing Services: Yes No *If no, please fill out the Self Directed Assistant Section Below*

Self-Directed Assistant Information

Self-Directed Assistant Name: Agency:

Self-Directed Assistant Email: Phone Number:

Employer Information

Who is designated as the Employer?: Consumer Someone Else Relationship to Consumer:

Employer Name:

Address: City County ZIP

Employer Phone Number: Employer Email:

SERVICE AUTHORIZATION INFORMATION

Purpose for Authorization: New Consumer Change to Services*

Monthly Service Start Date: Monthly Service End Date:

Termination of Service Effective Date: Reason for Termination:

PSW Name	Social Security #	CODE	Hourly Pay Rate	*Unit rate= Hourly Rate x 107.0% Unit Rate*		Hours Approved per Month	Maximum Monthly Dollar Amount
1. Happy Smith	567891234	55D	\$ 16.00	\$ 17.12	X	50	= \$ 856.00
2. Joe Smith	123894567	55D	\$ 15.00	\$ 16.05	X	25	= \$ 401.25
3. Blue Smith	987654012	55D	\$ 20.00	\$ 21.40	X	25	= \$ 535.00
4. <input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	X	<input type="text"/>	= \$ <input type="text"/>

* Pay rate changes must be received by the 4th of the month to take effect for that month's payroll. Pay rate changes received after the 4th will take effect the following month.

Total Monthly Amount = \$

I hereby authorize this service authorization and understand it is my responsibility to monitor and approve the provided budget for the individual consumer's service plan and monthly service maximum. I fully understand that failure to comply with the provided budget could result in the interruption of payroll for the direct support worker(s) until over budget issues are fully resolved.

Employer Signature: Date:

SDA Signature: Date:

ACES\$ USE ONLY

Date Received: Date Processed: Staff Initials:



SUBMIT SERVICE AUTHORIZATION:
 Fax: 217-528-9849 or 570-558-5570
 Email: budgetsIL@mycil.org

**ACES\$ ILLINOIS
 SERVICE AUTHORIZATION FORM**

CONSUMER INFORMATION

** Children and Young Adults: Parents/Step-parents/Guardians cannot work as PSW for consumers under the age of 18.

Waiver Type*:(check one) Adult HCBS Children and Young Adults HCBS

Consumer Name : Consumer Number:

First Middle Last

Address: City County Zip

Phone Number: Social Security Number RIN Number

Self Directing Services: Yes No *If no, please fill out the Self Directed Assistant Section Below*

Self-Directed Assistant Information

Self-Directed Assistant Name: Agency:

Self-Directed Assistant Email: Phone Number:

Employer Information

Who is designated as the Employer?: Consumer Someone Else Relationship to Consumer:

List Employer Information Below

Employer Name:

First Middle Last

Address: City County ZIP

Employer Phone Number : Employer Email :

SERVICE AUTHORIZATION INFORMATION

Purpose for Authorization: New Consumer Change to Services*

Monthly Service Start Date: Monthly Service End Date:

Termination of Service Effective Date: Reason for Termination:

	PSW Name	Social Security #	CODE	Hourly Pay Rate	*Unit rate= Hourly Rate x 107.0% Unit Rate*		Hours Approved per Month	= \$	Maximum Monthly Dollar Amount
1.	Happy Smith	567891234	55D	\$ 16.00	\$ 17.12	X	shared	= \$	shared
2.	Joe Smith	123894567	55D	\$ 15.00	\$ 16.05	X	shared	= \$	shared
3.	Blue Smith	987654012	55D	\$ 20.00	\$ 21.40	X	shared	= \$	shared
4.				\$	\$	X		= \$	

* Pay rate changes must be received by the 4th of the month to take effect for that month's payroll. Pay rate changes received after the 4th will take effect the following month.

Total Monthly Amount = \$ 1800.00

I hereby authorize this service authorization and understand it is my responsibility to monitor and approve the provided budget for the individual consumer's service plan and monthly service maximum. I fully understand that failure to comply with the provided budget could result in the interruption of payroll for the direct support worker(s) until over budget issues are fully resolved.

Employer Signature Date

SDA Signature Date

ACES\$ USE ONLY

Date Received: Date Processed: Staff Initials: