State of Illinois
Department of Healthcare and Family Services

Payment Affidavit

In order to review and process your payment, we will need the below information. Please complete this form and return it with the payment that will be remitted to HFS-BOC Technical Recovery Section P.O. Box 19146 Springfield, IL. 62794-9146 or send this form electronically to HFS.BOC.TRS.SPR.LE@illinois.gov or via fax to 217-524-6097 if the payment was inadvertently sent without this form.

Information Needed:

Provider Name: ______________________ Provider ID: ______________

Recipient's Name: ______________________ Recipient's Case#: ___ - ___ - ______

Recipient's RIN#: ______________ Date of Death (If applicable): ______________

Check#: ______________________ Check Date: ______________

Check Amount: $ __________ Remaining Balance in Account: $ __________ Type of Account: ______________

Select the reason(s) for the payment:

☐ Remaining balance from the room and board account. Balance is $ __________ .*

☐ Remaining balance in the trust account. Balance is $ __________ .*

* Payment of remaining room and board funds and/or trust account balances cannot be accepted if there is a living spouse or a minor/disabled child.

☐ Change in income

☐ Response to a Small Estate Affidavit (SEA) from our Department

☐ MEDI GCC (Group Care Credit) adjustment

☐ Voluntary payment- Payment due to change in assets/resources due to eligibility or a redetermination

☐ Voluntary payment- Due to excess payments made to nursing home for care/stay

☐ Other, please explain below:

If the recipient has moved to another facility and the payment is from the remaining balance from the room and board account or the trust account, please forward the payment to the next facility.

If there are **multiple sources or types of payments included in this payment**, please list each below:

1) Source/Type: ______________________ Amount: $ ______________

2) Source/Type: ______________________ Amount: $ ______________

3) Source/Type: ______________________ Amount: $ ______________

Is the facility an Authorized Representative? ☐ Yes ☐ No

If the facility is not an Authorized Representative, do they have permission to turn over the funds? ☐ Yes ☐ No

If you have any questions, please contact us at HFS.BOC.TRS.SPR.LE@illinois.gov