State of Illinois
Department of Healthcare and Family Services
Department of Human Services

Return completed form to:
Illinois Department of Healthcare and Family Services
607 East Adams St, 13th Floor
Springfield, IL 62701
(217) 524-7143

State Renal Number (9-digit) 97

Applications to State Chronic Renal Disease Program

Please Complete Every Blank on Front and Back

Patient's Name (Mr., Mrs., Miss) _____ (first) _____ (middle initial) _____ (last)

Patient's Address: _____ Number, Street, R.R. _____ City _____ State _____ Zip Code _____ County

Social Security Number: _____ Date of Birth _____ (Mo Day Year) Phone: ( )

Sex of Applicant: ☐ Male ☐ Female Race: ☐ White ☐ African American ☐ Other (Specify): _____

Date of First Chronic Dialysis: _____ Date of Transplantation: (leave blank if N/A) _____

Name of Dialysis Facility: _____ Facility's Medical Number: _____

Medicare Status: ☐ Uncovered ☐ Pending Effective Date Covered: _____

Treatment Modality and Location: ☐ Staff Assisted ☐ Self Care ☐ Home ☐ Hemodialysis ☐ Peritoneal

Members of family living in household, including patient - list head of household first

Name	Age	Relationship to Patient
1)	1)	1)
2)	2)	2)
3)	3)	3)
4)	4)	4)
5)	5)	5)
6)	6)	6)

Hospital and Medical Care Insurance Only

	Insurance Company Name	Policy Holder	Policy Number -- Group-Individual
Hospital:			
Medical:			

Total Annual Premium Paid by Family for this Insurance: $ _____

Insurance Pays Towards Out-Patient Dialysis: ☐ Yes ☐ No

Other Special Information Regarding Your Insurance Coverage: _____

Public Assistance Case Number: _____ Effective Date: _____ (Mo Day Year)

Patient Does Not Qualify for Assistance Because: _____

Signature (Social Worker or Financial Rep.): _____

IMPORTANT NOTICE: This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under Public Act83-99. Disclosure of this information is mandatory. This form has been approved by the Form Management Center.

Patient and members of family living at home - employed during the past year.
If patient is a minor, include parent's or guardian's income.

Name	Place of Employment	Annual Income During Past Year	Current Monthly Income	If Currently Unemployed, State Why and Last Day of Employment
1)	1)	1)	$	1)
2)	2)	2)	$	2)
3)	3)	3)	$	3)

Attach Copies of your most recent Federal Income Tax Return (1040 or 1040A) and Illinois Income Tax Return (1040) including all supplementary forms.

Notes : _____

Other Income During Past Year

Unemployment Compensation: $ _____ x _____ Months, or $ _____ Total

Disability or Pension: $ _____ x _____ Months, or $ _____ Total

Social Security Income: $ _____ x _____ Months, or $ _____ Total

Other Income: $ _____ x _____ Months, or $ _____ Total

Please specify other income: _____

Necessary and Unavoidable Expenditures

1.) Special care for children (explain): _____

2.) Support (Relative or alimony): _____

3.) Retirement of Social Security Benefits (explain): _____

4.) Employment expense (Union dues, special clothing and tools): _____

5.) Transportation for dialysis: _____

6.) Other (explain): _____

Family Medical Care Costs During the Past 12 Months (Including Patient)

Name	Describe Medical or Dental Needs	Dollar Amount of Costs				Total Paid by Insurance	Total Paid by Family	Total Owed
		Physician	Dentist	Hospital	Drugs			
1)	1)	1)	1)	1)	1)	1)	1)	1)
2)	2)	2)	2)	2)	2)	2)	2)	2)
3)	3)	3)	3)	3)	3)	3)	3)	3)
4)	4)	4)	4)	4)	4)	4)	4)	4)
5)	5)	5)	5)	5)	5)	5)	5)	5)
6)	6)	6)	6)	6)	6)	6)	6)	6)

Totals: $ _____ Special Information: _____

I hereby certify that the answers given on this application and financial profile are correct and true to the best of my knowledge. I authorize the Illinois Department of Healthcare and Family Services, or its representative to verify all facts herein stated relative to any financial condition or income. it is understood that all information will be treated as confidential.

Signature: _____ Date: _____
Mo Day Year

If additional space is needed, attach supplement sheets.

Print Form