HFS
Illinois Department of
Healthcare and Family Services

HFS Hardship WaiverApplication for Hardship Waiver

The hardship waiver applicant must complete the appropriate section(s) of this application and return it with supporting documents no more than **60 calendar days** from the date on the Notice of Right to Request Waiver or Estate Recovery accompanying this application. T**his application will not be considered if (1) the application or (2) any supporting documentation is submitted more than 60 calendar days from the date on the Notice. If additional information is needed after the application has been timely submitted, the documentation must be returned within 45 calendar days from the date in which the information was requested. If the applicant is experiencing a delay and needs to ask for an extension, please contact our office at 217-785-8711. If we are not contacted for an extension and the documentation is not received within 45 calendar days, it will not be considered.**

Deceased Medicaid Member Information				
Decedent's Last Name:	First:	Middle:		Case No:
Decedent's Medicaid ID Number:	Decedent's Social Security Number:		Decedent's Date of Birth: mm/dd/yyyy)	

Estate Asset Information				
Check all applicable assets and complete all related information. List all estate assets including property conveyed through joint tenancy, tenancy in common, life estate, living trust, annuities, life insurance policies, or retirement accounts. Please attach copies of any deeds, registrations, bank statements, listing agreements/contract, life insurance policy statements, stock, bonds, and annuity documentation, etc. Attach additional sheets if necessary.				
☐Real Property	Market Value: $		Tax Assessment Value: $	
	Mortgage Owed: $		Is property listed for sale? ☐ Yes ☐ No	
	If no, please explain:			
Estate Property Street Address:		City:	State:	Zip:
Is anyone living in the property? ☐Yes ☐ No	If yes how long have they lived in the property?	Name of person living there:	Relationship to decedent:	
☐ Bank Account(s)	☐Checking	Balance: $	Account No:	Bank Name:
	☐Savings	Balance: $	Account No:	Bank Name:
☐ Stocks/Bonds/Notes/Other		Type:	Value: $	Date Purchased
Annuities		Type:	Value: $	Date Purchased
Life Estate		Type:	Value: $	Date Established
Life Insurance		Type:	Value: $	Beneficiary (s)
Retirement Accounts		Type:	Value: $	Beneficiary (s)
☐Other	Description:			

HFS
Illinois Department of
Healthcare and Family Services

Applicant Information				
Applicant's Last Name:	First:	Middle:	Birth Date:	Age:
Street address:	Social Security No:	Home Phone No:		
P.O. Box:	City:	State:	Zip Code:	
Occupation:	Employer:	Employer Phone No:		
Applicant's Anticipated Share of Estate (Percentage %)	Relationship to Decedent:			
Marital Status:	Spouse's Last Name:	First:		
Spouse's Birth date:	Spouse's Age:	Spouse's Social Security No:	Spouse's Phone No:	
Spouse's Occupation:	Spouse's Employer:	Spouse's Employer Phone No:		

Applicant's Assets				
Please provide information on assets owned by the *applicant*. Attach additional sheets if needed.				
Real Estate: (include personal residence, vacation property, rental property, etc.)				
Property #1	Street Address:	City:	State:	Zip:
Property #2	Value: $	Mortgage Balance: $		
	Street Address:	City:	State:	Zip:
	Value: $	Mortgage Balance: $		
Bank Accounts: (include savings, checking, certificates of deposit, retirement accounts, etc.)				
Name of Institution:	Account No:	Type of Account:	Balance: $	
Name of Institution:	Account No:	Type of Account:	Balance: $	
Name of Institution:	Account No:	Type of Account:	Balance: $	
Motor Vehicles: (include all cars, trucks, motorcycles, boats, recreational vehicles, etc.)				
Year, Make, Model:	Date Purchased:	Value: $	Loan Balance: $	
Year, Make, Model:	Date Purchased:	Value: $	Loan Balance: $	
Other Assets: (miscellaneous items you own or are currently buying, e.g. stocks, bonds, etc.)				
Description:	Date Purchased:	Value: $	Loan Balance: $	

HFS

Illinois Department of
Healthcare and Family Services

Applicant's Monthly Income

Please attach a copy of the most recent federal and state income tax returns.

Applicant's Net Pay: (attach two month's most recent pay stubs) $	The amount is paid: ☐ Monthly ☐ Weekly ☐ Bi-weekly
Spouse's Net Pay: (attach two month's most recent pay stubs $	This amount is paid: ☐ Monthly ☐ Weekly ☐ Bi-weekly
Rents paid to Applicant: (please provide rental agreement) $	Business Income: (attach profit and loss statement)
Social Security: $	Disability: (attach most recent award letter

Alimony $	Royalties, Trust, other income $	Worker's Compensation $	Unemployment $
Retirement/Pensions/Annuities			

Monthly Public Assistance Benefit

TANF (Cash Assistance) $	SNAP (Food Stamps) $	IV-D Child Support $	Public Housing Assistance $
Other Public Assistance $		Total Monthly Income: $	

Applicant's Monthly Expenses

Monthly Expense:	**Amount $**	**Monthly Expense:**	**Amount $**	**Monthly Expense:**	**Amount $**
Mortgage/Rent Payments		Homeowner's/Renter's Insurance		Credit Cards #1 Name:	
Property Taxes		Auto Insurance		Credit Cards #2 Name:	
Water		Health Insurance		Credit Cards #3 Name:	
Sewer		Disability Insurance			
Heating		Life Insurance			
Electric		Long-Term Insurance			
Trash Collection		Installment Payments			
Cable/Internet Satellite		Personal Loans			
Telephone/Cell Data Plan		Student Loans			
Groceries/Food		Auto Loan			
Fuel/Gasoline		Prescription Medication			
Public Transportation (bus, subway, taxi, train, rideshare)					

HFS
Illinois Department of
Healthcare and Family Services

Answer all of the questions and provide documentation for each section that applies to you.

1. Would you become eligible for public assistance if the claim were collected? ☐ Yes ☐ No

2. Explain how recovery of the claim would cause you to come eligible for public assistance.

3. Would you be able to discontinue public assistance if the claim were not collected? ☐ Yes ☐ No
Explain who would be able to discontinue public and/or medical assistance if the state did not recover the claim.

4. What type of public and/or medical assistance do you currently receive?
☐ Medicaid ☐ Supplemental Security Income (SSI) ☐ Temporary Assistance for Needy Families (TANF) ☐ Subsidized Housing ☐ Supplemental Nutrition Assistance Program (SNAP)

Other:____

Family Members Residing in the Household

Heirs requesting this waiver must provide the following information about all family members living full time in the household.

Family Member Name	Social Security Number	Date of Birth (mm/dd/yyyy)	Relationship to Applicant

Heirs listed in Will

Name of Heir	Address	City	State	Zip Code

Documentation and Certification

HFS

Illinois Department of
Healthcare and Family Services

All of the information requested in the application is voluntary; however, failure to completely and accurately provide the information may result in denial of the waiver application. Any errors or omissions in the information provided by the applicant that would affect HFS's decision may be a basis for denial of the waiver application.
As appropriate, please include a copy of:

1. Decedent's Will showing names of heirs and the percentage of the estate each will receive;
2. Deeds to any real property owned by the decedent or the applicant;
3. Bank statements of the decedent; and
4. Appraisal showing the value of the decedent's real property.
5. Copy of Property Tax Assessment letter/bill
6. Photo copy of Decedent's Life Insurance
7. Applicant's most recent federal and state income tax returns; including supporting schedules.
8. Applicant's most recent pay stubs; and any other income that you receive or expect to receive.
9. Applicants bank statements for the past three months.
10. Proof of eligibility for public benefits.
11. List of outstanding credit cards and loans and the amount owed to each one, including providers (electric, gas, water, trash collection, etc.)
12. Applicant's birth certificate
13. Photo copy of Driver's license.

Certification

I understand that the statements I have made on this application are subject to investigation and verification. I declare under penalty of perjury, that the statements I have given on this form, to the best of my knowledge, are true and correct.

__________________________________ __________________________________
Signature of Applicant | Date

__________________________________ __________________________________
Print or Type Full Name | Telephone No.

Representative

If assisted by a Representative, please complete this section:

Name: Last	First:	Relationship:	
Address:	City:	State:	Zip Code:
Telephone Number (s)			