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

Instructions for Mail-In Application for Medical Benefits

(Esta solicitud está disponible en español.)
(This application is available in Spanish.)

Medical benefits are available to eligible persons who need help paying their medical bills.

This is **NOT** an application for cash assistance, food stamps, or the other programs listed on page 6 of these instructions. If you want to apply for cash assistance or food stamps, contact your local Department of Human Services (DHS) Family Community Resource Center (FCRC).

Voter's Registration Information

If you want to apply to register to vote, fill out the enclosed Illinois Voter Registration Application SBE (R-19) and return it to your DHS FCRC or your local election official. If you would like assistance or need translation services, contact your DHS FCRC. You may also call the Helpline at 1-800-843-6154, or 1-800-447-6404 (for TTY).
For information online, see www.dhs.state.il.us or www.elections.il.gov/

Note: Applying or declining to register to vote will not affect the amount of benefits you get from this agency.

WHAT MEDICAL SERVICES ARE COVERED?

Most needed medical services are covered. Payment will not be made for services that are free or paid for by another source, like health insurance. The following services are covered:

- hospital care
- nursing facility care
- supportive living care
- doctor services
- prescription drugs
- audiology services
- care at clinics
- renal dialysis
- laboratory tests and x-rays
- dental care (limited services for adults)
- eye care
- medical transportation
- hospice care
- home health care services
- physical, occupational and speech therapy
- family planning
- medical equipment, supplies and appliances
- podiatry care
- help for alcohol and substance abuse
- chiropractic care
- shots and check-ups for children
- mental health care

WHERE CAN YOU GET THESE MEDICAL SERVICES?

You may go to any medical provider who accepts the HFS medical card.

WHEN WILL YOU KNOW IF YOU QUALIFY?

If you are applying because you have a disability, DHS will send you a notice to tell you if you are eligible for medical benefits within 60 days of the date you apply. If you do not have a disability, the notice will be sent within 45 days.

WHAT IF YOU DISAGREE WITH THE DECISION?

If you are not satisfied with the actions taken on this application, you have the right to a fair hearing. You can ask for a fair hearing by calling 1-800-435-0774 (TTY: 1-877-734-7429) or by writing to the Department at 401 South Clinton Street, 6th Floor, Chicago, IL 60607. The call is free. Use this address only to ask for a fair hearing. **DO NOT SEND THIS APPLICATION TO 401 SOUTH CLINTON.**

For more information call 1-800-843-6154, (TTY: 1-800-447-6404). The call is free

INSTRUCTIONS: Read the application carefully and follow all instructions.

1. **Complete pages 1 - 6 of the application.** Depending on your situation, also complete the attached **Forms A through H**. Be sure to mail all documents together. Answer questions completely and accurately. If you cannot answer all of the questions, fill out as much as you can. If you need more space to answer questions, attach an extra sheet. If you have questions, call your local DHS FCRC office or call 1-800-843-6154 (TTY: 1-800-447-6404). This call is free.

   - Complete **Form A** if anyone applying for medical benefits has Medicare or other health insurance.
   - Complete **Form B** if anyone applying is blind, has a disability or is age 65 or older.
   - Complete **Form C** if anyone applying lives in or intends to move to a nursing home facility or a supportive living facility, or receives or has applied for services through the Department on Aging Community Care Program.
   - Complete **Form D** if the person is transferring income and assets to spouse.
   - Complete **Form E** if anyone applying is blind, has a disability or is age 65 or older and is employed **or** if a responsible relative living with the person is employed. A responsible relative is a spouse or a parent of a child younger than 18.
   - Complete **Form F** if anyone applying is married, but does not live with his or her spouse.
   - Complete **Form G** if the Social Security Administration has not yet decided if the person has a disability.
   - Complete **Form H** (Rebate Form for All Kids or FamilyCare) if you are applying for a child or caretaker relative including a parent who is already covered by health insurance or for whom you have arranged for health insurance to begin soon.

2. Sign the application.

3. Attach copies of any required Forms A through H and documents to the application. Failure to submit required forms or documents could result in denial of your application. See instructions pages 3 and 4.

4. Mail the application to your local DHS FCRC office. If you do not know the address visit the DHS website at www.dhs.state.il.us or call 1-800-843-6154, (TTY: 1-800-447-6404). The call is free.

Medical benefits programs comply with all state and federal laws, rules and regulations pertaining to equal access regardless of sex, race, disability, national origin, religion, or age. The State of Illinois is an equal opportunity employer that practices affirmative action. The State of Illinois provides reasonable accommodations according to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

To file a complaint of discrimination, contact any or all of these offices:

Illinois Department of Human Services (DHS)
Bureau of Civil Affairs
401 South Clinton Street, 2nd Floor
Chicago, Illinois 60607

Illinois Department of Healthcare and Family Services (HFS)
EEO/AA Office
401 South Clinton Street, 5th Floor
Chicago, Illinois 60607

U.S. Department of Health and Human Services (HHS)
Director, Office for Civil Rights
Room 506-F,
200 Independence Avenue, S.W.
Washington, D.C. 20201
Call
(202) 619-0403 (voice) or
(202) 619-3257 (TTY)

For more information call 1-800-843-6154, (TTY: 1-800-447-6404). The call is free

INFORMATION TO INCLUDE WITH THE APPLICATION

To get medical benefits, you must provide proof for some of the information you give. Please attach copies of the following documents with this application. Include all that apply. Please see the information on the next page about providing documents for U.S. citizens.

- **Income** - Send proof of each type of income listed on the application. If the person applying lives with his or her spouse, include the spouse's income. This may include:
    - Copies of pay stubs for earnings and proof of tips received during the last month. If anyone is self-employed, provide detailed business records that include income and expenses for the last month.
    - Copies of checks for the last month or award letters for Unemployment Benefits, Social Security Benefits and Veteran Benefits.
    - Copies of checks for the last month or a support order for spousal or child support.
    - Proof of other income including income from trusts, pensions, rental property, etc. Also send proof of expenses tied to rental income.
- **Support Paid** - To get credit for spousal or child support paid, provide proof of payments made in the last month.
- **Proof of Pregnancy** - If anyone applying for medical benefits is pregnant, provide a signed statement from her doctor or health clinic that includes the date she is expected to deliver and the number of babies expected.
- **Proof of Application for a Social Security Number** - If anyone applying for medical benefits does not have a Social Security Number, provide a signed statement from the Social Security Administration that application for a number has been made.
- **Medicare or Other Health Insurance** - If anyone applying has Medicare or other health insurance, complete the attached **Form A** or provide a copy (front and back) of the Medicare card or health insurance card. If anyone can get free health insurance through a job or union, provide information about the plan and qualifications.

For more information call 1-800-843-6154, (TTY: 1-800-447-6404). The call is free

- **Immigration Documents for Non-Citizens -** If anyone applying for medical benefits is not a U.S. Citizen, provide proof of their immigration status. Proof is a copy of any one of the following:
    - Alien Registration Receipt Card/Permanent Resident/Green Card (INS-3A); or
    - Passport with the following stamps or attachments: Arrival-Departure Record with the stamp showing status (I-94), or Resident Alien form (I-151 or I-551), or Temporary Resident Card (I-688); or
    - A court ordered notice for Asylees; or
    - INS documents with an A-number; or
    - Other proof of lawful immigration status.

  Pregnant women and children under age 19 who do not have proof of their immigration status may still qualify for medical benefits. However, you should provide proof if you have it.

  Other adults who want medical benefits must provide proof of their immigration status. We will contact the U.S. Bureau of Citizenship and Immigration Services to check their status. Adults must also have been in the U.S. for at least five years. The state can cover medical care provided in an emergency for adults whose legal immigration status can not be verified, or if they have been in the U.S. less than five years, only if they meet all other medical program requirements.

- **Documents for U.S. Citizens -** For anyone who is a U.S. citizen and requesting medical benefits, provide one of the following documents: U.S. Passport, Certificate of Naturalization (N-550 or N-570) or Certificate of Citizenship (N-560 or N-561). If these are not available, provide one document from each of the two categories listed below:

Place of Birth	and	Identity
• Certified copy of birth certificate from the state or county where the person was born; • Final Adoption decree; • Official military record that shows a place of birth; or • Papers showing the person was employed by the U.S. Government before 1976.		• Driver's license; • State issued ID card; • School ID; • U.S. Military ID; • U.S. Military dependent card; or • Other government ID (issued by city, county, state or federal) • For children under age 16, school or day care records or a report card.

If you receive Medicare, SSI or Social Security Disability income, you do not need to provide proof of your U.S. citizenship or identity.

- If you or your representative bring this application to your local FCRC office in person, or can come into the office after sending the application in, please bring original or certified copies of citizenship and identity documents.

- If you mail in copies with this application, we may ask you to show the original documents at a later time.

Persons who are blind, have a disability or are age 65 or older, go to next page.

INFORMATION TO INCLUDE WITH THE APPLICATION (cont.)

If anyone applying is blind, has a disability or is age 65 or older, provide proof of the following information if it applies.

- **Age -** If anyone applying for medical benefits is age 65 or older, provide proof of age. This may include a copy of the person's birth certificate, Social Security records, passport or Veteran Administration records.
- **Disability** - If anyone applying for medical benefits has a disability, provide proof of disability and complete **Form G**. If they get Supplemental Security Income (SSI), or Social Security Disability Insurance (SSDI) benefits, they do not have to provide other proof of disability. If the person does not get SSI or SSDI benefits, provide a current medical report.
- **Employment Expenses** - If anyone applying for medical benefits is employed, complete **Form E**. Also complete **Form E** for an employed spouse or parent of a child under age 18 if they live together. We will deduct the following from earnings if you provide proof of:
  - Federal, State, or City income taxes,
  - Social Security tax,
  - Transportation to work expenses at the most reasonable rate. We allow 24 cents per mile if you use your own car,
  - Special tools and uniforms required for the type of work performed,
  - Union dues, group life insurance premiums, group health insurance premiums and retirement plan with holdings, if required as a condition of employment, and
  - For persons with disabilities, special work expenses, such as special transportation to work or a telecommunication device for the hearing impaired, that allow them to work. To be allowed as a deduction, the expenses must be paid by the applicant and not be reimbursed by an agency or other person.
- **Resources -** Send proof of each resource listed on **Form B**. If the person lives with his or her spouse, include the spouse's resources. This may include, but is not limited to, copies of current bank statements, certificates of deposit, life insurance policies, vehicle titles, prepaid burial contracts, trust documents, property deeds, and property tax bills.
- **Resources and Income of Spouse -** Provide proof of a spouse's resources and income, if anyone applying wants to transfer resources or income to his or her spouse and the person applying:
  - lives in or intends to move to a nursing home facility,
  - lives in or intends to move to a supportive living facility, or
  - receives or has applied for services through the Department on Aging's Community Care Program.

  If any apply, complete **Form D**.

For more information call 1-800-843-6154, (TTY: 1-800-447-6404). The call is free

OTHER BENEFIT PROGRAMS OFFERED BY THE STATE OF ILLINOIS

You may also qualify for these programs:

- **Home and Community Based Services -** You or your family members may also qualify for one of the Illinois home and community based services programs. These programs allow eligible individuals to either remain in their own home or live in a community setting, rather than an institutional setting such as: a hospital, nursing home facility, supportive living facility or intermediate care facility for the developmentally disabled. For more information visit **www.hfs.illinois.gov/hcbswaivers/**

- The **Low Income Home Energy Assistance Program (LIHEAP)** helps qualified households pay for winter energy services. The amount of the benefit depends on income, household size, fuel type and geographic location. For more information, visit **www.liheapillinois.com**

- The **Illinois Department of Human Services' Child Care Program** provides low-income, working families with access to quality, affordable child care. Parents can learn about childcare in their community and see if they qualify for a subsidy by contacting their local Child Care Resource and Referral agency (CCR&R). Visit **www.ilchildcare.org** or call 1-800-649-1884 to find your local CCR&R. The call is free.

Here are other medical programs in Illinois:

- **Veteran's Care** offers access to affordable, comprehensive healthcare to veterans across Illinois. Veterans pay an affordable monthly premium of $40 or $70 and receive medical, dental and vision coverage. For additional information, please visit **www.illinoisveteranscare.com** or call 1-877-4VETS-RX (TDD: 1-877-504-1012). The call is free.

- **Health Benefits for Workers with Disabilities** is a comprehensive healthcare program for employed persons with disabilities. Working individuals between the ages of 16 and 64 may be eligible. To download an application, visit **www.hbwdillinois.com** or call 1-800-226-0768 (TTY: 1-866-675-8440). The call is free.

- The **Illinois Breast and Cervical Cancer Program (IBCCP)** provides cancer screening and treatment for eligible women 35 and older (younger women may be eligible in some cases). To find out if you qualify visit **www.cancerscreening.illinois.gov** or call the Women's Health Line 1-888-522-1282 (TTY: 1-800-547-0466). The call is free.

- The **Illinois Healthy Women (IHW)** program provides family planning and related services for women between 19 and 44 years old. To find out if you qualify, visit **www.ihwillinois.com** or call the Health Benefits hotline at 1-800-226-0768 (TTY: 1-866-675-8440). The call is free.

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

AGENCY USE ONLY
Date Received

Recycle any instruction pages sent with this application.

Case Number

Mail-In Application For Medical Benefits

If the applicant is in a health care facility, enter the date of the applicant's admission to the facility: ______________

the actual or expected discharge date ______________

and facility name ______________

Answer questions completely and accurately.

APPLICANT - The applicant is usually the person filling out this form or who has someone complete the form for them. The applicant can also be the parent, guardian or other relative a child lives with. The information you provide on this application is confidential and may only be used for purposes directly connected with the administration of the medical benefits programs. See Instructions 3 to 5 for a list of documents you may need to send with this application.

Name (Last, First, Middle Initial) ______________

Daytime phone and best time to call you ______________

Address (Please list Street, City, State, Zip and County) ______________

Mailing Address (if different than above) ______________

Other phone number ______________

If you are living in a nursing home, list the two places you lived prior to moving to the nursing home. If you have not yet moved to a nursing home, list the last two places where you lived prior to your current residence.

Address ______________ Address ______________

City ________ State ____ Zip ______ City ________ State ____ Zip ______

Language Preference

☐ English
☐ Spanish
☐ Other (please list) ______________

Race / Ethnic Group (for information purposes only)

Are you Hispanic or Latino? ☐ Yes ☐ No

Race (Mark all that apply)

☐ White ☐ Black or African American ☐ Asian
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Other (please list) ______________

1. PERSONAL INFORMATION

Enter the following for the person applying for medical benefits and all persons living with them. You do not have to give the Social Security Number or the U.S. citizenship status for a pregnant woman or anyone who does not want medical benefits. Attach an extra sheet if more space is needed.

A. Name (Last, First, Middle Initial)	Sex	Birth Date	Relationship To Applicant (wife, son, etc.)	Wants Medical Benefits	U.S. Citizen	Social Security Number
1) ______	☐ M ☐ F	1) ______	Applicant	☐ Yes ☐ No	☐ Yes ☐ No	1) ______
2) ______	☐ M ☐ F	2) ______	2) ______	☐ Yes ☐ No	☐ Yes ☐ No	2) ______
3) ______	☐ M ☐ F	3) ______	3) ______	☐ Yes ☐ No	☐ Yes ☐ No	3) ______
4) ______	☐ M ☐ F	4) ______	4) ______	☐ Yes ☐ No	☐ Yes ☐ No	4) ______

2. PERSONAL INFORMATION (continued)

B. For each person under age 18 applying for medical benefits, tell us about their parents. If a parent does not live with the child, also enter the parent's address.

First Child's Name	Second Child's Name	Third Child's Name
Mother's full name:	**Mother's full name:**	**Mother's full name:**
SSN:	**SSN:**	**SSN:**
Mother's Employer:	**Mother's Employer:**	**Mother's Employer:**
☐ Full-time ☐ Part-time	☐ Full-time ☐ Part-time	☐ Full-time ☐ Part-time
Address if other:	Address if other:	Address if other:
Father's full name:	**Father's full name:**	**Father's full name:**
SSN:	**SSN:**	**SSN:**
Father's Employer:	**Father's Employer:**	**Father's Employer:**
☐ Full-time ☐ Part-time	☐ Full-time ☐ Part-time	☐ Full-time ☐ Part-time
Address if other:	Address if other:	Address if other:

C. Is anyone applying a veteran or a spouse, child, widow(er) or parent of a veteran? ☐ Yes ☐ No

If yes, enter the person's name and relationship to the veteran: ______

D. Is anyone applying blind or have a disability? ☐ Yes ☐ No

If yes, enter the person's name: ______

Complete Form G if the Social Security Administration has not yet decided if the person has a disability.

E. Does everyone applying live in Illinois? ☐ Yes ☐ No

If no, enter the person's name: ______

2. PERSONAL INFORMATION (continued)

F. If anyone applying is a U.S. citizen, enter their name and the city and state where they were born. Send proof of their identity and their citizenship. See page 4 of the instructions for more information.

Name	City	State
1) ______	1) ______	1) ______
2) ______	2) ______	2) ______
3) ______	3) ______	3) ______

G. If anyone applying is not a U.S. citizen, enter their name. If the person has a valid Alien Registration Number, enter it also. Send a copy of proof of the Alien Registration Number. See page 4 of the instructions for more information.

Name	Valid Alien Registration Number
1) ______	1) ______
2) ______	2) ______
3) ______	3) ______

H. Does anyone applying live in a nursing home facility or supportive living facility? ☐ Yes ☐ No

If yes, you must complete forms B, C and D.

If yes, enter the person's name: ______

Was the person a resident in the facility prior to 07/01/96? ☐ Yes ☐ No ☐ Unknown

Facility Name: ______

Facility Street Address: ______

City, State, Zip Code: ______ **Facility Telephone Number and Area Code:** ______

I. Does anyone applying receive or has anyone applied for services through the Department on Aging's Community Care Program? ☐ Yes ☐ No

If yes, enter the person's name: ______

J. Is this an application to pay bills for someone who has died? ☐ Yes ☐ No

If yes, enter the person's name: ______

Date of Death: ______

2. PERSONAL INFORMATION (continued)

K. Does anyone applying have a legal guardian? ☐ Yes ☐ No

If yes, enter the guardian's name: ____________________

Attach copy of guardianship papers.

L. Is anyone applying pregnant or has anyone been pregnant within the last 3 months? ☐ Yes ☐ No

If yes, enter the person's name: ____________________ **,**

due date or delivery date: ____________ **,** **and number of babies expected or delivered:** ________ **.**

M. Did anyone applying receive any medical service during the 3 months before the month of this application? ☐ Yes ☐ No

If yes, do you want us to decide if they can get help to pay these bills? ☐ Yes ☐ No

If yes, list months: ____________________

N. Is anyone applying covered by Medicare or other health insurance? If yes, complete Form A. ☐ Yes ☐ No

O. Does anyone applying have a high cost medical condition? ☐ Yes ☐ No

If yes, enter the person's name: ____________________

Does the person have health insurance for the medical condition or can they get health insurance through a recent employer or through a relative's policy? ☐ Yes ☐ No

P. Can anyone applying get free health insurance through a job or union? ☐ Yes ☐ No

If yes, enter the person's name: ____________________

Q. Is anyone applying enrolled in the Illinois Comprehensive Health Insurance Plan (ICHIP) program? ☐ Yes ☐ No

If yes, enter the person's name: ____________________

3. SUPPORT PAID

Does anyone pay support for a person for whom they are legally responsible or for whom there is a court order for support? Attach proof. ☐ Yes ☐ No

If yes, enter the person's name who pays support:____________________________

Amount paid: $ __________ **How often paid:** __________ **Court ordered:** ☐ Yes ☐ No

4. INCOME AND BENEFITS

Enter all money that anyone applying for medical benefits receives. If married and living with spouse, also enter any money the spouse receives. If under age 18 and living with a parent, also enter any money the parent receives. Attach proof. Enter the amount before deductions like taxes or insurance. Check all that apply and enter details below:

- ☐ Social Security
- ☐ Veterans Benefits
- ☐ Dividends or Interest
- ☐ Disability Benefits
- ☐ Contributions
- ☐ Pensions/Retirement Benefits
- ☐ Railroad Retirement Benefits
- ☐ Royalties, Oil/Mineral Rights
- ☐ Unemployment Benefits
- ☐ Other: List additional income and benefits not shown here: ____________________
- ☐ Wages/Self-Employment
- ☐ Trust or Annuity Payments
- ☐ Worker's Compensation
- ☐ Farm Income
- ☐ SSI
- ☐ Child Support
- ☐ Rental Income
- ☐ Alimony

Person Who Receives Income	Source of Income. If work, enter employer's name.	Amount	How Often?	If Social Security, enter Claim Number
1)	1)	$	1)	1)
2)	2)	$	2)	2)
3)	3)	$	3)	3)

5. CHILD CARE

Do you or does anyone living with you pay for child care so they can work? ☐ Yes ☐ No

If yes, complete the following:

Child's Name	Care Giver Name	Monthly Amount	Person Paying for Care
1)	1)	$	1)
2)	2)	$	2)
3)	3)	$	3)

Read and Sign

Read carefully, then sign and date the application below.

1. We will keep what you tell us private as required by law.
2. Some families have to make a payment each month for this health insurance. This payment is called a premium. The amount of the premium depends on the family income.
3. Some families have to pay part of the bill when they visit the doctor, go into the hospital, or get a prescription filled. These payments are called co-payments. The amount of co-payment depends on the family income.
4. Some individuals have to incur medical expenses to qualify for a medical card. This is called a spenddown. This is similar to a health insurance deductible.
5. You agree the state may seek reimbursement for services the state covered for your family if those services should have been paid for by any other health coverage your family may have.
6. Be sure to answer the questions correctly. We may check all information on this form. You must help us if we ask you to prove that your information is right.
7. We will **not** share any information about immigration of any person who does not have an Alien Registration Number. We **will** verify the immigration status of any person if you gave us their Alien Registration Number. To do that, we will check the number with the U.S. Bureau of Citizenship and Immigration Services (USCIS). We may send USCIS other information such as copies of proof you sent of an Alien Registration Number and the person's Social Security Number, if they have one.
8. You must tell your caseworker within 10 days if any of the following happens:
    - Your income changes;
    - The number of people in your family who live with you changes;
    - You move or change your mailing address; or
    - Someone who gets health benefits moves out of Illinois, dies, or goes to jail or prison.
9. If we pay medical bills for you, you give your right to collect medical support payments to the State of Illinois. You must help us if we ask you to establish paternity or obtain medical support payments for members of your family. You may not have to do this if you have a good reason not to. Your children can get health insurance even if you do not help us when we ask you to help.
10. Anyone who misuses the health insurance card may be committing a crime.

I declare under penalty of perjury that I have read all statements on this form and the information I give is true, correct and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information.

The undersigned hereby consents and authorizes the Department of Human Services and Healthcare and Family Services to investigate, obtain and verify all information necessary in connection with the request for public assistance. Such information shall include, but not be limited to, documents of financial institutions, trusts, insurance, stocks/ mutual funds, real estate, pension, SSI/SSA, and any other type of financial resources. Failure to cooperate or provide documentation or information necessary to determine the applicant's eligibility may result in the denial of assistance.

Applicant's signature: ______________________________ Date: ______________

(Make a mark and have another adult sign next to your mark if you cannot sign your name.)

If you completed this application on behalf of the applicant, sign and complete the following.

Signature: ____________________ Date: ______________ Phone: ______________

Name (print): ____________________ Relationship to applicant: ____________________

If someone initiates this application on behalf of the applicant, identify the relative, or other person, who can answer questions about the applicant's financial situation.

Name: ____________________ Home Address: ____________________

Relationship: ______________________________ Phone: ______________

FORM A - MEDICARE AND OTHER HEALTH INSURANCE

MEDICARE

Complete for anyone who has Medicare or attach a copy (front and back) of the Medicare card.

Name	Medicare Claim Number	Effective Date			
		Part A		Part B	
1) ______	1) ______	Part A	______	Part B	______
2) ______	2) ______	Part A	______	Part B	______

HEALTH INSURANCE

Complete for anyone covered by private health insurance or group health insurance, including a plan through their most recent employer or attach a copy (front and back) of the insurance card.

Name of Covered Person #1: ______

Policy Holder Name: ______ Policy Holder Social Security Number (Optional): ______

Insurance Company: ______ Certificate/Policy Number: ______

Medical Claims Mailed To:

Name: ______ Street: ______

City: ______ State: ______ Zip: ______

Prescription Claims Mailed To:

Name: ______ Street: ______

City: ______ State: ______ Zip: ______

Dates of Coverage: Begin Date: ______ End Date: ______

If insurance is through employer/union, enter employer/union.

Name: ______ Street: ______

City: ______ State: ______ Zip: ______

Check all the following benefits provided: ☐ Major Medical ☐ Dental ☐ Vision ☐ LTC ☐ Prescription

Monthly Premium Amount: $ ______

Name of Covered Person #2: ______

Policy Holder Name: ______ Policy Holder Social Security Number (Optional): ______

Insurance Company: ______ Certificate/Policy Number: ______

Medical Claims Mailed To:

Name: ______ Street: ______

City: ______ State: ______ Zip: ______

Prescription Claims Mailed To:

Name: ______ Street: ______

City: ______ State: ______ Zip: ______

Dates of Coverage: Begin Date: ______ End Date: ______

If insurance is through employer/union, enter employer/union.

Name: ______ Street: ______

City: ______ State: ______ Zip: ______

Check all the following benefits provided: ☐ Major Medical ☐ Dental ☐ Vision ☐ LTC ☐ Prescription

Monthly Premium Amount: $ ______

FORM B - RESOURCE INFORMATION

Complete only for persons who are blind, have a disability or are age 65 or older. If married and living with spouse, also enter any resources the spouse owns. If yes to any of the following, enter the details below. Attach proof. Attach additional sheet(s) if needed.

Does anyone own any property(ies) such as a home, vacation home, time share, building or land? ☐ Yes ☐ No

Owner	Address	Type	Value	Amount Owed
1) ______	1) ______	1) ______	$ ______	$ ______
2) ______	2) ______	2) ______	$ ______	$ ______

Does anyone own a car, truck, motorcycle, boat, trailer or other vehicle? ☐ Yes ☐ No

Owner	Type	Make/Model/Year	Value	Amount Owed
1) ______	1) ______	1) ______	$ ______	$ ______
2) ______	2) ______	2) ______	$ ______	$ ______

Does anyone own any life insurance? ☐ Yes ☐ No

Owner	Insurance Company	Policy Number	Face Value	Cash Value
1) ______	1) ______	1) ______	$ ______	$ ______
2) ______	2) ______	2) ______	$ ______	$ ______

Do you have an insurance policy that pays when you are in a nursing home? ☐ Yes ☐ No

If yes, list the following: **Policy Number:** ______

Name of company: ______

Does anyone own any of the following resources? Check all that apply:

- ☐ Business
- ☐ Savings
- ☐ Money Market Account
- ☐ Stocks, Bonds
- ☐ Checking Account
- ☐ Funeral/Burial Plans
- ☐ Life Estate
- ☐ Deferred Comp
- ☐ Annuity
- ☐ Nursing Home Account
- ☐ Trust Funds
- ☐ Inheritance
- ☐ Burial Plots
- ☐ IRA / 401 K
- ☐ Certificates of Deposit
- ☐ Reverse Mortgage
- ☐ Mineral/Oil Rights
- ☐ Mutual Funds
- ☐ Other List, if other: ______
- ☐ Promissory Note/Loan
- ☐ Government Bonds

Owner(s)	Type of Resource	Account/Policy #	Value	Name of Bank, Company, etc.
1) ______	1) ______	1) ______	$ ______	1) ______
2) ______	2) ______	2) ______	$ ______	2) ______
3) ______	3) ______	3) ______	$ ______	3) ______
4) ______	4) ______	4) ______	$ ______	4) ______

Do you have resources that are held jointly with another person? ☐ Yes ☐ No

(Jointly held resources are those held in two or more names; for example, in your name and in the name of another person(s). This includes resources that may be held by you and your spouse, son or daughter, brother or sister, grandchild, friend, companion, etc.).

RESOURCE:	VALUE:	NAME AND RELATIONSHIP OF OTHER PERSON(S) HOLDING THE RESOURCE:
Property in Illinois:............................	$ ______	______
Property in another state:..................	$ ______	______
Checking / Savings account:.............	$ ______	______
Certificate of Deposit:.......................	$ ______	______
Stocks / Mutual Funds:......................	$ ______	______
Other:..	$ ______	______

FORM C - TRANSFER OF RESOURCES AND INCOME

Complete only for persons who live in a nursing home facility or a supportive living facility or who intend to move to a nursing home facility or a supportive living facility, or who receive or have applied for services through the Department on Aging 's Community Care Program.

1. Have you filed a State or Federal Income Tax Return in the last 5 years? ☐ Yes ☐ No

If YES, which years? ______ ______ ______ ______ ______

If YES, you are required to provide a copy of each of your tax returns, including all attachments, filed the last 5 years.

Have you or your spouse within the past 60 months sold or given away any resources; closed any bank accounts; or made any changes in the way a resource is held (such as, adding a name to a house deed or creating a trust or annuity)? ☐ Yes ☐ No

Have you or your spouse within the past 60 months: 1) Made any transfers from a revocable trust, or 2) created an irrevocable trust that does not permit payment to you? ☐ Yes ☐ No

Do you or your spouse have an irrevocable trust that has stopped payment within the past 60 months? ☐ Yes ☐ No

2. Has someone else been helping you handle your money and general financial affairs? ☐ Yes ☐ No

This would include helping you handle things such as checking and savings account; handling your life and health insurance payments; handling financial investments such as IRAs and Certificate of Deposit; handling your income such as Social Security checks, pension checks or annuity payments. This could be a family member, a friend, or a financial advisor or attorney, or power of attorney (POA).

If YES, list the name, address, phone number and relationship of each person who assists you with any of these matters:

Name: ______
Address ______
______
City ______ State ____ ZIP ______
Relationship: ______
Phone: ______
Is this person your POA? ☐ Yes ☐ No
If YES, for: ______ Property ______ Health

Name: ______
Address ______
______
City ______ State ____ ZIP ______
Relationship: ______
Phone: ______
Is this person your POA? ☐ Yes ☐ No
If YES, for: ______ Property ______ Health

3. Within the last 60 months, did you talk with a financial planner, attorney, family member or anyone else about your need to reside in a nursing home and discuss any of the following issues? ☐ Yes ☐ No

- How you can use your resources and income to pay for nursing care.
- How you might become eligible for Medicaid if you are unable to pay for the cost of nursing home care from your own resources.
- Estate Planning - that is, developing a plan to divide any of your resources between your spouse, members of your family, friends, church or any other organization or placing your resources in a trust for any of these persons.

If YES, who did you talk to? (This may include a financial planner, attorney, banker, family member, friend, community or service organization, other.)

Name: ______
Address ______
______
City ______ State ____ ZIP ______
Relationship: ______
Phone: ______

Name: ______
Address ______
______
City ______ State ____ ZIP ______
Relationship: ______
Phone: ______

If yes, enter details below. If you need more space, attach an additional page.

______

______

FORM C - TRANSFER OF RESOURCES AND INCOME (cont.)

4. In the last 5 years (60 months), did you transfer any of the things you own or any of your income? ☐ Yes ☐ No

What was transferred? ____________________

Who made the transfer?	Amount Received	To Whom?	Date of Transfer	Market value on the date of transfer. Attach proof of how you determined the market value.
____________	$____________	____________	____________	____________

Describe the transfer. For example, was it sold, given away, or was there a change in the way it was held?

____

Why was the transfer made?

____

____

What other transfers were made? ____________________

If you need more space, please attach an additional page.

Who made the transfer?	Amount Received	To Whom?	Date of Transfer	Market value on the date of transfer. Attach proof of how you determined the market value.
____________	$____________	____________	____________	____________

Describe the transfer. For example, was it sold, given away, or was there a change in the way it was held?

____

Why was the transfer made?

____

____

5. In the past 60 months, did you take out a reverse mortgage on your home? ☐ Yes ☐ No

If yes, how did you receive the money? Lump sum payout: $ ____________ Line of credit: $ ____________

Explain how the money was used: ____________________

FORM D - TRANSFER OF RESOURCES OR INCOME TO SPOUSE

Complete only for persons who are married and live in a nursing home facility or a supportive living facility or who intend to move to a nursing home facility or a supportive living facility, or who receive or have applied for services through the Department on Aging's Community Care Program.

Do you want to transfer resources to your spouse? ☐ Yes ☐ No

If yes, attach copies of your spouse's resources.

Do you want to give income to your spouse? ☐ Yes ☐ No

If yes, attach copies of your spouse's income.

Does your spouse live in a nursing home facility or a supportive living facility? ☐ Yes ☐ No

Does your spouse receive or has your spouse applied for services through the Department on Aging's Community Care Program? ☐ Yes ☐ No

Does your spouse receive medical benefits through the Department of Human Services or the Department of Healthcare and Family Services? ☐ Yes ☐ No

If yes, enter case number: ____________________

FORM E - EMPLOYMENT EXPENSES

Complete only for employed persons who are blind, have a disability or are age 65 or older. Also enter the employment expenses for an employed spouse or parent of a child under age 18 if they live together.

Employed person's name: (1) ____________________

Amount received before deductions (gross amount): $ ____________________

How often paid: ☐ Weekly ☐ Every Two Weeks ☐ Bi-Monthly ☐ Monthly

Federal, State and City taxes withheld: $____________ **Social Security tax withheld:** $ ____________

Does the person buy or bring lunch to work? ☐ Buy Lunch ☐ Bring Lunch

Does the person buy uniforms or special tools? ☐ Yes ☐ No

If yes, enter the items bought, how often, and cost. Attach proof. ____________________

How does the person get to and from work? ☐ Own Car ☐ Bus ☐ Other **Please list, if other:** ____________

If person uses own car, how many miles to and from work? ____________________

If a person takes the bus, what is the fare to and from work? $ ____________________

If other, enter type and cost. Attach proof. ____________________

Must the person pay union dues, group life insurance premiums, group health insurance premiums, or retirement plan withholding as a condition of employment? ☐ Yes ☐ No

Monthly amount: $ ____________

Employed person's name: (2) ____________________

Amount received before deductions (gross amount): $ ____________________

How often paid: ☐ Weekly ☐ Every Two Weeks ☐ Bi-Monthly ☐ Monthly

Federal, State and City taxes withheld: $____________ **Social Security tax withheld:** $ ____________

Does the person buy or bring lunch to work? ☐ Buy Lunch ☐ Bring Lunch

Does the person buy uniforms or special tools? ☐ Yes ☐ No

If yes, enter the items bought, how often, and cost. Attach proof. ____________________

How does the person get to and from work? ☐ Own Car ☐ Bus ☐ Other **Please list, if other:** ____________

If person uses own car, how many miles to and from work? ____________________

If a person takes the bus, what is the fare to and from work? $ ____________________

If other, enter type and cost. Attach proof. ____________________

Must the person pay union dues, group life insurance premiums, group health insurance premiums, or retirement plan withholding as a condition of employment? ☐ Yes ☐ No

Monthly amount: $ ____________

FORM F - ABSENT SPOUSE INFORMATION

Enter the following information for each absent spouse.

Absent Spouse's Name **Spouse of Whom?**

(1) ______________________ ______________________

Street	**Apt. No.**	**City**	**State**	**Zip**	**County**

Social Security Number: ______________________

Monthly Gross Income: $ ______________________

Source of Income: ______________________

(If employed, include employer's name and address below.)

Name: ______________________

Address: ______________________

Absent Spouse's Name **Spouse of Whom?**

(2) ______________________ ______________________

Street	**Apt. No.**	**City**	**State**	**Zip**	**County**

Social Security Number: ______________________

Monthly Gross Income: $ ______________________

Source of Income: ______________________

(If employed, include employer's name and address below.)

Name: ______________________

Address: ______________________

FORM G

Eligibility Worker: Form G is a required part of the 183 packet that goes to CAU, unless a completed 183 B is sent.

Complete this form only for persons who believe they have a disability, but the Social Security Administration has not made the disability determination.

Name of person who is requesting a disability determination: ____________________

EDUCATION

Highest Grade Completed	At What Age?	Date	Technical or Vocational Training?
____________	________	________	☐ Technical ☐ Vocational

Special Education Classes While in School? ☐ Yes ☐ No

If yes, please list: ____________________

Is the person able to read and write English? ☐ Yes ☐ No

Is the person able to speak English? ☐ Yes ☐ No

If no, what language is spoken? ____________________

WORK HISTORY

Has the person ever worked? ☐ Yes ☐ No

If no, how does the person support his or her self? ____________________

Give History of last 3 jobs.	Employment Dates	Full or Part Time	Reason for Leaving
Job Title (1): ____________	From: ________	☐ Full Time	____________
Duties (1): ____________	To: ________	☐ Part Time	____________
Job Title (2): ____________	From: ________	☐ Full Time	____________
Duties (2): ____________	To: ________	☐ Part Time	____________
Job Title (3): ____________	From: ________	☐ Full Time	____________
Duties (3): ____________	To: ________	☐ Part Time	____________

FORM G (cont.)

MEDICAL PROVIDERS TREATING THIS PERSON

Name of Doctor	Doctor's Phone Number	Doctor's Address

Has this person received treatment for this medical problem in the last three months? ☐ Yes ☐ No

Has this person been hospitalized or used community health services for this problem in the last 12 months? ☐ Yes ☐ No

If yes, where? ______________________________

FORM H

Rebate Form for All Kids and FamilyCare

Use this form if you want All Kids or FamilyCare Rebate.

A rebate is a monthly amount we will pay you if you already pay for health insurance for yourself, your spouse or your children. If you choose to get rebates, you will use your current insurance card to get health care.

Only families who have health insurance can get rebate payments. Also, only families with a certain amount of income can get rebates. You may be able to get rebates if your family is like one in the list below:

- ☐ You are the **only** person in your family ➡ You may qualify for rebates if the income you get each month is between $1,274 and $1,915.
- ☐ You have **two** people in your family ➡ You may qualify for rebates if the income you get each month is between $1,720 and $2,585.
- ☐ You have **three** people in your family ➡ You may qualify for rebates if the income you get each month is between $2,166 and $3,255.
- ☐ You have **four** people in your family ➡ You may qualify for rebates if the income you get each month is between $2,611 and $3,925.

To ask for rebates, you must send this form **with** the rest of your application.

Part A

The main person whose name is on the insurance must sign this part of the form. Often this person is called the policyholder. This person may get the health insurance from a job.

Policyholder's Name
(list last name, then first name): ______________________________

Home Address: ______________________________ **Apt. #:** __________

City: ____________________ **State:** ______________ **Zip:** __________

Social Security Number (Required): ____________________ **Phone Number:** ______________

We must have the Social Security Number (SSN) so we may pay the rebate to this person.

Policy Number: ____________________ **Group Number:** ______________

Tell us the names of the family members you want rebates for:

____

____

I agree to call All Kids/FamilyCare right away if this health insurance ends, someone is added or taken off the health insurance, the amount paid for the insurance changes, covered benefits change or someone else becomes the policyholder.

I authorize my employer, plan administrator and insurance company to provide the information requested in Part B on the next page for the purpose of determining whether I qualify for All Kids/FamilyCare. I also authorize my employer, plan administrator and insurance company to verify my coverage and any of the information below for any time when I get All Kids/FamilyCare Rebate.

Signature of Employee/Policyholder: ______________________________

Need help? Visit www.allkids.com or call 1-866-All-Kids (1-866-255-5437). If you use a TTY, call 1-877-204-1012. The call is free.

Part B

This part of the form must be completed by 1) the employer providing the health insurance, or 2) the insurance agent.

Note to Employer/Insurance Agent: The employee/policyholder named on the front of this form is applying for help to cover the cost of their family's health insurance premiums. Please assist them by completing the information below and returning the form to the employee/policyholder as soon as possible. (As used below "employee" applies to an employee or private policyholder.) For help in completing this form, call 1-877-805-5312. The call is free.

Employer (if employer policy): ______________________________

Employer address: ______________________________

City: ____________________ **State:** ____________ **Zip:** ____________

Person completing this form: ______________________________

Phone: ____________________ **Fax:** ____________________

Insurance Company: ____________________ **Policy Number:** ____________ **Group Number:** ____________

What benefits are covered?
Check all that apply.
☐ Physician Services ☐ Hospital Inpatient Services

Amount of premium (for physician and hospital inpatient) paid by employee: $ ____________
Include amounts paid for dental, vision and prescription coverage.

Premiums are paid:

☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

☐ Every 2 months ☐ Quarterly ☐ Semi-annually ☐ Annually

List the persons covered by the employee premium contribution:

____

____

Does the employer pay 100% of the cost of the employee's coverage? ☐ Yes ☐ No

If no, how much of the amount listed above is for physician and hospital inpatient coverage of the employee only (single rate)?

$ ____________ Include single rate amounts for dental, vision and prescription coverage.

Enrollment period for policy: ____________

Date the premium listed above began or begins: ____________

Date of next scheduled change in premium: ____________

Authorized signature of employer/agent ______________________________ **Date:** ____________

Return this completed form to the employee for submission with the application.

Need help? Visit www.allkids.com or call 1-866-All-Kids (1-866-255-5437).
If you use a TTY, call 1-877-204-1012. The call is free.