VETERANS CARE

Healthcare for Illinois Veterans

# Application

## For Veterans Care Health Insurance

There are thousands of veterans in Illinois who are living without health insurance because they can't afford it. The citizens of Illinois feel a sense of duty to provide medical benefits to those who have defended our country with honor. Thank you for taking the time to complete this form.

**Veterans Care** covers veterans who need health insurance.

**Apply now!** Please print in ink. Answer all the questions. If you need more space for any answers, please write it on an extra sheet of paper. If you need help, visit **www.illinoisveteranscare.com** to find an Illinois Department of Veterans Affairs Office near you or call 1-877-4VETSRX (1-877-483-8779) for help. If you use TTY, call 877-204-1012. The call is free.

## Other Important Information

Illinois has other health care insurance programs for families and people with disabilities. They cover some additional services. You can apply for these programs at your local Department of Human Service (DHS) office. If you need help, visit www.dhs.state.il.us to find a DHS office near you or call 1-800-843-6154 for help. The call is free. You can also apply for FamilyCare online at **www.allkids.com** or by calling 1-866-ALL-KIDS (1-866-255-5437) (TTY 1-877-204-1012).

**STATE OF ILLINOIS**

HFS 2378VC (R-7-08)
IL478-0383

IOCI0806-09
R3-09

## 1. Tell us about the applicant.

The applicant is usually the person filling out this form. The applicant must be a veteran who has served in any branch of the U.S. military.

Applicant's name _____
Last First

Birth date __ __ /__ __ /__ __ __ __ ☐ Male ☐ Female
*m m / d d / y y y y*

Social Security Number __ __ __- __ __ - __ __ __ __

Address _____ Apt. # _____

City _____ State _____ Zip _____ County _____

Phone (_____) _____ (_____) _____ (_____) _____
*Home* *Cell* *Work*

Is there someone else we can call, if we are unable to reach you?

Name _____ Phone (_____) _____

Language Preference: ☐ English ☐ Spanish ☐ Other (Specify) _____

Race or Ethnic Group: You can help us by giving your race or ethnic group, but you do not have to tell us. (Mark all that apply)

☐ White ☐ Black or African American ☐ Hispanic or Latino origin
☐ Native Hawaiian or other Pacific Islander ☐ Asian
☐ American Indian or Alaska Native ☐ Unknown

## Veteran's Spouse
**(You can help us by completing the following, but you do not have to tell us.)**

If you are married, please provide the following information (even if your spouse is not living with you):

Name of Spouse _____

Spouse's Social Security Number __ __ __ - __ __ - __ __ __ __

Name of Spouse's Employer (if employed) _____

Veteran's Name _____

## 2. USVA Eligibility

Have you applied for U.S. VA healthcare? ☐ Yes ☐ No

If yes, tell us the month, day and year you applied. __ __ / __ __ / __ __ __ __

Were you approved? ☐ Yes ☐ No ☐ Still Waiting

- Include a copy of your letter from U.S. VA if you were approved or denied.

**Have you ever been dishonorably discharged from the U.S. Military?**

☐ **Yes** ☐ **No**

- Include a copy of your military discharge (DD-214), if you have it. This may help us process your application faster.

The following questions will help us decide if you may qualify for U.S. VA health benefits:

Do you have a service-connected disability? ☐ **Yes** ☐ **No**

If yes, what is your rated percentage? _____%

Do you have a permanent severe disability? ☐ **Yes** ☐ **No**

Are you a former Prisoner of War? ☐ **Yes** ☐ **No**

Have you received a Purple Heart? ☐ **Yes** ☐ **No**

Do you receive a VA pension for a non-service connected disability or from participating in a VA vocational rehabilitation program? ☐ **Yes** ☐ **No**

Were you discharged because of a disability that happened in the line of duty? ☐ **Yes** ☐ **No**

Are you receiving care from the VA because of an exposure to radiation, Agent Orange, Gulf War Illness or a contaminant related to the Persian Gulf? ☐ **Yes** ☐ **No**

Have you been discharged or released from the military for less than 2 years and served during a period of disability after November 11, 1998? ☐ **Yes** ☐ **No**

Are your combined assets and yearly income less than $80,000, not counting the value of your home and family vehicles? ☐ **Yes** ☐ **No** (U.S. VA counts assets to decide who qualifies for federal health benefits. Assets are not counted for Illinois Veterans Care.)

Veteran's Name _____

## 3. Tell us about your health insurance.

Do you currently have health insurance? ☐ **Yes** ☐ **No**
If yes, answer the following three questions:

Is it through COBRA? ☐ **Yes** ☐ **No** (COBRA is group insurance you buy from a former job.)

Is it through TRICARE? ☐ **Yes** ☐ **No**

What does it cover? ☐ Hospitalization ☐ Doctor Visits

If the insurance ended, tell us the month, day, and year it ended and why. __ __/ __ __/__ __ __ __
*m m / d d / y y y y*

☐ You or your spouse's job ended

☐ Met lifetime limit

☐ Other: _____

Have you received medical care during the 3 months before the month of this application? ☐ **Yes** ☐ **No**

If yes, do you want help to pay these bills? ☐ **Yes** ☐ **No**

If yes, what months? _____, _____, _____,

## 4. Tell us about the people that live with you. Include your spouse and your children or step-children (under age 19) that live with you.

Children under 19 may be eligible for All Kids health benefits. 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.

**Name** _____ SSN __ __ __/ __ __/__ __ __ __

Birth date __ __/ __ __/ __ __ __ __ Relationship to applicant _____

**Name** _____ SSN __ __ __/ __ __/__ __ __ __

Birth date __ __/ __ __/ __ __ __ __ Relationship to applicant _____

**Name** _____ SSN __ __ __/ __ __/__ __ __ __

Birth date __ __/ __ __/ __ __ __ __ Relationship to applicant _____

Veteran's Name _____

## 5. Tell us if you or your spouse is currently employed or self-employed. If self-employed, enter "self" for employer.

- Send a copy of one pay stub (including tips) received in the last 30 days from each job. If either is self-employed, provide 30 days of detailed business records that include income and expenses.

**Name** _____ Employer _____

Employer address _____ Phone (____) _____

_____

Number of hours worked Amount paid before taxes How often

Weekly_____ (including tips) _____ paid _____

**Name** _____ Employer _____

Employer address _____ Phone (____) _____

_____

Number of hours worked Amount paid before taxes How often

Weekly_____ (including tips) _____ paid _____

## 6. Tell us about anyone named on this form who GETS money from any source other than employment (such as Social Security, child support, spousal support, rental property, unemployment benefits, pensions, trust). Complete the following.

- Send proof of one payment received in the last 30 days for each source of income you list. We will get proof of Social Security and unemployment benefits for you.

**Name** _____ Source _____

Payment amount _____ How often paid _____

If this is rental property income, does the person receiving the income manage the property? ☐ **Yes** ☐ **No**

**Name** _____ Source _____

Payment amount _____ How often paid _____

If this is rental property income, does the person receiving the income manage the property? ☐ **Yes** ☐ **No**

Veteran's Name _____

## 7. Tell us if you or your spouse PAY child support or spousal support. Tell us how much was paid in the last month.

- Send proof of one payment made to each person in the last 30 days and a copy of the court order.

**Name** _____ Amount _____ How often_____

**Name** _____ Amount _____ How often_____

## 8. Tell us about anyone named on this form that pays for child care so they can work.

- Send proof of one payment made in the last 30 days.

Name of
children in child care_____

Name of
caregiver _____

Person paying for care_____

Payment amount _____

Relationship of caregiver to child _____

How often paid _____

Veteran's Name _____

## 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. You have to make a payment each month for Veterans Care insurance. This payment is called a premium.

3. You have to pay part of the bill when you visit the doctor, go in the hospital, or get a prescription filled. These payments are called co-payments.

4. You agree the state may seek reimbursement for services the state covered for you if any other party should have paid for those services.

5. 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.

6. You must tell us within 10 days if any of the following happens:
   - Your family income changes;
   - The number of people in your family who live with you changes;
   - You move;
   - You go into a nursing home or move out of Illinois; or
   - If you get health insurance or Medicare.

7. We will cancel your health insurance if you go to jail or prison.

8. Anyone who misuses our 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.**

**I authorize the U.S. VA to provide information about my military service and discharge status to the state of Illinois for the purpose of determining eligibility for the Illinois Veterans Care Program.**

**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 (____) _____

## Final Checklist—Keep this page for your records.

- ✔ Did you answer all the questions?
- ✔ Did you sign and date the application?
- ✔ Do you have copies of all the proofs we said you would need? All the information that needs proof is marked with ●.

**Mail your application along with copies to:**

**Veterans Care**
**P.O. Box 19161**
**Springfield, IL 62794-9161**

## Next steps

- If any information changes after you send the application, call 1-800-226-0768 (TTY: 1-866-675-8440). The call is free.
- We will review your application as quickly as possible.
- If we find something is missing, we will send you a letter telling you what else to send.
- Please allow 45 days for us to make a decision.
- We will send you a notice to tell you if you can get Veterans Care. If you do not qualify, we will also send a notice and tell you why.

If you are not satisfied with the actions taken on your application, you have the right to a fair hearing. You can ask for a fair hearing by writing us, or by writing to the Department of Healthcare and Family Services, Bureau of Administrative Hearings, 401 South Clinton Street, Sixth Floor, Chicago, Illinois 60607 or by calling 1-800-435-0774 (TTY: 1-877-734-7429). The call is free. Use these numbers only to file an appeal.

**STATE OF ILLINOIS**