State of Illinois
Department of Healthcare and Family Services

Illinois Department on Aging (IDoA) Notification

TO: _____

_____

_____

DATE: _____

FROM: (CCU Stamp)

RE: NAME: _____

ADDRESS: _____

_____

CASE ID: _____

(Note: Enter Social Security Number for new applicant only).

CASE LOAD NUMBER (if available): _____

CARE COORDINATION UNIT

CONTACT PERSON _____

PHONE NUMBER _____

The FCRC must send the CCU copies of Form 267 and 360L for applicant receiving DoA Community Care Program services. See WAG 20-28-01.

This is to notify the FCRC that the person named above receives services from the Department on Aging (DoA) Community Care Program (CCP).

1. STATUS OF MEDICAID ELIGIBILITY (CHECK ONE)

☐ The person named above has completed an application for medical benefits. Form 2378H is attached.

☐ The person named above has an active medical case.

2. STATUS OF COMMUNITY CARE PROGRAM (CCP) SERVICES

Person is receiving CCP services. Effective ____/____/____ . The monthly costs of services are $ _____ .

Apply the costs of services towards the person's spenddown obligation.

3. CHANGE OF INFORMATION (CHECK AS APPROPRIATE)

☐ Death of client Date of death: ____/____/____

☐ CCP services denied/terminated effective ____/____/____

☐ Spouse receiving CCP services effective ____/____/____

☐ Spouse entered nursing facility or supportive living facility on ____/____/____

☐ Death of spouse Date of death: ____/____/____

Note: Determine if case is eligible for spousal diversion. See PM15-06-02-d.

The CCU will notify DHS/FCRC of any changes in services and /or monthly cost.

Print Form