End of CCR: Completing the Redetermination

HFS
Illinois Department of
Healthcare and Family Services

HFS
Illinois Department of
Healthcare and Family Services

OUR VISION FOR THE FUTURE

We improve lives.

- We address social and structural determinants of health.
- We empower customers to maximize their health and well being.
- We provide consistent, responive service to our colleagues and customers.
- We make equity the foundation of everything we do.

This is possible because:

We value our staff as our greatest asset.

We do this by:

Fully staffing a diverse workforce whose skills and experiences strengthen HFS.

Ensuring all staff and systems work together.

Maintaining a positive workplace where strong teams contribute, grow and stay.

Providing exceptional training programs that develop and support all employees.

We are always improving.

We do this by:

Having specific and measurable goals and using analytics to improve outcomes.

Using technology and interagency collaboration to maximize efficiency and impact.

Learning from successes and failures.

We inspire public confidence.

We do this by:

Using research and analytics to drive policy and shape legislative initiatives.

Clearly communicating the impacts of our work.

Being responsible stewards of public resources.

Staying focused on our goals.

HFS Goals

- Minimize the number of eligible customers who lose coverage
- Provide all customers with access to multiple customer-centered redetermination completion and submission opportunities
- Ensure all Medicaid eligible customers continue to connect with their healthcare providers

Agenda

- Accurate and Timely Submission of Redetermination
- Review of Notices
  - Ex Parte/Form A
  - Completing Form B Redetermination
  - Verification Checklist
  - Cancellation Notice

Accurate and Timely Submission of Form B Redeterminations

Redetermination Process by Month

End of Certification Period	Rede Mail Date	Rede Due Date Printed on Notice (Form B)	Cut-off Date: Form B not received	First day of Coverage Loss	Last day to return rede for potential reinstatement
06/30/2023	By 05/01/2023	06/01/2023	06/15/2023	07/01/2023	09/30/2023
07/31/2023	By 06/01/2023	07/01/2023	07/17/2023	08/01/2023	10/31/2023
08/31/2023	By 07/01/2023	08/01/2023	08/15/2023	09/01/2023	11/30/2023

Illinois Redeterminations will be spread out over 12 months – this is only the first 3 months of dates

Ex Parte (Form A) vs. Form B June 2023 Renewal Dates

Type	Total	Percentage	Notes
Ex Parte	58,323	51%	• Historic rate = Between 30% - 40%

Form B	55,283	49%	• Form B Reasons:
			  • Earned income exists on case and none was found in clearances
			  • SSN not provided
			  • AWVS income exceeds income limit
			  • Case record has self employment
			  • Unearned income on the case is not verifiable electronically

4 Ways To Complete Form B Redeterminations

- **Online through ABE.Illinois.gov**
- **Must have Manage My Case (MMC)**
- **If rede is due – Renew button and electronic version of redetermination questions will appear in MMC.**

- **By Phone: Call the DHS Call Center 1-800-843-6154/ 1-866-324-5553 TTY prompts to select TBD**
- **Starting May 1, hours of operation, 8:00 AM – 6:30 PM, except state holidays**

Return the Renewal Notice by mail or fax to:

Central Scanning Office (not local office).
Return envelope is included in mailing

P.O. Box 19138
Springfield, IL 62763 or
Fax: 1-844-736-3563

- **Return the form in person to Department of Human Services (DHS) office on Notice.**
- **Click here for list of Family Community Resource Centers**

For free help completing and submitting the form refer members to a Certified Application Assistant

Redeterminations – Verifying Answers to the Same ?s as on the Original Application

Remember – Redeterminations are for the State to verify whether someone remains eligible- based on information verified electronically or by the customer.

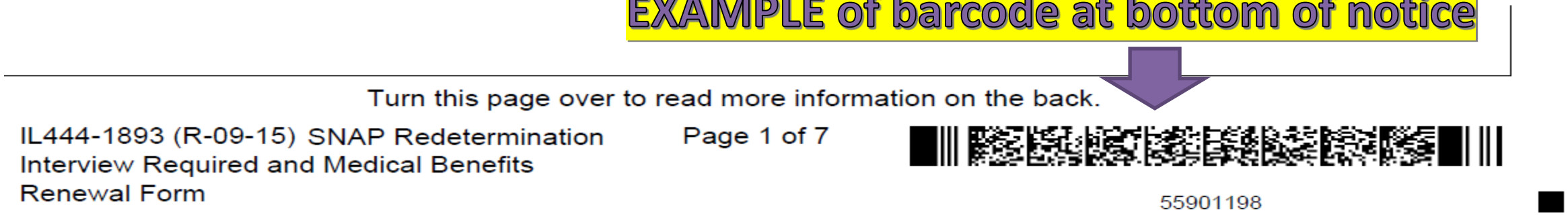
If you help someone **apply** for Medical and/or SNAP benefits– you are already familiar with the questions on the Medical and SNAP Rede forms – **they are the same questions – with some answers prefilled - making it much easier and faster.**

Think of it as updating the original application with any updated information

Dynamic Aspects: Renewal Forms

1. Each REDE form has a barcode that identifies: 1) the case; and 2) the form.
2. When the paper form is returned to Central Scanning, it is electronically scanned into IES and the case is automatically updated to show the redetermination form was received.
3. As long as IES shows the renewal is submitted by the due date, the case will stay open. Any future action will depend on eligibility when processed.

EXAMPLE of barcode at bottom of notice



Review of Key Customer Notices

Key Customer Notices

Medical Benefits Only Renewal Forms

- HFS2381A – Form A
- HFS2381 – Form B coversheet: Ready to Renew, goes with HFS643
- HFS643 (M, N, X)– Form B

Combined Snap Redetermination and Medical Benefits Renewal Form

- IL444-1893

Verification Check Lists - sent when proof documents are needed – with due date. Failure to return will result in case closure.

- IL444-0267 – Request for Verification documents
- 2378 VR– Verification of Resource Information (AABD)

Notice of Decision (NOD) - communicates decision (e.g. approval, denial, cancellation); contains lots of info and explains appeal rights

- 360C

This Information Will Appear at the top of the First Page of Every Notice

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

<MAILING BARCODE>
JOHN SMITH
401 S CLINTON ST.
CHICAGO IL, 60607

Date of Notice: May 1, 2023
Case Number: 987654321

Office Name: FCRC Name
Office Address: FCRC Address

Phone: FCRC phone
TTY: (FCRC TTY
Fax: FCRC Fax

You can manage your case online at abe.illinois.gov

Esta notificación está disponible en Español. Usted puede socitarla por Internet en abe.illinois.gov o llame al 1-800-843-6154 (TTY 1-800-447-6404)

Medical Only Rede Form A

HFS 2381A

- ✓ Mailed when eligibility can be verified electronically
- ✓ Action is not required by the customer unless info incorrect
- ✓ Coverage will continue with the start of a new certification/ benefit period

Medical Only Rede Form A –

HFS 2381A

No Action Needed

Medical Benefits Redetermination Notice

Dear John Smith,

Based on the information we have today, the person(s) listed in the table below are approved to keep getting **medical benefits** after June 30, 2023. However, if we get new information about a change in your circumstance your eligibility for medical benefits may change. If that happens, we will send you a new notice.

Name	Birth Date	Medical ID (RIN)	Medical Group	Start of Ongoing Coverage
John Smith	Jan 15, 1980	123456789	ACA Adult	July 1, 2023

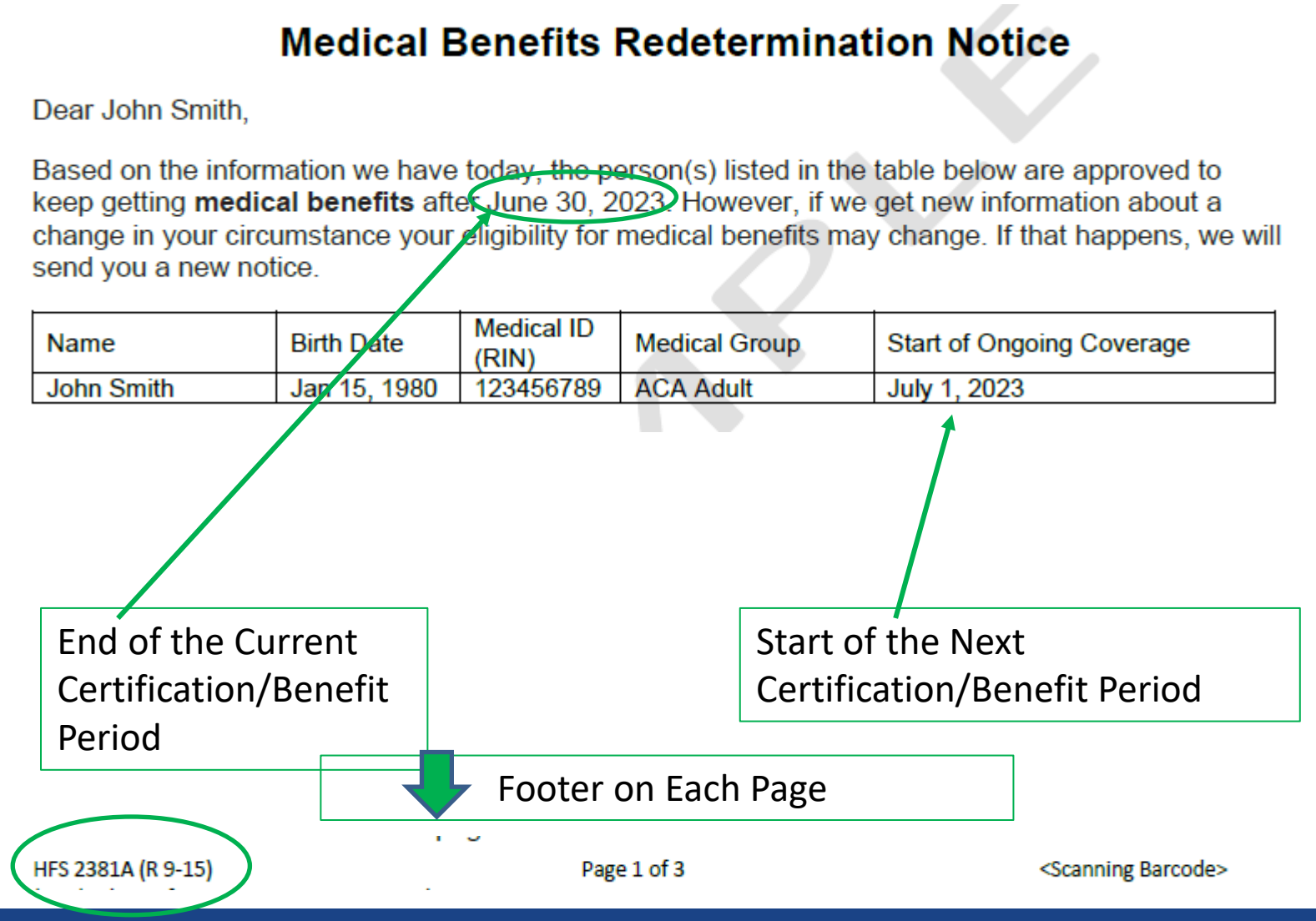
Footer on Each Page= form # and customer-specific barcode

HFS 2381A (R 9-15) Page 1 of 3 <Scanning Barcode>

Medical only Rede Form A –

HFS 2381A

No Action Needed



Medical Benefits Redetermination Notice

Dear John Smith,

Based on the information we have today, the person(s) listed in the table below are approved to keep getting **medical benefits** after June 30, 2023. However, if we get new information about a change in your circumstance your eligibility for medical benefits may change. If that happens, we will send you a new notice.

Name	Birth Date	Medical ID (RIN)	Medical Group	Start of Ongoing Coverage
John Smith	Jan 15, 1980	123456789	ACA Adult	July 1, 2023

End of the Current Certification/Benefit Period

Start of the Next Certification/Benefit Period

Footer on Each Page

HFS 2381A (R 9-15) Page 1 of 3 <Scanning Barcode>

Form B Process

If the customer is not eligible for the auto-Rede process, IES will then populate form 2381B (Time to Renew) and send it, along with the Rede form (643) to the household by the 30th day prior to the due date on the form which is the 60th day prior to end of the certification period.

The 2381B will be sent **along with** the following Rede form:

HFS-643 (M, N or X): for households receiving medical only

HFS-643M = MAGI populations (children, parents, pregnant women, ACA)

HFS-643N = Non-MAGI (AABD – aged, blind and disabled)

HFS 643X = LTC resident

Questions will be added depending on the specific HFS-643 form sent since specific information is needed for different populations (e.g. resources/assets for AABD).

Medical Only Rede Form B

HFS 2381/ HFS 643

Medical Benefits

Time To Renew Form B

HFS 2381 & 643

Action Required

- ✓ Mailed when eligibility can NOT be verified electronically
- ✓ Action IS required by the customer
- ✓ Must submit redetermination information by the due date on the form – using one of 4 methods (MMC, phone, Fax/Mail, or FCRC)
- ✓ Customer does NOT have to wait for letter to submit through MMC or by phone 1 month before form due date (eg: for those with June 1 due dates, "Renew My Benefits" button was in MMC and DHS call center will renew by phone starting **May 1**)

Medical Benefits Time to Renew Form B

HFS 2381

Due Date/ Instructions

Medical Benefits: Time to Renew Notice

Dear Maria Lopez,

It is time to renew your Medical benefits!

You must complete your redetermination to continue your Medical benefits after June 30, 2023

To learn how to renew your Medical benefits, read the first page of the Medical Benefits Renewal Form which is included in this envelope.

Call us at the phone number listed at the top of this form if you cannot send everything on time or if you have questions. We may be able to help you get the proofs you need.

Electronic Review of Eligibility for Medical Benefits

We checked our records for information about your household and put it on your Medical Benefits Renewal Form that is included with this notice. We need more information to decide if you are still eligible.

Please review the information on the Medical Benefits Renewal Form carefully. Correct any information that is wrong and add any information that is missing.

HFS 2381 (R 9-15)
(Medical Benefits: Time to Renew Notice)

Page 1 of 1

<Scanning Barcode>

Medical Benefits Time to Renew Form B

HFS 2381

Section appears if Assigned Approved Rep

Approved Representatives

You asked us to share information about your case with your Approved Representative. Based on our records, you have named the following person(s) or organization(s) as your Approved

Representative: [redacted]. You are responsible for the information your Approved Representative gives to us about you and your family.

[redacted] has your permission to do any of the things in the list below for you.

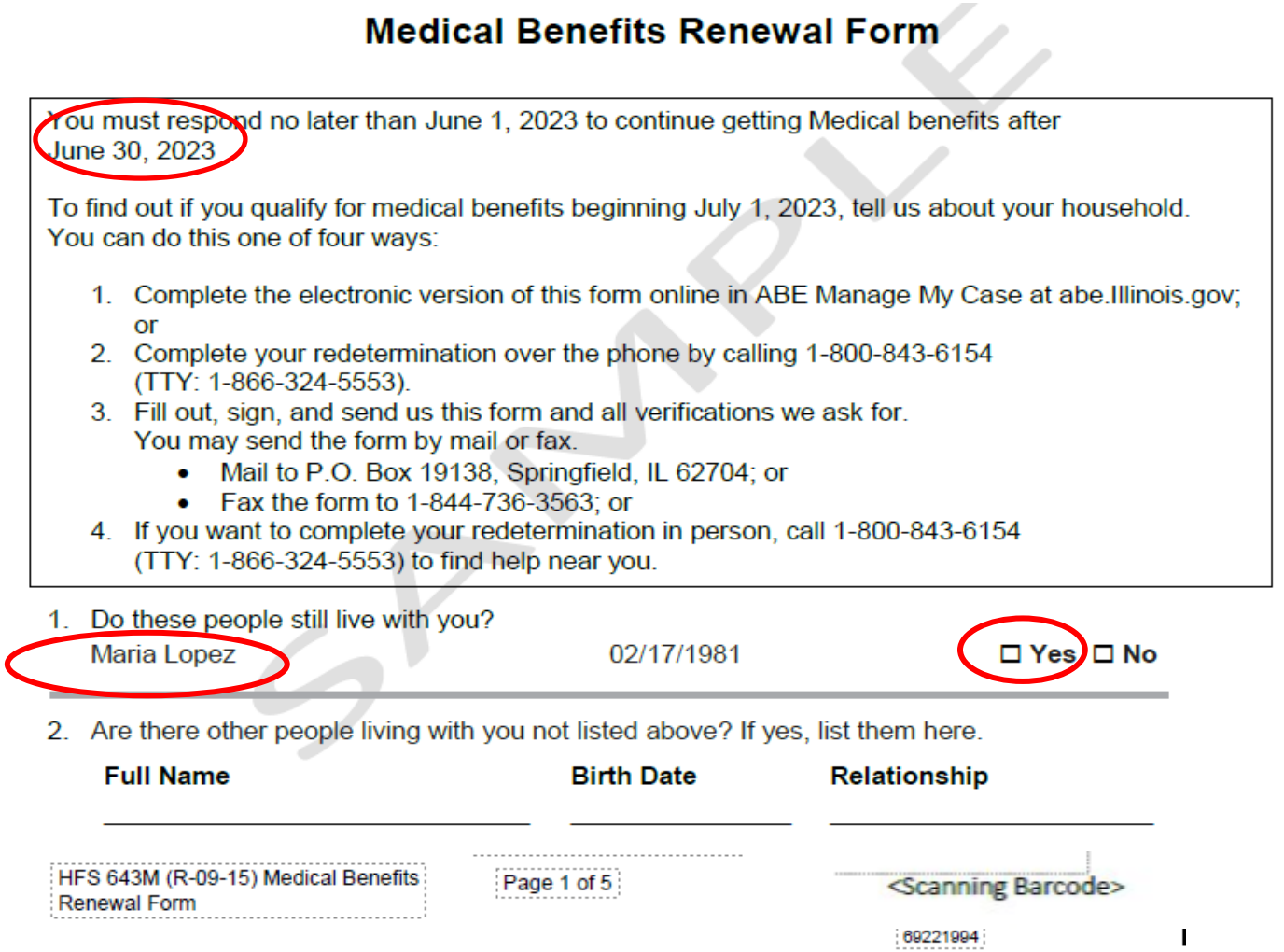
- Application for Benefits: Complete, sign and send an application for benefits. Get notices from us about the application. Represent you during the appeal process.
- Continuing Eligibility: Complete, sign and submit renewal forms. Get notices from us about the renewal. Represent you during the appeal process.
- Health Information: Get copies of communications (oral and in writing) from us about health information for you and members of your household (including information about substance abuse, mental health, genetic testing and HIV/AIDS or other contagious diseases).
- All Matters: Perform any task or get all of the information listed above plus get copies of all communications from the Agency, request services and make decisions for you about your benefits.

This Approved Representative Designation will last until you tell us you do not want the person(s) or organization(s) you named above to be your Approved Representative any longer. You can change Approved Representatives at any time. To change Approved Representative information or add an Approved Representative, contact your Family Community Resource Center shown at the top of the first page of this notice or go online to "ABE Manage My Case" at abe.illinois.gov

Page 1 of Medical Benefits Renewal Form (B)

HFS 643

Due Date/ how to respond/ Household info



Medical Benefits Renewal Form

You must respond no later than June 1, 2023 to continue getting Medical benefits after June 30, 2023

To find out if you qualify for medical benefits beginning July 1, 2023, tell us about your household. You can do this one of four ways:

1. Complete the electronic version of this form online in ABE Manage My Case at abe.Illinois.gov; or
2. Complete your redetermination over the phone by calling 1-800-843-6154 (TTY: 1-866-324-5553).
3. Fill out, sign, and send us this form and all verifications we ask for. You may send the form by mail or fax.
   - Mail to P.O. Box 19138, Springfield, IL 62704; or
   - Fax the form to 1-844-736-3563; or
4. If you want to complete your redetermination in person, call 1-800-843-6154 (TTY: 1-866-324-5553) to find help near you.

1. Do these people still live with you?

Maria Lopez 02/17/1981 ☐ Yes ☐ No

2. Are there other people living with you not listed above? If yes, list them here.

Full Name	Birth Date	Relationship

HFS 643M (R-09-15) Medical Benefits Renewal Form

Page 1 of 5

<Scanning Barcode>

69221994

SAMPLE

Page 2 of Medical Benefits Renewal Form (B)

HFS 643

Verifying addresses
&
Phone numbers and permission to receive texts

3. Is the address at the top of this page your correct mailing address? ☐ **Yes** ☐ **No** If No, tell us the correct mailing address:

_____

Our records show that you live at [redacted]. Is this correct?
☐ **Yes** ☐ **No** If No, tell us the correct address where you live:

_____

Our records show that these are your phone numbers. If not, tell us your correct numbers.

Phone Type	**Current Phone Number**	**New Phone Number**	**Receive Text Alerts and Reminders*** (please check one)
Home			☐
Work			
Cell			☐
Alternate			☐

*Standard fees may apply from your mobile service provider.

☐ **I do not wish to receive text alerts and reminders.**

Page 2 of Medical Benefits Renewal Form (B) HFS 643M

Employer & Income

☐ I do not wish to receive text alerts and reminders.

4. Please review the employment information we found for your household and let us know if it is correct.

Person	Employer	Monthly Income	Is this Correct?
	Grocery Store A	2550	☐ Yes ☐ No
	ICON Theater	500	☐ Yes ☐ No
	WAL-MART ASSOCIATES INC	1000	☐ Yes ☐ No

If a job listed above ended, tell us which job and the date of the last pay _____

If the employment information and the amount of monthly income above is correct, **you do not have to list it again in the next question. You do not have to send proof of this income if the amount is correct.** But we still need for you to complete other sections in this form and send it back.

Page 3 of Medical Benefits Renewal Form (B)

HFS 643M

Add other jobs

5. Does anyone get paid for working <a job marked as not correct or other jobs not listed above>? ☐ Yes ☐ No **If YES**, enter their name below. **Attach copies of the last 4 pay stubs if paid weekly, last 2 pay stubs if paid every other week or twice a month, and the last pay stub if paid monthly.** If self-employed, attach your income and expense statement for the last 30 days. If someone got tips that are not on their pay stubs, tell us Who? _____ and the total amount of tips received in the last 30 days. Total tips $ _____

According to our records, you told us your household had income from Dollar General. Tell us below if you still have this income and the new amount.

List the Name of Everybody Who is Working	Name of Employer If a person works more than one job, list all the employers.	Rate of Pay	Hours Worked Weekly	How often is the person paid? Weekly, every 2 weeks, twice a month, monthly, other?

Attach a sheet of paper if you need more room to list your family's income.

Page 3 of Medical Benefits Renewal Form (B)

HFS 643M

Other income, pregnant, health insurance ?s

6. During the last 30 days did anyone receive any other income such as Social Security, SSI, Unemployment, Contributions or any other money? ☐ **Yes** ☐ **No** **If YES**, complete the box below.

Name	Type of Income	Amount	How Often
		$	
		$	

Attach a sheet of paper if you need more room to list your family's income.

7. Are you or is anyone who lives with you pregnant?

If yes, name:_____ Due date:_____ Expected number of babies:_____ End date:_____

8. Do you or anyone living with you have health insurance? ☐ **Yes** ☐ **No**

If yes, name of insurance plan:_____ Policy Number _____

Who is covered by this health insurance? _____

Name of insurance plan:_____ Policy Number _____

Who is covered by this health insurance? _____

Page 4 of Medical Benefits Renewal Form (B)

HFS 643M

Family Planning, Tax filing ?s

9. Are you or anyone living with you interested in the partial-benefit program for Family Planning if no longer eligible for Medical Benefits? ☐ **Yes** ☐ **No**

If yes, name of the person(s) who want to Opt-In: _____

10. Will you or anyone who lives with you file a federal income tax return next year to report income received this year? ☐ **Yes** ☐ **No**

If yes, name of person(s) filing tax return: _____ Birth Date _____

If this person will **file jointly with a spouse,** write name of spouse: _____

If this person will **claim dependents** on the tax return, write name(s) of dependents:

_____ Birth Date _____ _____ Birth Date _____

_____ Birth Date _____ _____ Birth Date _____

11. Will you or anyone who lives with you be claimed as a dependent on anyone's tax return for this year? ☐ **Yes** ☐ **No**

If yes, name of dependent_____ Birth Date _____ Tax filer's name and relationship to dependent:_____

12. Do you or anyone living with you pay any expense that can be deducted on your federal income tax return? ☐ **Yes** ☐ **No**

If yes, list the expense: _____ How Much? _____ How Often? _____

Page 5 of Medical Benefits Renewal Form (B)

HFS 643M

Voter Registration info & Signature of Form

Voter's Registration Information

If you want to register to vote, fill out the attached Illinois Voter Registration Application SBE (R-19) and give it to your DHS office or your local election official. For help filling it out or for translation services, contact your DHS Family Community Resource Center. You may also call the Helpline at 1-800-843-6154, or 1-866-324-5553 (for TTY). For information online, see www.dhs.state.il.us or www.elections.il.gov/.

Read and sign below:

- I understand that officials in charge of my health benefits may check all information on this form.
- I understand they may check my information electronically. If they ask for my help checking information, I must cooperate.
- I understand that anyone who knowingly lies or provides untrue information, or arranges for someone to knowingly lie or provide untrue information, or intentionally misuses the health benefits card issued by the State of Illinois, may be committing a crime which can be prosecuted or punished under federal law, state law, or both.
- If the Illinois Department of Healthcare and Family Services pays medical bills for me, the State of Illinois may collect my medical support payments instead of me.
- I am signing this form under the penalty of perjury. That means the information I have provided on this renewal form is true to the best of my knowledge, and I may be punished under law if I provide false or untrue information.

Your Signature

Today's Date

Medical Benefits Renewal Form (B)

HFS 643N
HFS 643X

Additional questions added

Non-MAGI populations (Aged, Blind and Disabled) will get a 643N

Long Term Care Residents will get a HFS 643X.

In addition to the general questions outlined in the 643M (minus the tax filing status questions), there will be additional questions asking about things like:

- Expenses;
- Resources/Assets;
- Payment on a house or mobile home;
- Own or pay on land or buildings;
- Weather they have: Life Insurance; Health insurance; or other insurance that covers long-term care.
- Questions on transfer of Resources or income (LTC residents)

As with all forms or applications, be sure all questions are answered and the form is signed and dated.

Combined SNAP and Medical Redetermination Form (B)

IL 444-1893

Combined SNAP and Medical Redetermination Form (B)

IL 444-1893

- ✓ Mailed when customer has Medical and another benefit.
- ✓ Customer Action is required by the due date. Must:
  1. Do SNAP interview; and
  2. Return renewal to State

Combined Medical & SNAP/CASH Rede Form (B)

IL444-1893

Page 1

SNAP Redetermination Interview Required and Medical Benefits Renewal Form

Your SNAP and Medical benefit period is ending June 30, 2023. If you do not complete a redetermination your benefits will stop. To keep getting benefits without a break and to allow time for us to process your redetermination, please complete it by June 1, 2023, but, no later than June 15, 2023.

Use one of the 3 easy ways below:

1. Complete the electronic version of this form online in ABE Manage My Case at abe.Illinois.gov; or
2. Fill out, sign, and send us this form and all verifications we ask for. You may send the form by mail or fax.
   - Mail to P.O. Box 19138, Springfield, IL 62763; or
   - Fax the form to 1-844-736-3563; or
3. Complete your redetermination in person. Bring this form and your verifications to the office listed above.

You must have an interview with a caseworker to reapply for SNAP. An interview is not needed for medical benefits. Check one of the boxes below if you are returning this form to the Family Community Resource Center.Check one of the boxes below so we can schedule your interview.

☐ I am elderly, ill, disabled, employed, or have some other hardship and need to be interviewed by phone. **Enter Telephone Number Here:**

☐ I am able to come to the office for an interview.

We will schedule your interview when your application is returned to us. If you do not keep a scheduled interview, it is up to you to ask for another one.

Combined Medical & SNAP/CASH

IL444-1893

Eating Together

Similar Questions to Medical Only Form B

- Who lives together, Birth date, relationship, and
- *New:* whether that person eats with the Head of Case.

2. Are there other people living with you not listed above? If yes, list them here.

Full Name	Birth Date	Relationship	Eats with you?
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

For additional persons, please attach a separate sheet.

Combined Medical & SNAP/CASH

IL444-1893

SNAP-specific: Rent, LIHEAP, other expenses

Similar Questions to Medical Only Form B
SNAP Specific:

9. How much is your rent: $ _____ Lot rent: $ _____ Mortgage $ _____ Enter any taxes and homeowner's insurance paid separately: $ _____ Are any of these paid by someone else? ☐ **Yes** ☐ **No If YES,** tell us who and how much: _____

10. Did you receive an energy assistance payment of $21 or more this month or in the last 12 months from the Low Income Home Energy Assistance Program (LIHEAP), (in Chicago paid through CEDA)? ☐ **Yes** ☐ **No** Answering YES will not reduce your benefits. **If NO,** do you pay for or are you billed separately from your rent or mortgage for heat or air conditioning, or excess cost for heat or air conditioning? ☐ **Yes** ☐ **No** Note: Air conditioning is a window air or central air conditioning unit. **If NO,** do you pay any other utilities? ☐ **Yes** ☐ **No If YES,** what utilities? _____

11. Does anyone in your household pay child support? ☐ **Yes** ☐ **No If YES,** who makes the payments, how much and how often? _____

12. Does anyone in your household pay for the care of a child or disabled adult living in your home so someone can work, attend training, or school, to prepare for a job? ☐ **Yes** ☐ **No If YES,** who is the care for, who provides the care, how much do you pay for the care and how often? _____

13. Does anyone who is age 18 or over attend school, other than high school, half-time or more? ☐ **Yes** ☐ **No If YES,** who? _____

14. Does someone in your unit who is 60 or older or is blind or disabled have monthly medical expenses of $36 or more that are paid by you and not reimbursed or paid by someone else? ☐ **Yes** ☐ **No**

Combined Medical & SNAP/CASH

IL444-1893

Remember:

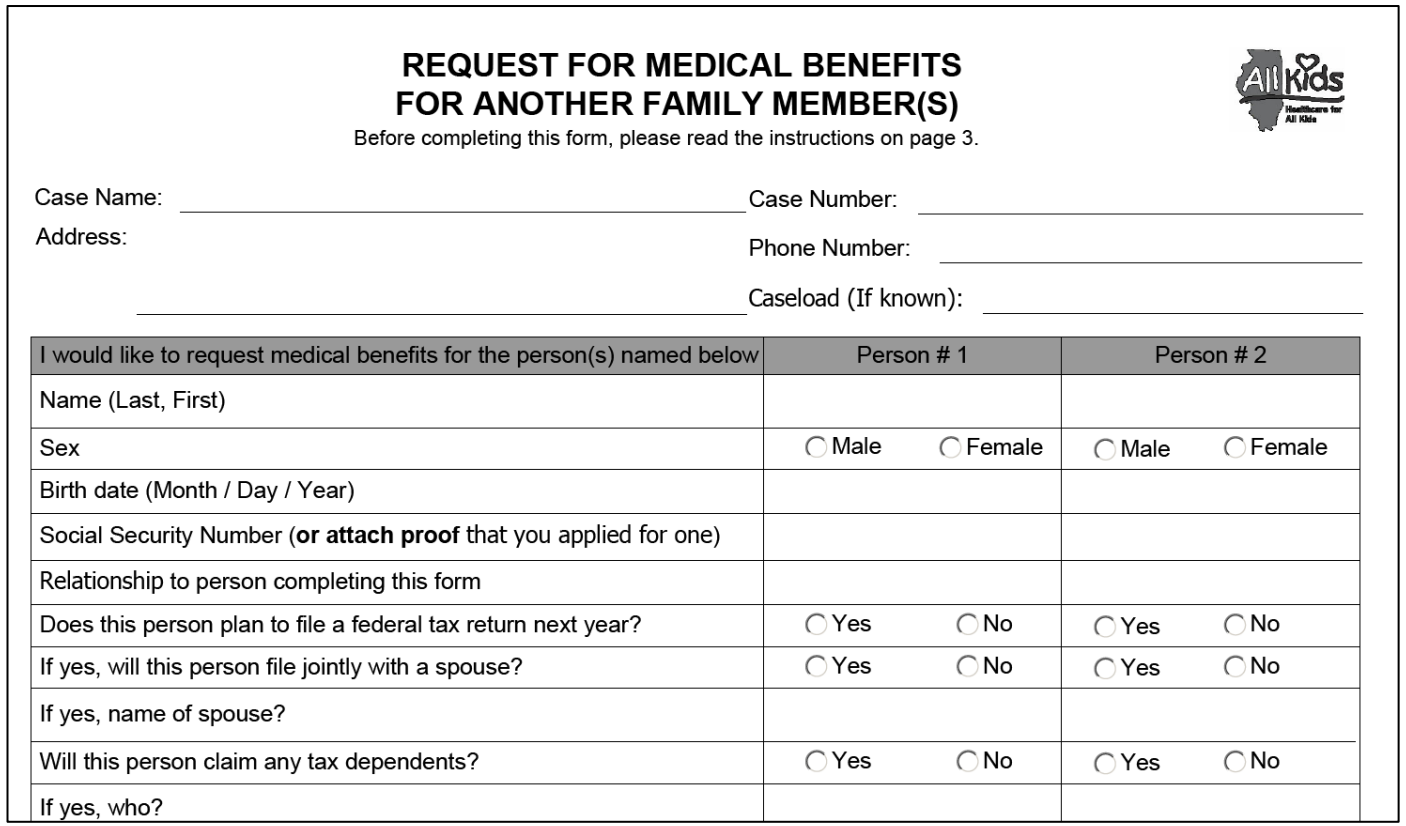
These forms are Dynamic – Form questions will differ depending on the population category of the person receiving it.

If someone is on AABD medical and receiving SNAP, there will be more questions for the medical portion of the redetermination – for things like Resources.

Special Populations - "Add-on" Forms

Transitions: Babies turning 1

For families with babies who have turned, or are turning 1, who were deemed eligible at birth, an HFS-243C Request Medical Benefits Form will be sent to the HoH at time of redetermination. In addition, SSNs will be required if the child is documented or a US citizen.



REQUEST FOR MEDICAL BENEFITS FOR ANOTHER FAMILY MEMBER(S)

Before completing this form, please read the instructions on page 3.

Case Name: _____ Case Number: _____

Address: Phone Number: _____

_____ Caseload (If known): _____

I would like to request medical benefits for the person(s) named below	Person # 1	Person # 2
Name (Last, First)		
Sex	◯ Male ◯ Female	◯ Male ◯ Female
Birth date (Month / Day / Year)		
Social Security Number (**or attach proof** that you applied for one)		
Relationship to person completing this form		
Does this person plan to file a federal tax return next year?	◯ Yes ◯ No	◯ Yes ◯ No
If yes, will this person file jointly with a spouse?	◯ Yes ◯ No	◯ Yes ◯ No
If yes, name of spouse?		
Will this person claim any tax dependents?	◯ Yes ◯ No	◯ Yes ◯ No
If yes, who?		

Transitions: Children Turning 19

At the time of a case/family redetermination when rede paperwork is sent out, an additional form, the **643A, 19 Year Old Aging Out of All Kids Medical Benefits** will be included for households in which a member turned 19 during PHE or the unwinding period. This form gathers information to determine whether the youth will remain on parent's case or establish their own case. This determination is based on tax status:

- If the child will be claimed by their parents on tax documents, they will remain on their parents' Medicaid case after turning 19, if still income eligible.
- If the child will no longer be claimed by parents, a new case will be established for the 19 year old.
- The form must be completed even if the teen will remain on parent's case.

Parent CANNOT sign the 643A! The 19-year-old must sign the form before it is submitted with all redetermination documents. If the 19-year-old doesn't sign the form and are not claimed as dependents by parents, the state cannot open a new case for the individual and the youth will lose coverage.

Aging Out of All Kids

HFS 643A – Included with Rede form for Case

19 Year Old Aging Out of All Kids Medical Benefits

Dear <IES Case Name>,
You received this form because a member of your household is reaching age 19. Have this member complete, sign and return this form so we can decide if a medical case can be opened in the member's name. If the member is not able to complete this form, the person who will be the head of household for the member should complete the form. Answer the questions on this form about the member.

Aging Out of All Kids

HFS 643A

Signature Page – to be signed by 19 year old

Read and sign below:

- I understand that officials in charge of my health benefits may check all information on this form.
- I understand they may check my information electronically. If they ask for my help checking information, I must cooperate.
- I understand that anyone who knowingly lies or provides untrue information, or arranges for someone to knowingly lie or provide untrue information, or intentionally misuses the health benefits card issued by the State of Illinois, may be committing a crime which can be prosecuted or punished under federal law, state law, or both.
- If the Illinois Department of Healthcare and Family Services pays medical bills for me, the State of Illinois may collect my medical support payments instead of me.
- I am signing this form under the penalty of perjury. That means the information I have provided on this renewal form is true to the best of my knowledge, and I may be punished under law if I provide false or untrue information.

Print your Name

Your Signature | Today's Date | Daytime or Cell Phone Number

HFS 643A (N-01-18) 19 Year Old Aging Out of All Kids Medical Benefits

COMPLETE AND SEND

Page 4 of 4

Verification Check List (VCL)

Verification Checklist

IL444-0267

Mailed if/when proof documents are needed to make decision

Verification Checklist

We need the items listed below to determine your eligibility. If you have an office interview **BRING** the items with you. If you have a phone interview or are applying for medical only, return these items as described in the instructions on the last page of this document.

What you need to give us - Give us the information that is marked below by the due dates listed below.

Please return at least **one of the requested examples** for each verification and person listed below **by no later than the due dates listed below**. If you do not respond by **the due date** your SNAP, Cash and/or Medical benefits could be reduced, cancelled or denied.

Name of Person	What is Needed	Examples	Required For	Due Date
CINDY SUNSHINE	Provide paystubs or proof of gross income (before taxes and deductions) from the last 30 days	Copy of check stubs or earnings statement; if applying for medical, only one pay stub or earnings statement from the last 30 days is needed; Copy of statement from employer showing gross income	Medical	06/01/2023

NOTICE OF DECISION
IL444-360C

Notice of Decision (NOD)

360C

Will be mailed whenever there is a Decision to Report:

Approval of Benefits - of application, redetermination, or change request

Denial of Benefits – no longer eligible, could include things like no longer a resident, over-income, etc.

Cancellation of Case – Key reason: Failure to Respond to Rede form or Verification Checklist

Notice of Decision (NOD)

360C

Key Parts of the Notice:

Summary: Reason for decision; benefits affected

Detailed section(s) of benefits (future and past) and information used to make decision

Appeal rights

Medical Card – for those on case approved for ongoing benefits (always last 2 pages)

Notice of Decision (NOD)

360C

Summary of Changes

Notice of Decision

Beginning [redacted], your benefits will change as follows:

Your eligibility for **Supplemental Nutrition Assistance Program (SNAP)** is not changed by this action.

The local office reviewed your reported change in circumstances and your SNAP benefits will not be increased. Your SNAP amount will remain the same. If there is a change in the future you will be notified in writing.

Your eligibility for **Medical Benefits** is not changed by this action.

How To Use Your Benefits

Once you stop using the cash or SNAP benefits in your Illinois Link account for a period of 274 days, those benefits will be deleted from your account and will no longer be available to you.

You can manage your case online through ABE (www.abe.illinois.gov). To learn how, read the **Manage My Case Online** section in this notice.

This notice contains important information. If you cannot read this notice, please call us at 1-800-843-6154 (TTY 1-866-324-5553) for help. Please stay on the line while you are connected with an interpreter.

Notice of Decision (NOD)

360C

Specifics on customer's medical coverage

Medical Benefits

The person(s) listed in the table below are **eligible** for ongoing Medical benefits.

Name	Birth Date	Medical ID (RIN)	Medical Group	Start of Ongoing Coverage
GEORGE SMITH	March 1, 1980	123456789	FamilyCare	July 01, 2023
CHANDLER SMITH	May 06, 2010	987654321	All Kids Assist	July 01, 2023

The person(s) listed in the table below have been **approved** for coverage for earlier dates.

Name	Birth Date	Medical ID (RIN)	Medical Group	Coverage Dates
GEORGE SMITH	March 1, 1980	123456789	FamilyCare	Oct 01, 2017 -Jun 30, 2023
CHANDLER SMITH	May 06, 2010	987654321	All Kids	Apr 01, 2020 -Jun 30, 2023

Notice of Decision (NOD)

360C

Customer specifics and Income Used for determination

Medical Benefits

Not Eligible for Medical Benefits

The person(s) listed in the table below have been **denied** for Medical Benefits.

Name	Birth Date	Dates of Coverage Denied	Reason	Policy Reference
CINDY SUNSHINE	Apr 06, 1968	No eligible dates of coverage	Household income is more than the limit for this individual for this program.	PM I-03-00

The application(s) for health coverage for CINDY SUNSHINE have been sent to the Federal Health Insurance Marketplace. Please refer to the attached *You Can Get Help to Buy Health Insurance* form for more information.

CINDY SUNSHINE was denied for having more income than the limit. The following amounts were used to make this decision:

MAGI Based Budget		Apr 01, 2023	May 01, 2023	Jun 01, 2023
Total gross earned income		$2687.00	$2687.00	$2687.00
Total self employment income	+	$0.00	$0.00	$0.00
Self employment expenses	-	$0.00	$0.00	$0.00
Total unearned income	+	$0.00	$0.00	$0.00
Gross monthly income	=	$2687.00	$2687.00	$2687.00
MAGI deductions	-	$0.00	$0.00	$0.00
Total countable monthly income	=	$2687.00	$2687.00	$2687.00
Income standard for your household size 1		$1677.00	$1677.00	$1677.00

Notice of Decision (NOD)

360C

Facts used to decide
&
possible next steps of Choosing MCO if approved & required

How We Decided Your Eligibility for Medical Benefits

If you have any changes in income or if anyone moves in or out of your household, you must report the change to us within 10 days by going to Manage My Case at abe.illinois.gov or by calling the phone number on the first page of this notice.

Eligibility for medical benefits for the following person(s) is based on household income, who is living with the applicant and how they are related to each other, or whether someone in the household files income taxes or is a dependent on someone else's tax return. This is called Modified Adjusted Gross Income (MAGI) methodology. You can find the income limits for each Medical Group online at illinois.gov/hfs/MedicalClients and then clicking "Medical Program Income Standards."

The facts we used to decide **Susie Sunshine's** ongoing Medical eligibility are:

The number of people counted in the family size is 2.
Countable monthly income is $1500

Choosing a Health Plan and/or Primary Care Physician (PCP)

You may be required to pick a health plan and a primary care doctor participating in your health plan. If so, you will get a notice from the Illinois Client Enrollment Broker to tell you about your health plan choices. When you get this notice, you will have 30 days to pick a primary care doctor and health plan for you and each member of your family. It is important to pick a health plan and doctor for you and each member of your family. If you do not choose a primary care doctor for each member of your family, you will be assigned to a primary care doctor and health plan.

Notice of Decision

360C

Appeal Rights

SNAP

If Your SNAP Application Was Denied

You may apply for SNAP benefits again any time you think you may be eligible. If you don't agree with our decision to deny your application, you may ask for a fair hearing. You will not receive any SNAP benefits just because you ask for a fair hearing. You will have the chance to explain your disagreement to a Family Community Resource Center worker and later to a hearing officer. If it is decided that you are right, you may be entitled to SNAP benefits from the date you applied.

If Your SNAP Application Was Approved

You may ask for a fair hearing if you don't agree with the decision. You will then have the chance to explain your disagreement to a Family Community Resource Center worker and later to a hearing officer.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION

If you do not agree with our decision, you have the right to appeal and be given a fair hearing. You may represent yourself at this hearing or you can ask someone else, such as a lawyer, relative or friend to represent you. If you are appealing the decision on your cash and/or medical benefits decision you must do so within 60 days after the "Date of Notice." If you are appealing a decision about SNAP you must do so within 90 days after the "Date of Notice." You can ask for a fair hearing by calling (800) 435-0774, if you use a TTY, by calling (877) 734-7429, going online to abe.illinois.gov/abe/access/appeals, emailing DHS.BAH@Illinois.gov, faxing (312) 793-3387, or in writing to DHS Bureau of Hearings, 69 W. Washington, 4th Floor, Chicago, IL 60602.

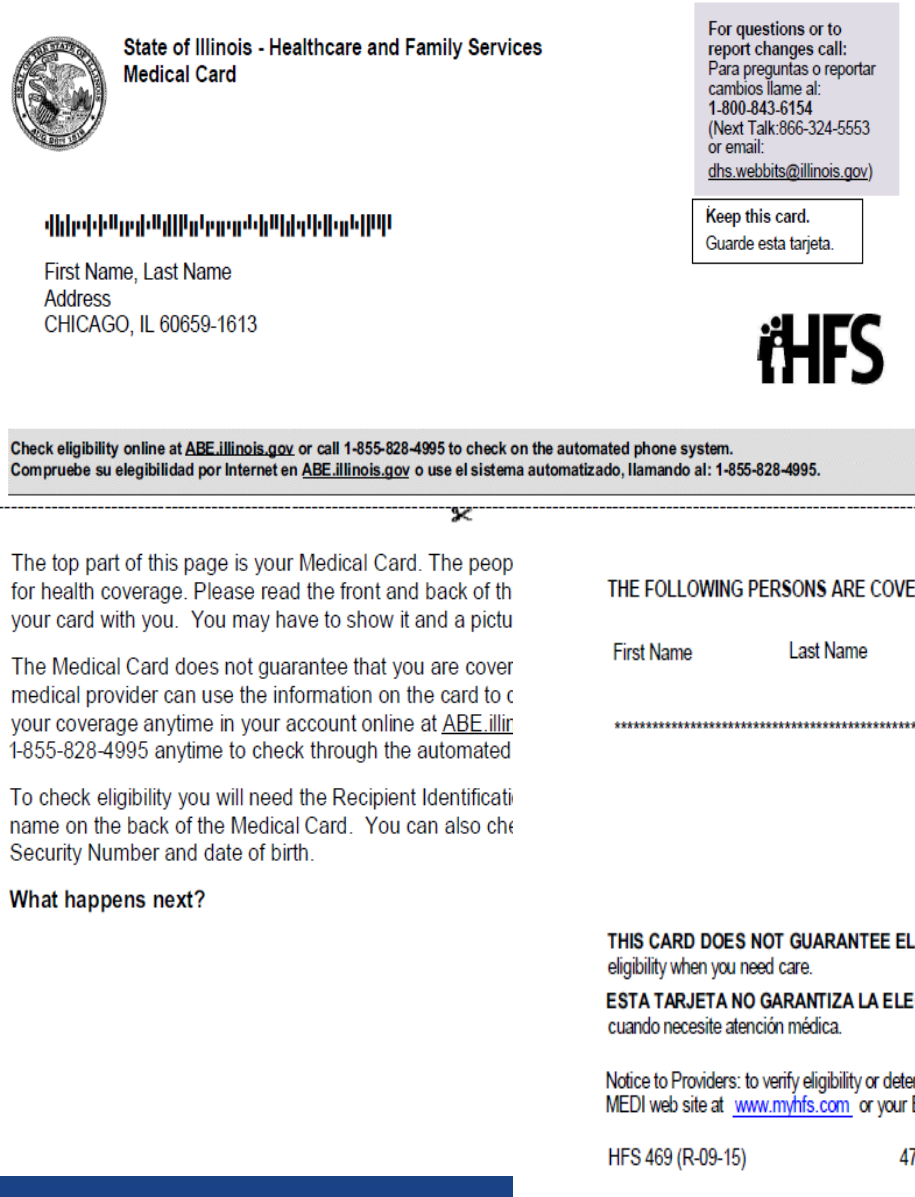
To apply for free legal help:

- ✓ In Cook County (including the City of Chicago) - Legal Assistance Foundation of Metropolitan Chicago: (312) 341-1070
- ✓ In other counties in Northern or Central Illinois with area codes (309), (815) or (847) - Prairie State Legal Services: (800) 531-7057
- ✓ In other counties in Central or Southern Illinois where the area code is (217) or (618) - Land of Lincoln Legal Assistance Foundation: (877) 342-7891

Notice of Decision

360C

Last 2 Pages is the medical card if anyone on case approved



State of Illinois - Healthcare and Family Services
Medical Card

For questions or to report changes call:
Para preguntas o reportar cambios llame al:
1-800-843-6154
(Next Talk:866-324-5553 or email:
dhs.webbits@illinois.gov)

Keep this card.
Guarde esta tarjeta.

First Name, Last Name
Address
CHICAGO, IL 60659-1613

HFS

Check eligibility online at ABE.illinois.gov or call 1-855-828-4995 to check on the automated phone system.
Compruebe su elegibilidad por Internet en ABE.illinois.gov o use el sistema automatizado, llamando al: 1-855-828-4995.

The top part of this page is your Medical Card. The peop
for health coverage. Please read the front and back of th
your card with you. You may have to show it and a pictu

The Medical Card does not guarantee that you are cover
medical provider can use the information on the card to c
your coverage anytime in your account online at ABE.illir
1-855-828-4995 anytime to check through the automated

To check eligibility you will need the Recipient Identificati
name on the back of the Medical Card. You can also che
Security Number and date of birth.

What happens next?

THE FOLLOWING PERSONS ARE COVERED:

MEDICAL CARD PAGE 2

First Name	Last Name	Recipient Identification Number (RIN) 1234567891	DOB: 07-07-1987

THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR PAYMENT FOR SERVICES. Medical providers must verify identity and eligibility when you need care.

ESTA TARJETA NO GARANTIZA LA ELEGIBILIDAD O PAGO. Los proveedores médicos deben verificar la identidad y elegibilidad cuando necesite atención médica.

Notice to Providers: to verify eligibility or determine health plan enrollment on the date of service for the person(s) named above, use the MEDI web site at www.myhfs.com or your EDI vendor or HFS's automated Voice Response System (AVRS).

HFS 469 (R-09-15)	47624874	02042021	IL478-0234

REMINDERS

- ✓ A Customer's medical benefits will stay active until their Redetermination date – No changes will be processed affecting medical until redetermination time for that case.

- ✓ As LONG as the Form B redetermination is in our IES system BY THE DUE DATE/no later than cut-off in the month the redetermination is due – the case will stay open, until it is processed by a caseworker and a determination is made. If eligible, the customer will start a new certification/benefit period.

- ✓ If someone **does not** get their Form B Redetermination submitted timely, they have a 90 day reinstatement period. It's better to submit a late redetermination within the reinstatement period, than submit a new application. Only if someone misses the reinstatement period will they need to reapply

- ✓ Please encourage customers to look for other coverage – either employer sponsored or the ACA Marketplace, if they are no longer eligible for Medicaid. Staying covered and accessing care is the priority.

APPENDIX
Customer Notifications: Page by Page

Customer Notifications Defined

Form	Form Name and Number	Form Defined
Ex Parte (Form A)	HFS 2381A (R 9-15) - Medical Benefits Redetermination Notice	Sent to customers that have electronically verifiable information such as income that does not require customer action, unless there has been a change in circumstance.
Form B	HFS 2381 (R 9-15) - Medical Benefits: Time to Renew Notice attached to 643 (M, N,or X)	Sent to customers that do not have electronically verifiable information such as income that does require customer action.
Verification Check List (VCL)	IL444-0267 (R-09-15) Verification Checklist	Sent to customers to request information, when the info is due, the name of the person from whom information is needed, what is needed, examples that can be used as verification, and the program for which proof is required.
Denial	IL444-0360C (R-09-15) Notice of Decision	Sent to customers who are no longer eligible.
Cancellation	IL444-0360C (R-09-15) Notice of Decision	Sent to customers that do not respond to renewal.

Ex-Parte (Form A)Renewal

SAMPLE FORM A

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

Date of Notice: Aug 1, 2019
Case Number: 98765432

Office Name: South Loop
Office Address: 1112 S Wabash
Chicago, IL 60605
Phone: (312)-793-7500
TTY: (866)-217-8037
Fax: (312)-793-7671

You can manage your case online at abe.illinois.gov

Esta notificación está disponible en Español. Usted puede socitarla por Internet en abe.illinois.gov o llame al 1-800-843-6154 (TTY 1-800-447-6404)

<MAILING BARCODE>
JOHN SMITH
401 S CLINTON ST.
CHICAGO IL, 60607

Medical Benefits Redetermination Notice

Dear John Smith,

Based on the information we have today, the person(s) listed in the table below are approved to keep getting **medical benefits** after September 30, 2019. However, if we get new information about a change in your circumstance your eligibility for medical benefits may change. If that happens, we will send you a new notice.

Name	Birth Date	Medical ID (RIN)	Medical Group	Start of Ongoing Coverage
John Smith	Jan 15, 1980	123456789	ACA Adult	Oct 01, 2019

We will send you a new medical card before October 2019.

Important Information about Your Medical Group(s)

Medical benefits covered are different depending on your Medical Group. Some Medical Groups provide full medically necessary health coverage.

List of Common Services Provided for Medical Groups with Full Coverage

- Doctor and clinic visits
- Inpatient and outpatient hospital
- Emergency room
- Prescription medicine
- Surgery
- Podiatric (feet) services
- Hospice care
- Emergency medical transportation
- Lab tests and x-rays
- Medical supplies and equipment
- Family planning (birth control)
- Medical transportation
- Home Health service
- Chiropractic services
- Physical and Occupational therapy
- Dental care (limited for adults over age 20)
- And more, check with your health care provider for details

Turn this page over to read more information on the back.

Medical groups providing full health coverage meet the requirements for insurance under federal law, so you do not have to pay any tax penalty.

Find the Medical Group for each person in the ongoing Medical benefits eligibility table and then read below for more information about the benefits for each Medical Group.

Information about ACA Adult

ACA Adult is health coverage for adults age 19-64 who do not have dependent children living with them. ACA Adult health coverage provides the services listed above for full health coverage.

Adults pay copays for some services.

Doctor and clinic services	$3.90 per visit
Inpatient hospital services	$3.90 per day
Outpatient hospital services	$0.00 per visit
Emergency room	$3.90 per visit
Prescription medicine	
Generic	$2.00 per prescription
Brand name	$3.90 per prescription

Copays may change in the future.

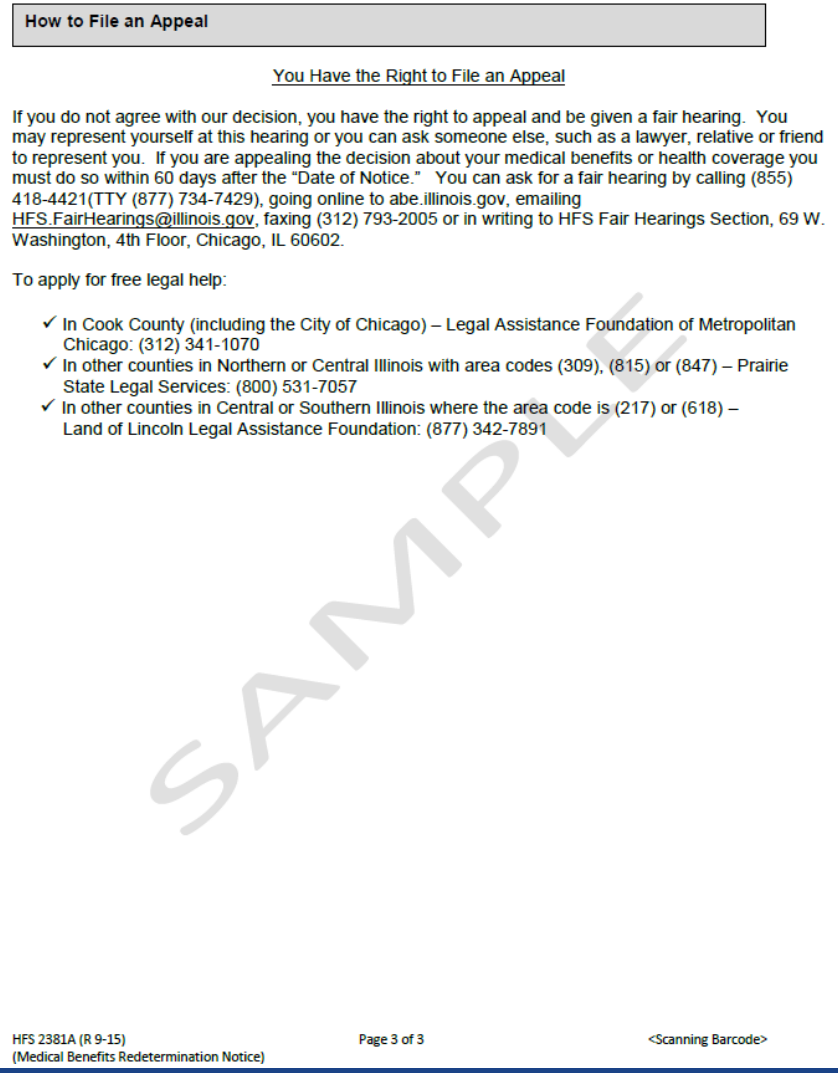
How We Decided Your Eligibility for Medical Benefits

If you have any changes in income or if anyone moves in or out of your household, you must report the change to us within 10 days by going to Manage My Case at abe.illinois.gov or by calling the phone number on the first page of this notice.

Eligibility for medical benefits for the following person(s) is based on household income, who is living with the head of household and how they are related to each other, whether someone in the household files income taxes or is a dependent on someone else's tax return. This is called Modified Adjusted Gross Income (MAGI) methodology. You can find the income limits for each Medical Group online at illinois.gov/hfs/MedicalClients and then clicking "Medical Program Income Standards."

The facts we used to decide **John Smith's** ongoing Medical eligibility are:
The number of people counted in the family size is 1.
Countable monthly income is $200.
Countable monthly income calculation is based on household income, who is living with the applicant and whether someone in the household files income taxes or is a dependent on someone else's tax return.
Monthly income standard is $1,436.

Ex-Parte (Form A)Renewal



How to File an Appeal

You Have the Right to File an Appeal

If you do not agree with our decision, you have the right to appeal and be given a fair hearing. You may represent yourself at this hearing or you can ask someone else, such as a lawyer, relative or friend to represent you. If you are appealing the decision about your medical benefits or health coverage you must do so within 60 days after the "Date of Notice." You can ask for a fair hearing by calling (855) 418-4421(TTY (877) 734-7429), going online to abe.illinois.gov, emailing HFS.FairHearings@illinois.gov, faxing (312) 793-2005 or in writing to HFS Fair Hearings Section, 69 W. Washington, 4th Floor, Chicago, IL 60602.

To apply for free legal help:

- ✓ In Cook County (including the City of Chicago) – Legal Assistance Foundation of Metropolitan Chicago: (312) 341-1070
- ✓ In other counties in Northern or Central Illinois with area codes (309), (815) or (847) – Prairie State Legal Services: (800) 531-7057
- ✓ In other counties in Central or Southern Illinois where the area code is (217) or (618) – Land of Lincoln Legal Assistance Foundation: (877) 342-7891

SAMPLE

HFS 2381A (R 9-15) (Medical Benefits Redetermination Notice) Page 3 of 3 <Scanning Barcode>

Ex Parte Defined

- Electronically verifiable eligibility criteria
- Customer action is not required
- Notice sent to address on file

Ex Parte Increase

- Pre Pandemic = 30% - 40%
- **Current for 06/2023 due date = 51%**

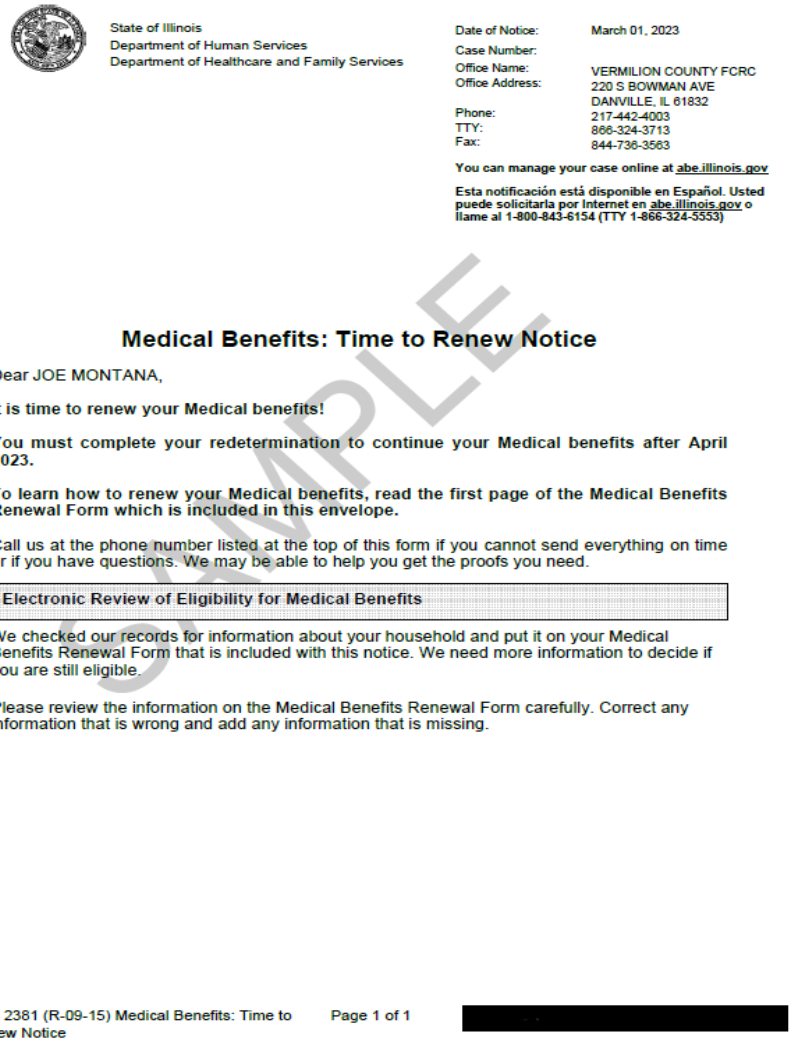
Form B Process

- If the customer is not eligible for the Ex Parte process, IES will populate form 2381: (Time to Renew)

- It will be sent with the Rede form to the household by the 60th day prior to the end of the certification date which is the 30th day prior to the due date on the form.

- The 2381B will be sent with the following Rede form:
  HFS-643 (M, N or X): <u>For households receiving medical only</u>
  M = MAGI
  N = Non-MAGI
  X = LTC

Form B Renewal



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

Date of Notice: March 01, 2023
Case Number:
Office Name: VERMILION COUNTY FCRC
Office Address: 220 S BOWMAN AVE
DANVILLE, IL 61832
Phone: 217-442-4003
TTY: 866-324-3713
Fax: 844-736-3563

You can manage your case online at abe.illinois.gov

Esta notificación está disponible en Español. Usted puede solicitarla por Internet en abe.illinois.gov o llame al 1-800-843-6154 (TTY 1-866-324-5553)

Medical Benefits: Time to Renew Notice

Dear JOE MONTANA,

It is time to renew your Medical benefits!

You must complete your redetermination to continue your Medical benefits after April 2023.

To learn how to renew your Medical benefits, read the first page of the Medical Benefits Renewal Form which is included in this envelope.

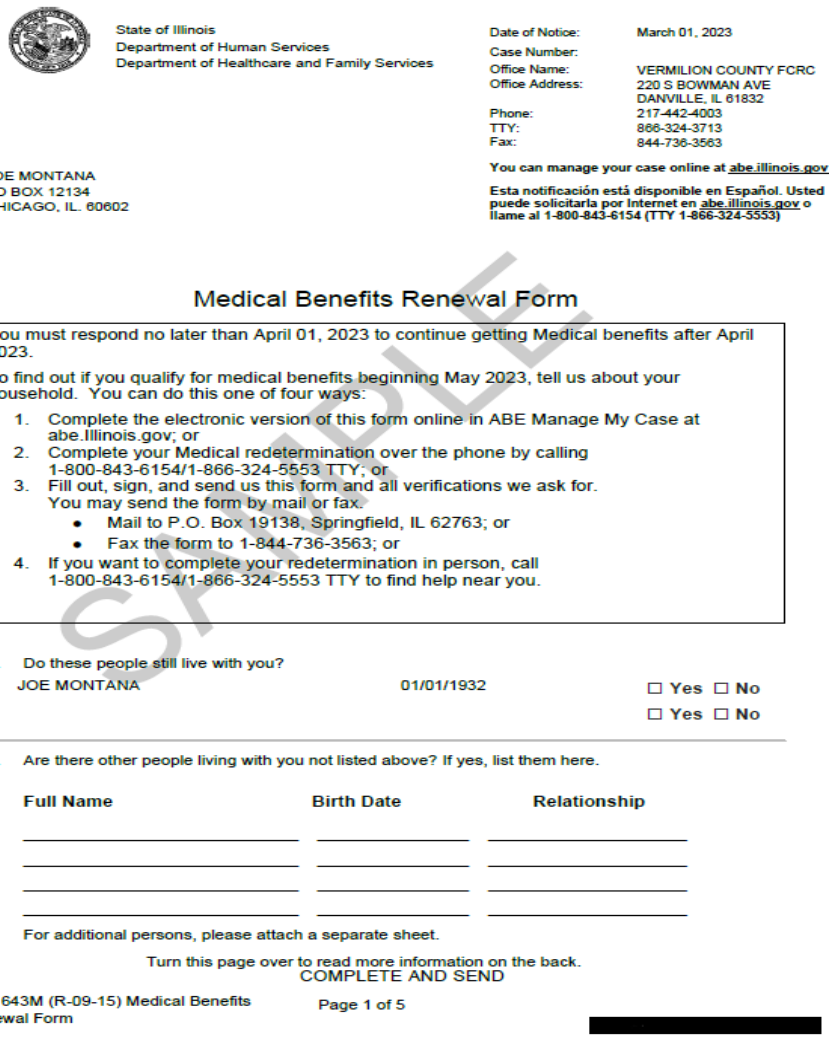
Call us at the phone number listed at the top of this form if you cannot send everything on time or if you have questions. We may be able to help you get the proofs you need.

Electronic Review of Eligibility for Medical Benefits

We checked our records for information about your household and put it on your Medical Benefits Renewal Form that is included with this notice. We need more information to decide if you are still eligible.

Please review the information on the Medical Benefits Renewal Form carefully. Correct any information that is wrong and add any information that is missing.

FS 2381 (R-09-15) Medical Benefits: Time to enew Notice Page 1 of 1



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

Date of Notice: March 01, 2023
Case Number:
Office Name: VERMILION COUNTY FCRC
Office Address: 220 S BOWMAN AVE
DANVILLE, IL 61832
Phone: 217-442-4003
TTY: 866-324-3713
Fax: 844-736-3563

JOE MONTANA
PO BOX 12134
CHICAGO, IL. 60602

You can manage your case online at abe.illinois.gov

Esta notificación está disponible en Español. Usted puede solicitarla por Internet en abe.illinois.gov o llame al 1-800-843-6154 (TTY 1-866-324-5553)

Medical Benefits Renewal Form

You must respond no later than April 01, 2023 to continue getting Medical benefits after April 2023.

To find out if you qualify for medical benefits beginning May 2023, tell us about your household. You can do this one of four ways:

1. Complete the electronic version of this form online in ABE Manage My Case at abe.Illinois.gov; or
2. Complete your Medical redetermination over the phone by calling 1-800-843-6154/1-866-324-5553 TTY; or
3. Fill out, sign, and send us this form and all verifications we ask for. You may send the form by mail or fax.
   - Mail to P.O. Box 19138, Springfield, IL 62763; or
   - Fax the form to 1-844-736-3563; or
4. If you want to complete your redetermination in person, call 1-800-843-6154/1-866-324-5553 TTY to find help near you.

1. Do these people still live with you?
   JOE MONTANA 01/01/1932 ☐ Yes ☐ No
   ☐ Yes ☐ No

2. Are there other people living with you not listed above? If yes, list them here.

Full Name	Birth Date	Relationship

For additional persons, please attach a separate sheet.

Turn this page over to read more information on the back.
COMPLETE AND SEND

HFS 643M (R-09-15) Medical Benefits Renewal Form Page 1 of 5

Form B Renewal

3. Is the address at the top of this page your correct mailing address? ☐ **Yes** ☐ **No** If No, tell us the correct mailing address:

_____

Our records show that you live at P.o. Box 295 FITHIAN IL 61844. Is this correct? ☐ **Yes** ☐ **No** If No, tell us the correct address where you live:

_____

Our records show that these are your phone numbers. If not, tell us your correct numbers.

Phone Type	Current Phone Number	New Phone Number	Receive Text Alerts and Reminders* (please check one)
Home			☐
Work			
Cell			☐
Alternate			☐

*Standard fees may apply from your mobile service provider.

☐ **I do not wish to receive text alerts and reminders.**

4. Please review the employment information we found for your household and let us know if it is correct.

Person	Employer	Monthly Income	Is this Correct?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

If a job listed above ended, tell us which job and the date of the last pay _____

If the employment information and the amount of monthly income above is correct, **you do not have to list it again in the next question. You do not have to send proof of this income if the amount is correct.** But we still need for you to complete other sections in this form and send it back.

Turn this page over to read more information on the back.

COMPLETE AND SEND

[redacted]

5. Does anyone get paid for working <a job marked as not correct or other jobs not listed above>? ☐ Yes ☐ No **If YES**, enter their name below. **Attach copies of the last 4 pay stubs if paid weekly, last 2 pay stubs if paid every other week or twice a month, and the last pay stub if paid monthly.** If self-employed, attach your income and expense statement for the last 30 days. If someone got tips that are not on their pay stubs, tell us Who? _____ and the total amount of tips received in the last 30 days. Total tips $ _____

According to our records, you told us your household had income from Lucky Charms INC Tell us below if you still have this income and the new amount.

List the Name of Everybody Who is Working	Name of Employer If a person works more than one job, list all the employers.	Rate of Pay	Hours Worked Weekly	How often is the person paid? Weekly, every 2 weeks, twice a month, monthly, other?
JOE MONTANA	LUCKY CHARMS	$10	40	Every 2 weeks

Attach a sheet of paper if you need more room to list your family's income.

6. During the last 30 days did anyone receive any other income such as Social Security, SSI, Unemployment, Contributions or any other money? ☐ Yes ☐ No **If YES**, complete the box below.

Name	Type of Income	Amount	How Often
		$	
		$	

Attach a sheet of paper if you need more room to list your family's income.

7. Are you or is anyone who lives with you pregnant?

If yes, name:_____ Due date:_____ Expected number of babies:_____ End date:_____

8. Do you or anyone living with you have health insurance? ☐ **Yes** ☐ **No**

If yes, name of insurance plan:_____ Policy Number _____

COMPLETE AND SEND

[redacted]

Form B Renewal

Who is covered by this health insurance? _____

Name of insurance plan:_____ Policy Number _____

Who is covered by this health insurance? _____

9. Are you or anyone living with you interested in the partial-benefit program for Family Planning if no longer eligible for Medical Benefits? ☐ **Yes** ☐ **No**

If yes, name of the person(s) who want to Opt-In: _____

10. Will you or anyone who lives with you file a federal income tax return next year to report income received this year? ☐ **Yes** ☐ **No**

If yes, name of person(s) filing tax return: _____ Birth Date _____

If this person will **file jointly with a spouse,** write name of spouse: _____

If this person will **claim dependents** on the tax return, write name(s) of dependents:

_____ Birth Date _____ _____ Birth Date _____

_____ Birth Date _____ _____ Birth Date _____

11. Will you or anyone who lives with you be claimed as a dependent on anyone's tax return for this year? ☐ **Yes** ☐ **No**

If yes, name of dependent_____ Birth Date _____ Tax filer's name and relationship to dependent:_____

12. Do you or anyone living with you pay any expense that can be deducted on your federal income tax return? ☐ **Yes** ☐ **No**

If yes, list the expense: _____ How Much? _____ How Often? _____

Turn this page over to read more information on the back.

COMPLETE AND SEND

[redacted]

Voter's Registration Information

If you want to register to vote, fill out the attached Illinois Voter Registration Application SBE (R-19) and give it to your DHS office or your local election official. For help filling it out or for translation services, contact your DHS Family Community Resource Center. You may also call the Helpline at 1-800-843-6154, or 1-866-324-5553 (for TTY). For information online, see www.dhs.state.il.us or www.elections.il.gov/.

Read and sign below:

- I understand that officials in charge of my health benefits may check all information on this form.
- I understand they may check my information electronically. If they ask for my help checking information, I must cooperate.
- I understand that anyone who knowingly lies or provides untrue information, or arranges for someone to knowingly lie or provide untrue information, or intentionally misuses the health benefits card issued by the State of Illinois, may be committing a crime which can be prosecuted or punished under federal law, state law, or both.
- If the Illinois Department of Healthcare and Family Services pays medical bills for me, the State of Illinois may collect my medical support payments instead of me.
- I am signing this form under the penalty of perjury. That means the information I have provided on this renewal form is true to the best of my knowledge, and I may be punished under law if I provide false or untrue information.

_____ _____

Your Signature Today's Date

COMPLETE AND SEND

[redacted]

Form B Renewal

ILLINOIS VOTER REGISTRATION APPLICATION

FOR ILLINOIS RESIDENTS ONLY

TO VOTE YOU MUST:

- Be a United States citizen
- Be at least 18 years old (some 17 year olds may vote in the General Primary, Consolidated Primary or Caucus)
- Live in your election precinct at least 30 days
- Not be convicted and incarcerated.
- Not claim the right to vote anywhere else

TO VOTE IN THE NEXT ELECTION:

- **Mail or deliver this application to your County Clerk or Board of Election Commissioners** no later than 28 days before the next election. Go to http://www.elections.il.gov

IMPORTANT INFORMATION:

- If you do not have a driver's license, State Identification Card or social security number, and this form is submitted by mail, and you have never registered to vote in the jurisdiction you are now registering in, then you must send, with this application, either (i) a copy of a current and valid photo identification, or (ii) a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows the name and address of the voter. If you do not provide the information required above, then you will be required to provide election officials with either (i) or (ii) described above the first time you vote in person or prior to voting by mail.
- If you change your name you must re-register.
- If you register at a public service agency, any information regarding the agency that assisted you will remain confidential as will any decision not to register.
- If you do not receive a Notice within 2 weeks of mailing or delivering this application, call your County Clerk or Board of Election Commissioners.

TO COMPLETE THIS FORM: SBE R-19

- Box 1-If you do not have a middle name, leave blank.
- Box 3-If mailing address is same as Box 2, write "same".
- Box 4-By providing an email address you agree to receive election related notices via email.
- Box 5-If you have never registered before, leave blank. If you do not remember your former address; provide as much information as possible.
- Box 6-If you have not changed your name, leave blank.
- Box 10-If you have an Illinois Driver's License or Secretary of State ID, check the first box and fill in the number. If you do not have a Driver's License or SOS ID, check the second box and fill in the last four digits of your Social Security Number. If you do not have a SSN, check the third box and send a copy of the appropriate document (as described in the "Important Information" section) along with this form.
- Box 11-Read, date and personally sign your name or make your mark in the box.

IF YOU HAVE NO STREET ADDRESS, below describe your home: list the name of subdivision; cross streets; roads; landmarks; mileage and/or neighbor's names.

N / W / E / S

If you have questions about completing this form, please call the State Board of Elections at (217)782-4141 or (312)814-6440 (or webmaster@elections.il.gov).

TYPE OR PRINT CLEARLY IN BLACK OR BLUE INK

Are you a citizen of the United States of America? (check one) yes☐ no☐ **Office Use**

Will you be 18 years of age on or before the next election day OR are you currently 17 and will be 18 by the day of the next General or Consolidated Election? (check one) yes☐ no☐

If you checked "no" in response to either of these questions, then do not complete this form.

You can use this form to: (Check One) ☐ apply to register to vote in Illinois ☐ change your address ☐ change your name

1. Last Name First Name Middle Name or Initial Suffix(Circle One) Jr. Sr. II III IV
2. Address where you live (House No., Street Name, Apt. No.) City/Village/Town Zip Code County Township
3. Mailing address (P.O. Box) City/Village/Town, State Zip Code
4. Email (Optional)
5. Former Registration Address: (include City and State and Zip Code) Former County
6. Former Name: (if changed)
7. Date of Birth: MM/DD/YY
8. Sex (circle one) M F
9. Home telephone number including area code (optional) ( ) -
10. ID number - check the applicable box and provide the appropriate number
    - ☐ IL Driver's License or, if none, Sec. of State ID or
    - ☐ Last 4 digits of Social Security Number
    - ☐ I have none of the above-listed identification numbers.

11. Voter Affidavit - Read all statements and sign within the box to the right.

I swear or affirm that:

- I am a citizen of the United States;
- I will be at least 18 years old on or before the next election (or the next General or Consolidated Election);
- I will have lived in the State of Illinois and in my election precinct at least 30 days as of the date of the next election;
- The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, then I may be fined, imprisoned, or if I am not a U.S. citizen, deported from or refused entry into the United States.

This is my signature or mark in the space below.

Today's Date: ____ / ____ / ____

12. If you cannot sign your name, ask the person who helped you fill in this form to print their name, address and telephone number.
Name of person assisting. Full Address Telephone No.

Back of SBE No.R-19

YOUR ADDRESS

PUT FIRST CLASS STAMP HERE

MAIL TO: LINDSAY LIGHT, ELECTION DIVISION
201 NORTH VERMILION STREET
SUITE 110
DANVILLE, IL 61832

CHANGE OF ADDRESS

PCT	WARD	CODE	ADDRESS	CITY	ZIP	COUNTY	DATE	CLERK

SUSPENSION, CANCELLATION AND REINSTATEMENT

DATE	EXPLAIN	CLERK	DATE	EXPLAIN	CLERK

To Election Judges	Voting Record	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
For Primary, mark	Primary																			
D for Democrat	General																			
R for Republican	NonPartisan																			
for all other elections markV	Special																			

Example of Verification Check List (VCL)

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

Date of Notice: April 19, 2023
Case Number: 425564534
Office Name: CHAMPAIGN COUNTY FCRC
Office Address: 206 W ANTHONY DR
CHAMPAIGN , IL 61822
Phone: 217-278-5605
TTY: 866-451-5784
Fax: 844-736-3563

You can manage your case online at abe.illinois.gov

Esta notificación está disponible en Español. Usted puede solicitarla por Internet en abe.illinois.gov o llame al 1-800-843-6154 (TTY 1-866-324-5553)

CINDY SUNSHINE
1301 N CUNNINGHAM AVE
URBANA, IL 61802

Verification Checklist

We need the items listed below to determine your eligibility. If you have an office interview **BRING** the items with you. If you have a phone interview or are applying for medical only, return these items as described in the instructions on the last page of this document.

What you need to give us - Give us the information that is marked below by the due dates listed below.

Please return at least **one of the requested examples** for each verification and person listed below **by no later than the due dates listed below**. If you do not respond by **the due date** your SNAP, Cash and/or Medical benefits could be reduced, cancelled or denied.

Name of Person	What is Needed	Examples	Required For	Due Date
CINDY SUNSHINE	Provide paystubs or proof of gross income (before taxes and deductions) from the last 30 days	Copy of check stubs or earnings statement; if applying for medical, only one pay stub or earnings statement from the last 30 days is needed; Copy of statement from employer showing gross income	Medical	05/01/2023

Turn this page over to read more information on the back.
IL444-0267 (R-09-15) Verification Checklist Page 1 of 2

Verification Document Cover Sheet

IMPORTANT: Return this Verification Document Cover Sheet when you return your verifications to us to avoid a delay in processing your benefits.

From: **CINDY SUNSHINE** Number of Pages Returned: _____

Case Number: **425564534** (including this sheet)

Instructions to Submit Your Verifications

Write in the number of pages you are returning to us in the space above. Do not write anywhere else on this coversheet. If you need to tell us about anything else, write it on a separate sheet. If you have questions, please call CHAMPAIGN COUNTY FCRC at 217-278-5605 or 866-451-5784.

There are several ways you can return your verifications to us

ABE	If you already have an ABE account and access to a scanner, go to abe.illinois.gov, log on to your ABE account and follow the instructions to upload your scanned documents. Include this coversheet. Need to create an ABE account? Go to abe.illinois.gov and follow the instructions to create a new account.
Fax	Send all requested verification including this cover sheet to Data Preparation/IES Central Scanning at 1-844-736-3563. If your documents have information on both sides be sure to scan both sides of the page before including it in the fax.
Mail	Mail all requested documents including this cover sheet to: Data Preparation/IES Central Scanning P.O. Box 19138 Springfield, IL 62763
In Person	Take all requested documents including this coversheet to the following Family Community Resource Center: CHAMPAIGN COUNTY FCRC 206 W ANTHONY DR CHAMPAIGN IL 61822

IL444-1120 (R-09-15) Document Coversheet Page 1 of 1

Verification Check List (VCL)

State of Illinois
Department of Healthcare and Family Services

Help Sheet for U.S. Citizenship & Identity Documentation

This form only applies to persons who are U.S. citizens.

Because of a new federal law, we must ask people who are United States citizens to show documents that prove they are citizens. The law does not affect people who are not U.S. citizens.

This new law affects most children and adults if they are citizens who request medical benefits or get medical benefits. U.S. citizens who get SSI (Supplemental Security Income), Social Security Disability or Medicare do not have to show documents.

This form tells you what documents we need to see for all persons who are citizens who are requesting medical benefits or are named on your medical card.

If you have the following documents for anyone on your medical card, take them to your local Illinois Department of Human Services office.

- U.S. Passport
- Certificate of Naturalization (N-550 or N-570)
- Certificate of Citizenship (N-560 or N-561)

If you do not have one of the documents listed above, then we need to see two documents for each person on your medical card. You need to bring one item from EACH box for each person.

If anyone's name is different than the name on the documents that prove they are citizens, we need to see another document that caused the name change. For example, this could be a certificate of marriage, or court order, or other official document.

Papers that show Place of Birth

- Certified copy of a 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

ID Card with Photo or other information that identifies the person.

- Driver's license;
- State issued ID card;
- School ID;
- U.S. military ID;
- U.S. Military dependent card; OR
- Other government ID (city, county, or U.S. state issued).
- For children under age 16, school or day care records.

Turn this page over to read more information on the back.

State of Illinois
Department of Healthcare and Family Services

Your medical benefits may be stopped if you do not send or bring these documents to us.

If you do not have documents for someone on your medical card, you must try to get them.

You can get birth certificates from the state or county where the person was born. You may have to pay for official copies of birth certificates. Usually, you need to know the person's name, date of birth, place of birth and parents' names to order their birth certificate.

- Persons who were born in Illinois can get their birth certificates from the county where they were born. Here are a few county phone numbers and websites:

County	Phone and Website
Champaign	1-217-384-3720 or www.champaigncountyclerk.com/vitals
Cook	1-312-603-7799 or www.cookctyclerk.com
DuPage	1-630-682-7035 or www.co.dupage.il.us
Lake	1-847-377-2411 or www.lakecountyil.gov
Kane	1-630-232-5950 or www.co.kane.il.us/coc/
Peoria	1-309-672-6059 or www.co.peoria.il.us./
Rock Island	1-309-786-4451 or www.co.rock-island.il.us
Will	1-815-740-4615 or www.thewillcountyclerk.com

You can get a complete list of where to go for a birth certificate for any county in Illinois on the Internet at www.vitalrec.com/il.html#County. The Illinois Department of Public Health can help you find a county office if you call 1-217-782-6553.

- Persons who were born in Illinois can also get birth certificates from the Illinois Department of Public Health by calling 217-782-6553. You can order your birth certificate over the Internet at www.idph.state.il.us/vitalrecords if you use a credit card.
- The National Center for Health Statistics can help you find out where to get birth certificates for people who were born in a state other than Illinois. Call 1-866-441-6247. The call is free. If you can use a computer, you can find out where to go to get birth certificates for someone born in another state at www.cdc.gov/nchs .

If you cannot get these documents, call the office that is handling your case. There may be other documents that you can use to show that you or your family member is a U.S. citizen.

Denial Notice – No longer eligible

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

Date of Notice:	April 19, 2023
Case Number:	123456789
Client Name:	CINDY SUNSHINE
Individual ID:	1287852368
Office Name:	CHAMPAIGN COUNTY FCRC
Office Address:	206 W ANTHONY DR CHAMPAIGN , IL 61822
Phone:	217-278-5605
TTY:	866-451-5784
Fax:	844-736-3563

CINDY SUNSHINE
PO BOX 1234
HAPPY LAND, IL 61802

You can manage your case online at abe.illinois.gov

Esta notificación está disponible en Español. Usted pue solicitarla por Internet en abe.illinois.gov o llame al 1-800-843-6154 (TTY 1-866-324-5553)

Notice of Decision

We reviewed your application for Medical benefits. This notice explains our decision. The notice also tells you how you can appeal if you think our decision is wrong.

Your application for **Medical Benefits** filed on April 19, 2023 is **denied**. Read the Medical Benefits section of this notice to find out why.

You can manage your case online through ABE (www.abe.illinois.gov). To learn how, read the **Manage My Case Online** section in this notice.

This notice contains important information. If you cannot read this notice, please call us at 1-800-843-6154 (TTY 1-866-324-5553) for help. Please stay on the line while you are connected with an interpreter.

Turn this page over to read more information on the back.

IL444-0360C (R-09-15) Notice of Decision Page 1 of 5

Scanning Barcode

Medical Benefits

Not Eligible for Medical Benefits

The person(s) listed in the table below have been **denied** for Medical Benefits.

Name	Birth Date	Dates of Coverage Denied	Reason	Policy Reference
CINDY SUNSHINE	April 1, 1968	No eligible dates of coverage	Household income is more than the limit for this individual for this program.	PM I-03-00

The application(s) for health coverage for CINDY SUNSHINE have been sent to the Federal Health Insurance Marketplace. Please refer to the attached *You Can Get Help to Buy Health Insurance* form for more information.

CINDY SUNSHINE was denied for having more income than the limit. The following amounts were used to make this decision:

MAGI Based Budget		Apr 01, 2023	May 01, 2023	Jun 01, 2023
Total gross earned income		$2687.00	$2687.00	$2687.00
Total self employment income	+	$0.00	$0.00	$0.00
Self employment expenses	-	$0.00	$0.00	$0.00
Total unearned income	+	$0.00	$0.00	$0.00
Gross monthly income	=	$2687.00	$2687.00	$2687.00
MAGI deductions	-	$0.00	$0.00	$0.00
Total countable monthly income	=	$2687.00	$2687.00	$2687.00
Income standard for your household size 1		$1677.00	$1677.00	$1677.00

IL444-0360C (R-09-15) Notice of Decision Page 2 of 5

Scanning Barcode

Denial Notice – No longer eligible

CINDY SUNSHINE's denial was decided using MAGI methodology. If you have a permanent disability you might qualify under non-MAGI methodology for a different medical group. See the Your Rights section of this notice for information about how to request a review.

Turn this page over to read more information on the back.

Scanning Barcode

Your Rights

YOU HAVE CERTAIN RIGHTS
CASH AND MEDICAL

If you were denied cash or medical benefits, you have the right to talk with a DHS or HFS caseworker to ask about the reason for denial. The talk will be informal. Any added information you have should be presented at that time. You have the right to be represented at this meeting by any person(s) you choose. If you wish such a meeting, contact the office named on the first page of this notice. You should do this right away. If you choose not to have an informal meeting, you still have a right to appeal this action.

SNAP

If Your SNAP Application Was Denied

You may apply for SNAP benefits again any time you think you may be eligible. If you don't agree with our decision to deny your application, you may ask for a fair hearing. You will not receive any SNAP benefits just because you ask for a fair hearing. You will have the chance to explain your disagreement to a Family Community Resource Center worker and later to a hearing officer. If it is decided that you are right, you may be entitled to SNAP benefits from the date you applied.

If Your SNAP Application Was Approved

You may ask for a fair hearing if you don't agree with the decision. You will then have the chance to explain your disagreement to a Family Community Resource Center worker and later to a hearing officer.

Scanning Barcode

Denial Notice – No longer eligible

YOU HAVE THE RIGHT TO APPEAL THIS DECISION

If you do not agree with our decision, you have the right to appeal and be given a fair hearing. You may represent yourself at this hearing or you can ask someone else, such as a lawyer, relative or friend to represent you. If you are appealing the decision on your cash and/or medical benefits decision you must do so within 60 days after the "Date of Notice." If you are appealing a decision about SNAP you must do so within 90 days after the "Date of Notice." You can ask for a fair hearing by calling (800) 435-0774, if you use a TTY, by calling (877) 734-7429, going online to abe.illinois.gov/abe/access/appeals, emailing DHS.BAH@Illinois.gov, faxing (312) 793-3387, or in writing to DHS Bureau of Hearings, 69 W. Washington, 4th Floor, Chicago, IL 60602.

To apply for free legal help:

- ✓ In Cook County (including the City of Chicago) - Legal Assistance Foundation of Metropolitan Chicago: (312) 341-1070
- ✓ In other counties in Northern or Central Illinois with area codes (309), (815) or (847) - Prairie State Legal Services: (800) 531-7057
- ✓ In other counties in Central or Southern Illinois where the area code is (217) or (618) - Land of Lincoln Legal Assistance Foundation: (877) 342-7891

Manage My Case Online

Go to **abe.illinois.gov** and click on the Manage My Case button to set up an online account. You'll need the individual ID displayed to the right in order to access information in ABE Manage My Case. You can apply for benefits online, and once you access Manage My Case you can check the status of your application, view any upcoming appointments, or upload documents.

Name	Individual ID
CINDY SUNSHINE	1234567890

IL444-0360C (R-09-15) Notice of Decision Page 5 of 5

Scanning Barcode

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

Date of Notice: April 19, 2023
Case Number: 123456789
Office Name: CHAMPAIGN COUNTY FCRC
Office Address: 206 W ANTHONY DR
CHAMPAIGN , IL 61822
Phone: 217-278-5605
TTY: 866-451-5784
Fax: 844-736-3563

You can manage your case online at abe.illinois.gov

Esta notificación está disponible en Español. Usted puede solicitarla por Internet en abe.illinois.gov o llame al 1-800-843-6154 (TTY 1-866-324-5553)

CINDY SUNSHINE
PO BOX 1234
HAPPY LAND, IL 61802

Privacy Notice

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Read It Carefully.

The law requires The Illinois Department of Healthcare and Family Services (HFS) to protect the privacy of your medical information. This notice explains how HFS can use or share the medical information that HFS has about you or your family. It also explains your rights.

For some people, HFS pays for all health benefits. For others, HFS pays for certain services like prescription drugs. HFS must receive and keep your medical information so you can have these benefits. HFS may contract with other organizations or individuals to help provide your health benefits. These contractors may also receive and keep your medical information.

Effective September 23, 2013, HFS must follow this Notice until it is replaced. HFS can change the terms of this Notice at any time. If HFS changes this Notice, HFS will send a new Notice to all persons enrolled at that time. HFS can make the new changes apply to all your medical information kept by HFS before and after the date of the new Notice. The Notice is posted on the HFS website.

HFS may use or share your medical information without your permission for the reasons below.

- **So you can get medical care.** For example, HFS may share your medical information with your doctor or pharmacy so that they can give you medical care and the right medicine.
- **So HFS can pay your medical bills.** For example, HFS may use and share your medical information so your doctor can send a bill to HFS and so HFS can pay your medical bills. HFS may also share your medical information to recover payment from other medical insurance or benefits you may have.
- **So HFS can perform its duties.** For example, HFS may use or share your medical information to assess quality of care; to decide who is eligible for medical benefits; to manage your care; to direct and plan HFS programs and budget; to coordinate with another public benefit program; to develop better services for you; or for audits.
- **To tell you about other health services.** For example, HFS may call or write to tell you about treatment options or other health-related services.

Turn this page over to read more information on the back.

HFS 3806 (R-09-15) Privacy Notice Page 1 of 3

Scanning Barcode

Denial Notice – No longer eligible

- **To comply with the law.** For example, the law requires HFS to allow the U.S. Department of Health and Human Services to audit HFS records. HFS may share your medical information to comply with other laws.
- **For other reasons.** Examples include:
  - To comply with legal proceedings, such as a court or administrative order or subpoena;
  - For worker's compensation claims To enforce other laws or protect someone's health and safety;
  - So a family member, friend or other person can help you to get or pay for your health care;
  - So a personal representative you appoint or a court appoints for you can help you get health benefits;
  - To support research as long as the information will be protected by the researchers;
  - So a coroner or medical examiner can identify a deceased person or cause of death or so a funeral director can arrange burial;
  - To support an organ procurement organization in limited circumstances;
  - To protect you against a serious threat to your health or safety or the health or safety of others;
  - To support a government agency overseeing health care programs
  - For lawful national security purposes;
  - To correctional institutions or law enforcement officers if you are an inmate of a correctional institution or if necessary (1) for the institution to provide you with medical care; (2) to protect your health and safety or the health and safety of others; (3) for the safety of the correctional institution
  - For health research;
    - For public health purposes; and
    - For military purposes, if you are a member of the armed forces.

HFS will make the following uses and disclosures only with your written permission:

- To use and disclose information for marketing purposes;
- To use and disclose information that would be the sale of protected health information;
- To use and disclose psychotherapy notes (should we have such notes)
- Other uses and disclosures not described in this notice.

HFS will not use or share your medical information for any other reason unless you give HFS written permission. You may withdraw your permission in writing at any time. However, if HFS used or shared your information for a long-term project like a research study, HFS may continue to use or share your information for that purpose only. Your permission for HFS to use or share your information will end when HFS gets your written notice to withdraw your permission. You can find forms for these purposes on the HFS website and at Illinois Department of Human Services local offices HFS is not allowed to use your genetic information to decide whether to cover you or set the price of the covering your benefits.

Your rights. You may ask HFS to do any of the following if you ask in writing. HFS will decide if it can do what you want it to do. HFS will write to tell you what it decides.

- You may ask HFS not to use or share your medical information for treatment, payment and health care operations. HFS does not always have to agree. To ask HFS to not use or share your medical information, contact us in writing by mail or e-mail at the address listed at the bottom of this Notice.

- You may ask HFS to contact you about your medical information privately in a different way or at a different place than HFS is currently doing. HFS does not always have to agree unless the change is necessary to protect you, and HFS can still pay your medical bills. When you write to ask for this change, you must tell HFS how to contact you in private.
- You may ask to see or get copies of your medical information. You may be charged a small fee for copies.
- You may ask HFS to correct your medical information. HFS does not have to agree to make the change. To ask for a correction, make your request, in writing, to the address or e-mail at the bottom of this Notice.
- You have the right to be contacted and informed about a breach of your medical information.
- You may ask for a list of ways HFS or its contractors shared your medical information going back 6 years from the date of the request. You may write to ask HFS to send you another copy of this Notice.

If you want any of these things, contact the HFS Privacy Officer at the address below. HFS will help you make your written request.

Complaints. If you believe HFS has not protected your right to privacy, you have the right to complain to HFS or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with HFS at the address below. HFS will not hold it against you if you file a complaint.

Privacy Officer. To get more copies of this Notice or more information about HFS privacy practices or your rights, or to file a complaint, contact the Privacy Officer at the following address:

Privacy Officer
Office of the General Counsel
Healthcare and Family Services
201 S. Grand Ave. East, 3rd Floor
Springfield, IL 62763-1000

Toll-free telephone: 1-800-226-0768 (Health Benefits Hotline)
Toll-free for persons using a TTY: 1-877-204-1012
Fax: 1-217-524-2397
HFS.privacy.officer@illinois.gov

Denial Notice – No longer eligible – Referral to ACA Marketplace

State of Illinois
Department of Healthcare and Family Services

Important News
You Can Get Help to Buy Health Insurance

Even though you cannot get Medicaid coverage, you may be able to buy private health insurance through the Health Insurance Marketplace.

On the Health Insurance Marketplace, health insurance companies sell affordable coverage to people whose employers do not offer insurance and who do not qualify for Medicaid.

* You may qualify to get financial help through the Health Insurance Marketplace so you pay less each month for health insurance.
* Health Insurance Marketplace plans will cover preventive care, doctor visits, prescription drugs, maternity care, emergency services, hospital stays and more.
* Insurance companies cannot deny anyone because they are sick or because they have a preexisting health condition.

We will send the information from your Medicaid application to the Health Insurance Marketplace because you do not qualify for Medicaid. But this may take some time.

To be sure you are covered as soon as possible, apply directly to the Health Insurance Marketplace. Be prepared to give them the Medicaid denial notice you received with this flyer. You can:

* Apply online. Log on to Healthcare.gov;
* Call 1-800-318-2596 (TTY: 1-855-889-4325) to ask questions or choose a health plan over the phone; or
* Get in-person help through a community assister near you -- it's free. Call 1-866-311-1119 (TTY: 1-888-259-3922) or go to www.GetCoveredIllinois.gov and click on "Get Help in your Area" to get a list of community assisters.

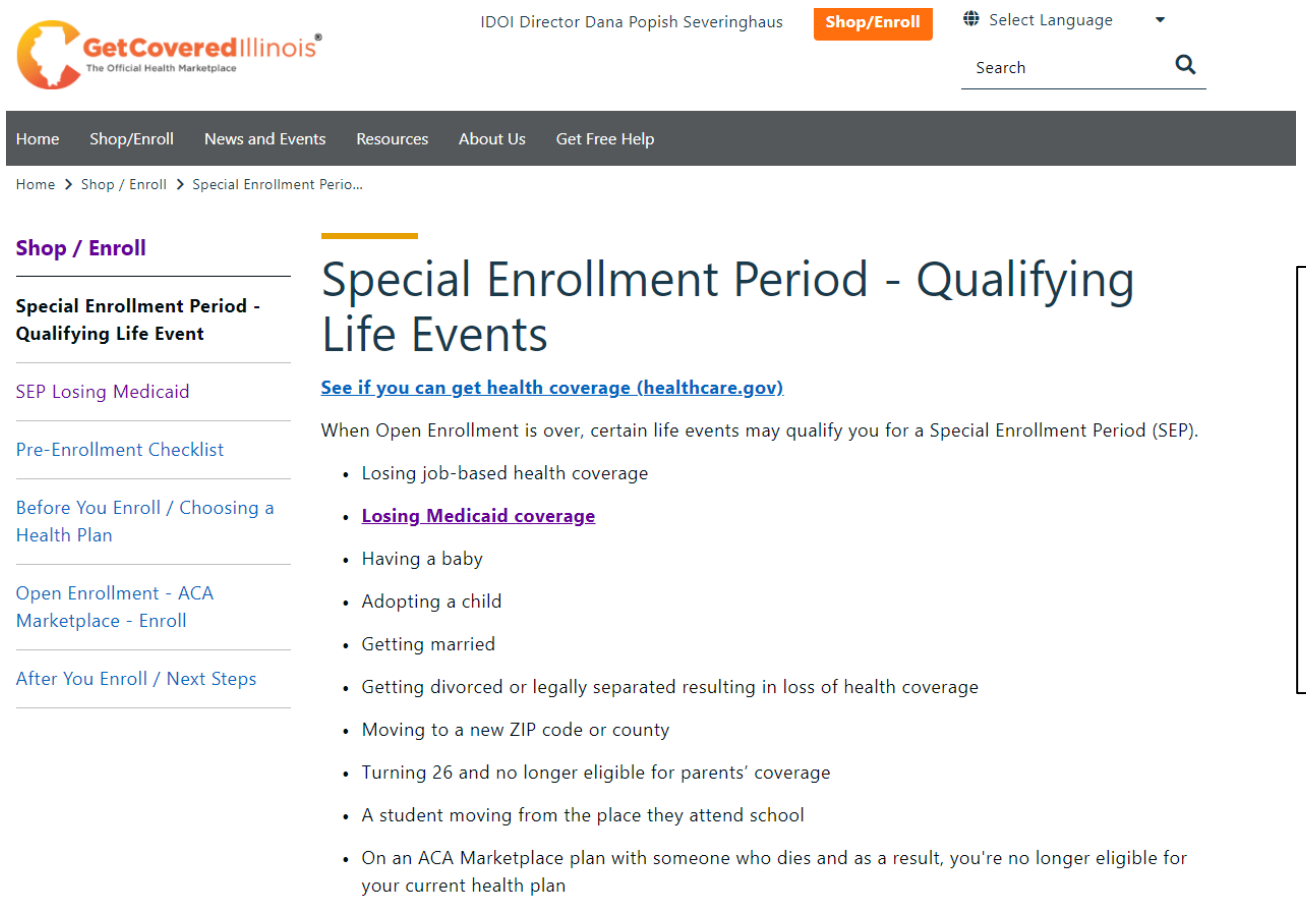
The Department of Human Services and the Department of Healthcare and Family Services caseworkers cannot help you with the Health Insurance Marketplace.

Federal law requires that all U.S. citizens and legal permanent residents have minimum essential health coverage starting in 2014. Insurance from a job, private insurance, Medicaid, All Kids, Medicare and some VA health care programs count as minimum essential health coverage.

For more information on what counts as minimum essential coverage, go to www.healthcare.gov or www.va.gov/aca.

HFS 3704 (R-09-15) You Can Get Help to Buy Health Insurance Page 1 of 1 Scanning Barcode

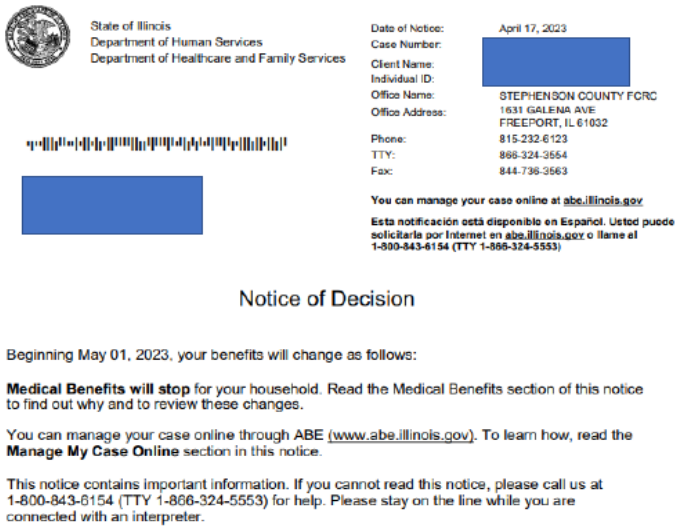
Get Covered Illinois



Helpful Links

- FAQs - Special Enrollment Period - Losing Medicaid Coverage
- Special Enrollment Period - Qualifying Life Events

Cancellation Notice – Renewal not returned



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

Date of Notice: April 17, 2023
Case Number: [redacted]
Client Name:
Individual ID:
Office Name: STEPHENSON COUNTY FCRC
Office Address: 1631 GALENA AVE
FREEPORT, IL 61032
Phone: 815-232-6123
TTY: 866-324-3554
Fax: 844-736-3563

[redacted]

You can manage your case online at abe.illinois.gov

Esta notificación está disponible en Español. Usted puede solicitarla por Internet en abe.illinois.gov o llame al 1-800-843-6154 (TTY 1-866-324-5553)

Notice of Decision

Beginning May 01, 2023, your benefits will change as follows:

Medical Benefits will stop for your household. Read the Medical Benefits section of this notice to find out why and to review these changes.

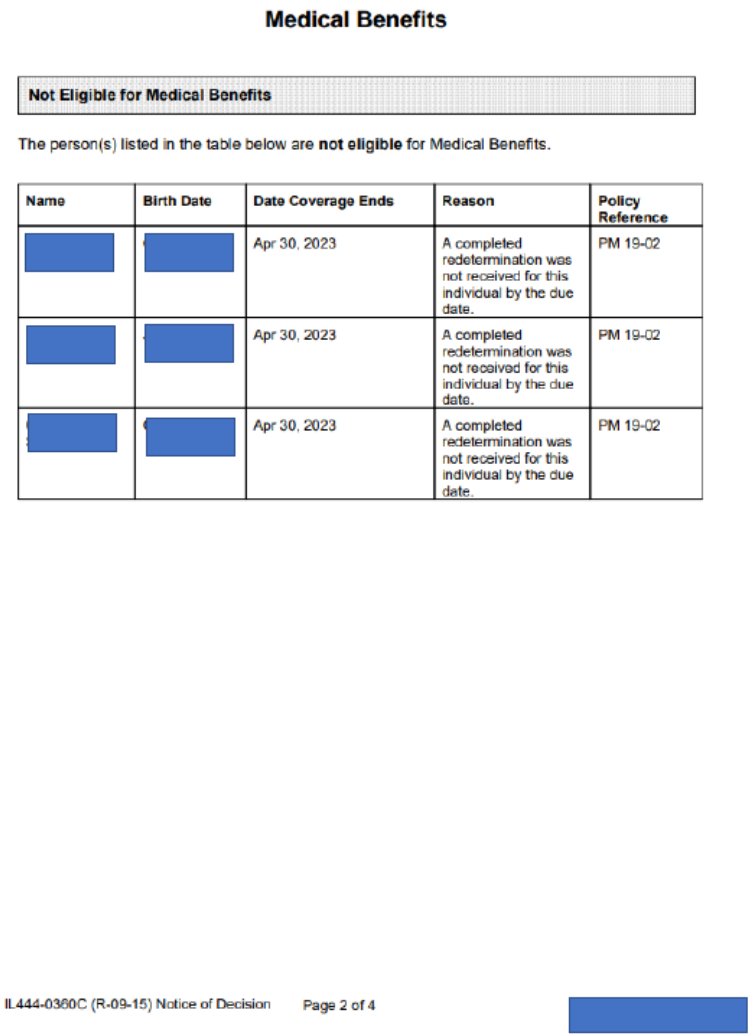
You can manage your case online through ABE (www.abe.illinois.gov). To learn how, read the **Manage My Case Online** section in this notice.

This notice contains important information. If you cannot read this notice, please call us at 1-800-843-6154 (TTY 1-866-324-5553) for help. Please stay on the line while you are connected with an interpreter.

Turn this page over to read more information on the back.

IL444-0360C (R-09-15) Notice of Decision Page 1 of 4

[redacted]



Medical Benefits

Not Eligible for Medical Benefits

The person(s) listed in the table below are **not eligible** for Medical Benefits.

Name	Birth Date	Date Coverage Ends	Reason	Policy Reference
[redacted]	[redacted]	Apr 30, 2023	A completed redetermination was not received for this individual by the due date.	PM 19-02
[redacted]	[redacted]	Apr 30, 2023	A completed redetermination was not received for this individual by the due date.	PM 19-02
[redacted]	[redacted]	Apr 30, 2023	A completed redetermination was not received for this individual by the due date.	PM 19-02

IL444-0360C (R-09-15) Notice of Decision Page 2 of 4

[redacted]

Cancellation Notice – Renewal not returned

Your Rights

YOU HAVE CERTAIN RIGHTS
CASH AND MEDICAL

If you were denied cash or medical benefits, you have the right to talk with a DHS or HFS caseworker to ask about the reason for denial. The talk will be informal. Any added information you have should be presented at that time. You have the right to be represented at this meeting by any person(s) you choose. If you wish such a meeting, contact the office named on the first page of this notice. You should do this right away. If you choose not to have an informal meeting, you still have a right to appeal this action.

SNAP

If Your SNAP Application Was Denied

You may apply for SNAP benefits again any time you think you may be eligible. If you don't agree with our decision to deny your application, you may ask for a fair hearing. You will not receive any SNAP benefits just because you ask for a fair hearing. You will have the chance to explain your disagreement to a Family Community Resource Center worker and later to a hearing officer. If it is decided that you are right, you may be entitled to SNAP benefits from the date you applied. If you become eligible to receive Supplemental Security Income (SSI) or Temporary Assistance for Needy Families (TANF), you may be eligible for SNAP.

If Your SNAP Application Was Approved

You may ask for a fair hearing if you don't agree with the decision. You will then have the chance to explain your disagreement to a Family Community Resource Center worker and later to a hearing officer.

Turn this page over to read more information on the back.

IL444-0360C (R-09-15) Notice of Decision Page 3 of 4

[redacted]

YOU HAVE THE RIGHT TO APPEAL THIS DECISION

If you do not agree with our decision, you have the right to appeal and be given a fair hearing. You may represent yourself at this hearing or you can ask someone else, such as a lawyer, relative or friend to represent you. If you are appealing the decision on your cash and/or medical benefits decision you must do so within 60 days after the "Date of Notice." If you are appealing a decision about SNAP you must do so within 90 days after the "Date of Notice." You can ask for a fair hearing by calling (800) 435-0774, if you use a TTY, by calling (877) 734-7429, going online to abe.illinois.gov/abe/access/appeals, emailing DHS.BAH@illinois.gov, faxing (312) 793-3387, or in writing to DHS Bureau of Hearings, 69 W. Washington, 4th Floor, Chicago, IL 60602.

To apply for free legal help:

- ✓ In Cook County (including the City of Chicago) - Legal Assistance Foundation of Metropolitan Chicago: (312) 341-1070
- ✓ In other counties in Northern or Central Illinois with area codes (309), (815) or (847) - Prairie State Legal Services: (800) 531-7057
- ✓ In other counties in Central or Southern Illinois where the area code is (217) or (618) - Land of Lincoln Legal Assistance Foundation: (877) 342-7891

Manage My Case Online

Go to **abe.illinois.gov** and click on the Manage My Case button to set up an online account. You'll need the individual ID displayed to the right in order to access information in ABE Manage My Case. You can apply for benefits online, and once you access Manage My Case you can check the status of your application, view any upcoming appointments, or upload documents.

Name	Individual ID
[redacted]	[redacted]

IL444-0360C (R-09-15) Notice of Decision Page 4 of 4

[redacted]

CLOSING COMMENTS

The 3 Cs of Manage My Case (MMC)

Create	Check	Change
• **Create** a Login • **Link** Accounts	• **Check** your renewal date • **Review** your case Information • **Check** for notices from HFS and DHS • **Check** upcoming appointments and reschedule	• **Submit your renewal** • **Change** your address • **Change** of Income • **Add** household members to your case • **Report** Expenses • **Upload** documents

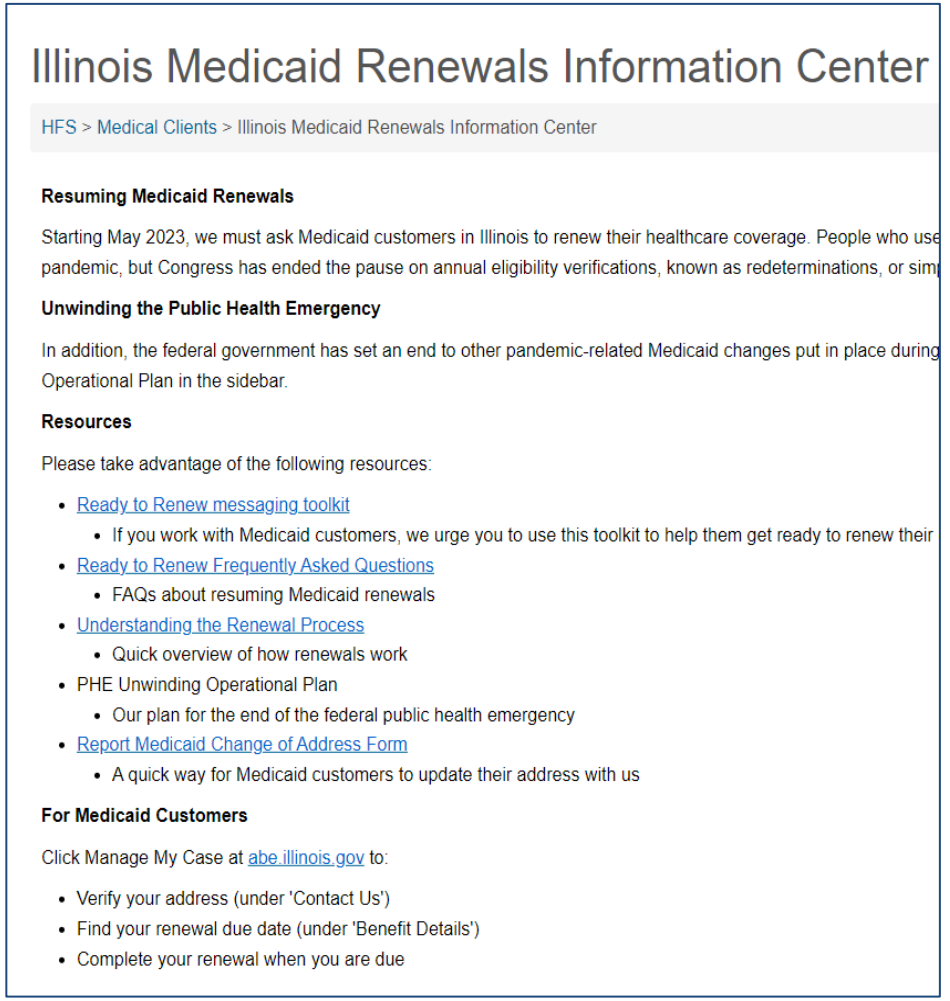
MMC is one of the easiest way for consumers to submit redeterminations!

- MMC allows customers to make fewer visits to their local DHS office, stay informed on the status of their benefits, and manage their case information.
- We urge all agencies with customer contact and resources available to assist customers in setting up MMC accounts.

Communications Phase 2, Ready to Renew!

Illinois Medicaid Renewals Information Center:

Medicaid.Illinois.gov



Illinois Medicaid Renewals Information Center

HFS > Medical Clients > Illinois Medicaid Renewals Information Center

Resuming Medicaid Renewals

Starting May 2023, we must ask Medicaid customers in Illinois to renew their healthcare coverage. People who use
pandemic, but Congress has ended the pause on annual eligibility verifications, known as redeterminations, or simp

Unwinding the Public Health Emergency

In addition, the federal government has set an end to other pandemic-related Medicaid changes put in place during
Operational Plan in the sidebar.

Resources

Please take advantage of the following resources:

- Ready to Renew messaging toolkit
  - If you work with Medicaid customers, we urge you to use this toolkit to help them get ready to renew their
- Ready to Renew Frequently Asked Questions
  - FAQs about resuming Medicaid renewals
- Understanding the Renewal Process
  - Quick overview of how renewals work
- PHE Unwinding Operational Plan
  - Our plan for the end of the federal public health emergency
- Report Medicaid Change of Address Form
  - A quick way for Medicaid customers to update their address with us

For Medicaid Customers

Click Manage My Case at abe.illinois.gov to:

- Verify your address (under 'Contact Us')
- Find your renewal due date (under 'Benefit Details')
- Complete your renewal when you are due

Ready to Renew Toolkit

Key Messaging:

1. Click Manage My Case at abe.illinois.gov
   - ❖ Create or login to your account at abe.illinois.gov to manage your benefits.
2. Verify your address
   - ❖ Click Manage My Case and verify your household information under ‘Contact Us,' or call 1-800-843-6154.
3. Find your due date (also called a redetermination date).
   - ❖ To find your due date (redetermination date), check your ‘Benefit Details’ tab at abe.illinois.gov
4. Watch your mail
   - ❖ We will mail your renewal a month before it is due.
5. Complete your renewal
   - ❖ If your letter says you need to, complete and submit your renewal before the due date (also called redetermination date) to avoid losing your Medicaid

Toolkit is available in 15 languages!

Helpful Links:

- Becoming and All Kids Application Agent
- Using Manage My Case
- Ready to Renew Toolkit
- Redetermination FAQs
- Three-Part Webinar Series: Training for the End of the Continuous Coverage Requirement
- Health Choice Illinois: Learn about your Managed Care Plan

The Illinois Department of Healthcare and Family Services (HFS) utilizes a range of social media accounts to better reach our customers and stakeholders. We encourage you to follow us on:

1. **Twitter: https://twitter.com/ILDHFS**
2. **Facebook: https://www.facebook.com/ILDHFS**
3. **LinkedIn: https://www.linkedin.com/company/ildhfs/**

for important news, announcements and alerts. And please spread the word to your own followers.

Together, let's keep those we serve well informed, educated and empowered!

Scam Alert – Some States are Already Experiencing Scams

For MCO/Provider Outreach

Please remind customers to beware of scams. Illinois will never ask them for money to renew or apply for Medicaid. Report scams to the fraud report website or the Medicaid fraud hotline at 1-844-453-7283/1-844-ILFRAUD

Director Customer Outreach – Include on Website/Social Media/other

Beware of scams. Illinois will never ask you for money to renew or apply for Medicaid. Report scams to the fraud report website or the Medicaid fraud hotline at 1-844-453-7283/1-844-ILFRAUD

For more information please visit:

Illinois Medicaid Renewals Information Center

Medicaid.Illinois.gov

Thank you