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State/Territory Name: Illinois

State Plan Amendment (SPA) #:13-0017-MM2

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

March 19, 2015

Felicia F. Norwood, Director
Illinois Department of Healthcare and Family Services (HFS)
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

ATTN: James Parker

RE: TN IL-13-0017-MM2

Dear Ms. Norwood:

Enclosed for your records is an approved copy of the following State Plan Amendment (SPA).

Transmittal #IL-13-0017-MM2 - Eligibility Process
-Effective Date: October 1, 2013

If you have any questions, please have a member of your staff contact Cathy Song at (312) 353-5184 or by email at Catherine.Song1@cms.hhs.gov.

Sincerely,

/s/
Alan Freund
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures

cc: Jamie Ursch, HFS
Kim Pearce, HFS
Pat Curtis, HFS
Jacquetta Ellinger, HFS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

March 19, 2015

Felicia F. Norwood, Director
Illinois Department of Healthcare and Family Services (HFS)
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

ATTN: James Parker

Dear Ms. Norwood:

This letter is being sent as a companion to Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA) transmittal IL#13-0017-MM2. CMS is granting approval for Form S94 – Eligibility Process IL#13-0017-MM2, which was submitted to CMS on December 30, 2013. Our review of this submission included the review of the multiple program application and streamlined application developed by the state.

Until October 31, 2015, the state is using an interim alternative single streamlined online application. This interim application needs to be revised to reflect the following changes. **MAGI-based Online Application Necessary Changes**	**Completion Date**
The request for child-support income will be removed for applicants applying on the basis of MAGI	March 31, 2015
The question about past health coverage will ask only about the last 90 days, and will only be asked of applicants under age 19.	March 31, 2015
The state agrees to add logic to ask questions about access to employer sponsored coverage only for applicants who appear ineligible for Medicaid and CHIP.	December 31, 2015

Please submit the revised alternative single streamline online application to CMS for review no later than December 1, 2015 to ensure approval by December 31, 2015. We continue to be available to provide technical assistance.

If you have any questions about this letter, please contact Cathy Song at (312) 353-5184 or catherine.song1@cms.hhs.gov.

Sincerely,

/s/
Alan Freund
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Illinois**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

IL-13-0017

Proposed Effective Date

10/01/2013 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 435, Subpart J and Subpart M

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$0.00
Second Year	2015	$0.00

Subject of Amendment

IL 13-0017 General Eligibility Requirements- Eligibility Process

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:

- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**

  Describe:

  The Governor has authorized the director of Healthcare and Family Services to act as his designee to review, approve and submit State Plan amendments under Title XIX of the Social Security Act. The director has reviewed this submission and has no comments.

Signature of State Agency Official

Submitted By:	**Jamie Ursch**
Last Revision Date:	**Mar 13, 2015**
Submit Date:	**Dec 30, 2013**

DATE RECEIVED
12/30/2013

DATE APPROVED:
03/19/2015

PLAN APPROVED - ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL:
10/1/2013

SIGNATURE OF REGIONAL OFFICIAL:
/s/

TYPED NAME
Alan Freund

TITLE:
Associate Regional Administrator

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 13-0017-MM2	**STATE:** Illinois
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S94 - Eligibility Process, page S94-1, S94-2	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** Section 2, Page 10, section 2.1(a), TN # 91-29; Approval Date: 2/14/92; Eff. Date: 10/1/01; Section 2, Page 11a, section 2.1(d), TN # 99-3, Approval Date: 06/08/01; Eff. Date: 04/01/99

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements Eligibility Process	S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☒ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☐ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

○ Yes ◉ No

Medicaid Eligibility

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

State of Illinois
Department of Human Services
Request for Cash Assistance - Medical Assistance - Supplemental Nutrition Assistance Program (SNAP)

Last Name: _____ First Name: _____ MI: ___ Maiden Name: _____

Present Address: _____ Apartment Number: _____

City: _____ State: _____ Zip Code: _____ County: _____

Are you homeless? ☐ Yes ☐ No

Mailing Address (if different from above): _____

City: _____ State: _____ Zip Code: _____ County: _____

Telephone number(s) Home: _____ Work: _____ Other: _____

Daytime phone: _____ Best time to call you: _____

Signing here will start your application. You must sign Page 18 before we approve you for any benefits.

Signature: _____ Date: _____

Approved Representative

When you sign to have an approved representative it means you give permission for this person (1) to sign your application for you, (2) to receive official information about this application, and (3) to act for you on all matters with this agency.

Do you want to name an approved representative? ☐ Yes ☐ No If yes, complete the following:

Name of approved representative: _____ Address: _____

Phone Number: _____ Organization Name: _____ ID # if applicable: _____

Signature of applicant: _____

Instructions to person(s) applying for Cash, Medical, and/or SNAP benefits

Cash - **Medical -** **SNAP -**

1. Please print all of your answers on the application form so that we can read and understand your answers.
2. You have the right to immediately file the application as long as the top of this page (Page 1) is completed with your name, address and signature. The filing of this signed page (Page 1) starts the application processing timetable.
3. Read pages 14 & 15 to know your rights and responsibilities for SNAP benefits.
   Read pages 16, 17 and 18 to know your rights and responsibilities for Cash and Medical benefits.
4. **Before you can get any benefits, you must sign page 18.**
5. If applying for SNAP benefits, a decision on your eligibility will be made within 30 days. If determined eligible, SNAP benefits will be issued from the date the application is filed.
6. You may be entitled to receive SNAP benefits right away if:
   * your gross nonexempt income and liquid assets are less than your monthly rent or mortgage payment and the appropriate utility standard: or,
   * you have assets of $100 or less **and**
     - your gross monthly income for the month of application is less than $150; or
     - at least one person applying is a migrant who is "out of funds."
7. You may complete this form at home and mail or bring it to a Department of Human Services (DHS) office. Another member of the household or an adult who knows you may complete and return the form to us also. If someone else completes this form for the household, they are to answer the questions for the person(s) they are applying for, not himself or herself. You have the right to choose the office where you apply. Once you submit your application to an office it will be processed by that office.
8. If you want to register to vote, fill out the enclosed 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 1-800-447-6404 (for TTY).
   For information online, see www.dhs.state.il.us or www.elections.il.gov/.
   Filling out the Voter Registration Application as part of this application is optional. Registering to vote is your choice and will not affect the amount of benefits you get from this agency.

Citizenship/Immigration Status

If you or any other persons are not applying because you do not wish to provide information about your immigration status, you do not have to give us that information. The failure to provide immigration information will not affect processing the application for the remaining persons. However, any person who is applying for benefits for himself or herself has to provide information on their immigration status.

Are all persons U.S. Citizens? ☐ Yes ☐ No

Complete the following for any non-citizens who are applying for benefits. If you need more room, attach another sheet of paper.

Name	Age	Arrival Date in the United States	Registration document/number
1.			
2.			
3.			
4.			

If there are persons who are not applying for SNAP and/or cash benefits because they do not wish to provide proof of their immigration status, please list them below. **We will only ask questions about their income & assets.**

Name (Last) (First) (MI)	Name (Last) (First) (MI)
1.	3.
2.	4.

General Household Questions

1. Are you or is anyone who lives with you blind? ☐ Yes ☐ No Disabled? ☐ Yes ☐ No
2. Does anyone in the household receive Social Security Disability or Railroad Retirement benefits? ☐ Yes ☐ No
   If yes, who: _____ What is their SSN or RRB claim number? _____
3. Does anyone have a physical, mental or emotional health condition that limits common activities (like bathing, dressing, daily chores, etc)? ☐ Yes ☐ No
   If yes, who: _____
4. Does anyone applying live in a nursing home facility, supportive living facility, or other facility or institution? ☐ Yes ☐ No
   If yes, who: _____ Name of facility: _____
5. Does anyone in your household want help paying for medical bills from the last 3 months? ☐ Yes ☐ No
6. Has anyone in your household been in foster care at age 18 or older? ☐ Yes ☐ No
   If yes, name of person: _____
7. Is anyone in your household age 18 or older a full time student? (college, or trade school) ☐ Yes ☐ No
   If yes, name of person: _____

Language Preference

Does the adult member of your household who will discuss your case with DHS speak English fluently? ☐ Yes ☐ No

If no, please list your preferred spoken language: _____

Does the adult member of your household who will usually receive mail or written information from DHS read English fluently? ☐ Yes ☐ No

If no, please list your preferred written language: _____

Household Composition

How many people live with you (include yourself)? _____

Complete the following for everyone in the household. Include people who live with you who are not requesting assistance. You must give us the Social Security Number for each person for whom you are requesting benefits. You **do not** have to give us the number for any person for whom you are not requesting benefits, but if you do, it may speed up the application process.

Person 1	Mark the box for the program this person is applying for:			☐ SNAP ☐ Medical	☐ Cash
First	M.I.	Last	Suffix	Former Name, if any	Relationship to you **SELF**
Social Security #	Sex ☐ M ☐ F	Birth Date	Marital Status	Pregnant? If yes, due date	How many babies expected?

If you are applying for Medical assistance answer question 1.

1. Do you plan to file a Federal Tax Return next year? ☐Yes ☐No If yes, answer 2-4 below	
2. Will you file jointly with a spouse? ☐Yes ☐No	If yes, name of spouse:
3. Do you have any dependents? ☐Yes ☐No	If yes, list name(s):
4. Will you be claimed as a dependent on someone else's tax return?	☐Yes ☐No
If yes, list the name of the tax filer:	How are you related to the tax filer?

The following questions are for informational purposes only: (optional)

Are you Hispanic or Latino? ☐Yes ☐No

What is your race? (Select one or more)

☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Person 2	Mark the box for the program this person is applying for:			☐ SNAP ☐ Medical	☐ Cash
First	M.I.	Last	Suffix	Former Name, if any	Relationship to you
Social Security #	Sex ☐ M ☐ F	Birth Date	Marital Status	Pregnant? If yes, due date	How many babies expected?

If this person is applying for Medical assistance answer question 1.

1. Does this person plan to file a Federal Tax Return next year? ☐Yes ☐No If yes, answer 2-4 below	
2. Will this person file jointly with a spouse? ☐Yes ☐No	If yes, name of spouse:
3. Does this person have any dependents? ☐Yes ☐No	If yes, list name(s):
4. Is this person claimed as a dependent on someone else's tax return?	☐Yes ☐No
If yes, list the name of the tax filer:	How is this person related to the tax filer?

The following questions are for informational purposes only: (optional)

Is this person Hispanic or Latino? ☐Yes ☐No

What is this person's race? (Select one or more)

☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Household Composition (Continued)

Person 3	Mark the box for the program this person is applying for:			☐ SNAP	☐ Medical	☐ Cash
First	M.I.	Last	Suffix	Former Name, if any		Relationship to you
Social Security #	Sex ☐ M ☐ F	Birth Date	Marital Status	Pregnant? If yes, due date		How many babies expected?

If this person is applying for Medical assistance answer question 1.	
1. Does this person plan to file a Federal Tax Return next year? ☐ Yes ☐ No If yes, answer 2-4 below	
2. Will this person file jointly with a spouse? ☐ Yes ☐ No	If yes, name of spouse:
3. Does this person have any dependents? ☐ Yes ☐ No	If yes, list name(s):
4. Is this person claimed as a dependent on someone else's tax return?	☐ Yes ☐ No
If yes, list the name of the tax filer:	How is this person related to the tax filer?
The following questions are for informational purposes only: (optional)	
Is this person Hispanic or Latino? ☐ Yes ☐ No	
What is this person's race? (Select one or more)	
☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	

Person 4	Mark the box for the program this person is applying for:			☐ SNAP	☐ Medical	☐ Cash
First	M.I.	Last	Suffix	Former Name, if any		Relationship to you
Social Security #	Sex ☐ M ☐ F	Birth Date	Marital Status	Pregnant? If yes, due date		How many babies expected?

If this person is applying for Medical assistance answer question 1.	
1. Does this person plan to file a Federal Tax Return next year? ☐ Yes ☐ No If yes, answer 2-4 below	
2. Will this person file jointly with a spouse? ☐ Yes ☐ No	If yes, name of spouse:
3. Does this person have any dependents? ☐ Yes ☐ No	If yes, list name(s):
4. Is this person claimed as a dependent on someone else's tax return?	☐ Yes ☐ No
If yes, list the name of the tax filer:	How is this person related to the tax filer?
The following questions are for informational purposes only: (optional)	
Is this person Hispanic or Latino? ☐ Yes ☐ No	
What is this person's race? (Select one or more)	
☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	

Household Composition (Continued)

Person 5	Mark the box for the program this person is applying for:			☐ SNAP ☐ Medical	☐ Cash
First	M.I.	Last	Suffix	Former Name, if any	Relationship to you
Social Security #	Sex ☐ M ☐ F	Birth Date	Marital Status	Pregnant? If yes, due date	How many babies expected?

If this person is applying for Medical assistance answer question 1.	
1. Does this person plan to file a Federal Tax Return next year? ☐Yes ☐No If yes, answer 2-4 below	
2. Will this person file jointly with a spouse? ☐Yes ☐No	If yes, name of spouse:
3. Does this person have any dependents? ☐Yes ☐No	If yes, list name(s):
4. Is this person claimed as a dependent on someone else's tax return?	☐Yes ☐No
If yes, list the name of the tax filer:	How is this person related to the tax filer?
The following questions are for informational purposes only: (optional)	
Is this person Hispanic or Latino? ☐Yes ☐No	
What is this person's race? (Select one or more)	
☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	

Person 6	Mark the box for the program this person is applying for:			☐ SNAP ☐ Medical	☐ Cash
First	M.I.	Last	Suffix	Former Name, if any	Relationship to you
Social Security #	Sex ☐ M ☐ F	Birth Date	Marital Status	Pregnant? If yes, due date	How many babies expected?

If this person is applying for Medical assistance answer question 1.	
1. Does this person plan to file a Federal Tax Return next year? ☐Yes ☐No If yes, answer 2-4 below	
2. Will this person file jointly with a spouse? ☐Yes ☐No	If yes, name of spouse:
3. Does this person have any dependents? ☐Yes ☐No	If yes, list name(s):
4. Is this person claimed as a dependent on someone else's tax return?	☐Yes ☐No
If yes, list the name of the tax filer:	How is this person related to the tax filer?
The following questions are for informational purposes only: (optional)	
Is this person Hispanic or Latino? ☐Yes ☐No	
What is this person's race? (Select one or more)	
☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	

If needed, please list extra household members on an additional piece of paper.

If you are applying for SNAP benefits complete this page.

How much money do you or anyone who lives with you have in cash, checking, and/or savings? $_____

What is the monthly **gross income** (income of all sources before any deductions) for you and everyone who lives with you? $_____

How much money have you or anyone who lives with you received or expect to receive from any source in the month of application?

$ _____ When? _____ Who: _____ Source: _____

Shelter Costs

1. How much are you charged each month for your rent or mortgage? $_____
   (For mortgage include property taxes and insurance.)
   Do you share this expense with anyone? ☐ Yes ☐ No
2. Are you receiving, or expecting to receive Low Income Home Energy Assistance Program (LIHEAP), (in Chicago paid through CEDA)? ☐ Yes ☐ No
3. If No, are you billed separately from rent or mortgage for:
   NOTE: Air conditioning is a window air or central air conditioning unit.
   A. Heat or air conditioning? ☐ Yes ☐ No
   B. Excess cost for heat or air conditioning? ☐ Yes ☐ No
   C. Does anyone outside of your SNAP household pay or help pay for your housing costs? ☐ Yes ☐ No
   D. Does anyone outside of your SNAP household pay your utility expenses? ☐ Yes ☐ No
   If yes, please list the bills and the amounts paid: _____

Please complete the following information if you answered No, to question 2 or 3 and are not billed for heat or air conditioning separately

Expenses	Amount	How Often Due	Amount You Pay	Paid By Others
Electricity				
Water and/or Sewerage				
Garbage				
Cooking Fuel				
Basic Phone Service (including cell phone)				
Septic Tank Installation Maintenance				
Well Installation /Maintenance				
A Fee for Starting Utility Service				
A Flat Amount for Utilities				
Explain:				

Migrant or Seasonal Farmworker Questions

Is this a SNAP household of migrant or seasonal farm workers? ☐ Yes ☐ No

If yes, did the income recently stop? ☐ Yes ☐ No If yes, date the income stopped? _____

Are liquid assets of household $100 or less **AND** does the household have a destitute migrant or seasonal farmworker?
☐ Yes ☐ No

Are you or is anyone who lives with you expecting to receive more than $26 in income from a new source within the next 10 days? ☐ Yes ☐ No

Benefit Information

Has the primary applicant received SNAP benefits in any state in the month of application? ☐ Yes ☐ No

Is the applicant a resident of a domestic violence shelter? ☐ Yes ☐ No

Medical Deduction for Persons Disabled or Age 60 or Older

If a SNAP household member is disabled or age 60 or older your SNAP household may be entitled to a Standard Medical Deduction. To get the Standard Medical Deduction, you have to prove you pay out of pocket monthly medical expenses of $36 or more.
*If you do not live in a group home the Standard Medical Deduction is $245.
*If you live in a group home the Standard Medical Deduction is $485.

Can you prove that you pay $36 or more monthly in medical expenses? ☐ Yes ☐ No

If yes and you give us proof, we will allow the Standard Medical Deduction that applies to your household. If your monthly medical expenses that you pay are more than $245/$485 and you give us proof, we will allow your actual medical expenses.

Application Interview - Cash and SNAP

Please complete the following:

We will interview you within 14 days, or right away if you qualify for an expedited SNAP interview.

☐ I am able to come to an office interview.

☐ I must be interviewed by phone because: _____

☐ I am applying for SNAP

- ☐ And someone in my household is employed.
- ☐ Problems with health, transportation, caring for a child or disabled adult, ongoing severe weather or educational activities conflict with work hours.

☐ I am applying for cash assistance

- ☐ Hours of work or educational activities conflict with office hours.
- ☐ Problems with health, transportation, caring for a child or disabled adult, ongoing severe weather or educational activities conflict with work hours.

I can be reached by phone Monday - Friday between 8:30 and 5:00 at: _____

Income - Benefits - Expenses

Is anyone in your household currently employed? ☐Yes ☐No

If yes, complete the following:

Name of Person: _____ Employer: _____

Employer Address: _____ Employer Phone: _____

Number of hours worked weekly: _____ Amount Paid (including tips) before taxes $ _____

How often paid: ☐Weekly ☐Every two weeks ☐Twice a month ☐Monthly

Name of Person: _____ Employer:

Employer Address: _____ Employer Phone: _____

Number of hours worked weekly: _____ Amount Paid (including tips) before taxes $ _____

How often paid: ☐Weekly ☐Every two weeks ☐Twice a month ☐Monthly

Is anyone in your household self-employed? ☐Yes ☐No If yes, name of person: _____

What kind of work do they do? _____

How much will they make this month, once they pay business expenses? $ _____

Complete only if your income changes from month to month. If you don't expect changes, skip this section.
What is the total income for each person for this year? If you anticipate a change, what will it be next year?

Person: _____ Total income this year: $ _____ Total income next year: $ _____

Person: _____ Total income this year: $ _____ Total income next year: $ _____

Person: _____ Total income this year: $ _____ Total income next year: $ _____

Does anyone named on this form RECEIVE money from any source other than employment (such as Social Security, educational benefits, child support, spousal support, rental property, unemployment benefits, pensions, retirement, trusts)? ☐Yes ☐No

If yes, complete the following:

Name of Person: _____ Source: _____ Monthly Amount $ _____

Name of Person: _____ Source: _____ Monthly Amount $ _____

Name of Person: _____ Source: _____ Monthly Amount $ _____

(Include additional pages, if needed.)

If this income is from rental property, is this person receiving the income also the property manager? ☐Yes ☐No

In the past year, has anyone in your household changed jobs, stopped working or started working fewer hours? ☐Yes ☐No

If yes, name of Person: _____

Does anyone in your household pay any of the following expenses?

Alimony paid: $ _____ How often? ☐Weekly ☐Every two weeks ☐Twice a month ☐Monthly

Student loan interest: $ _____ How often? ☐Weekly ☐Every two weeks ☐Twice a month ☐Monthly

Daycare: $ _____ How often? ☐Weekly ☐Every two weeks ☐Twice a month ☐Monthly

Child Support paid : $ _____ How often? ☐Weekly ☐Every two weeks ☐Twice a month ☐Monthly

Other deductions (Do not include any expenses you have already reported)

Type of expense: _____ $ _____ How often? ☐Weekly ☐Every two weeks ☐Twice a month ☐Monthly

American Indian or Alaska Native Family Member (AI/AN)

Are you or anyone in your family American Indian or Alaska Native (AI/AN)? ☐Yes ☐No

Are you or anyone in your household a member of a federally-recognized tribe? ☐Yes ☐No

If yes, tribe name: _____

If No, skip to next section.

Indian Health Services

List any family members who received services from the Indian Health Service, a tribal health program, or urban Indian health program. If nobody received these services, is anyone qualified to receive them?

List the names of anyone who received services: _____

_____

List the names of anyone who qualifies for services: _____

_____

Tribal Related Income

Does the income you listed on Page 7 include money from any of the following?
Payments from a tribe that come from natural resources, usage rights, leases or royalties? ☐Yes ☐No

If yes, amount: $ _____

Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations)? ☐Yes ☐No

If yes, amount: $ _____

Money from selling things that have cultural significance? ☐Yes ☐No

If yes, amount: $ _____

SNAP and Cash Applicants:

Have you or any other person applying for Cash been convicted of a felony involving drugs on or after 08/22/96? ☐Yes ☐No

If yes, Name of Person: _____

If the drug-related felony conviction was NOT Class X or Class I, did the felony take place more than 2 years ago, or has the person completed a drug treatment program, or is the person in a drug treatment program now? ☐Yes ☐No

Has any person been convicted in state or federal court of misrepresenting an address to receive assistance in two or more states at the same time? ☐Yes ☐No

If yes, who _____

Is any person in violation of their parole or probation? ☐Yes ☐No

If yes, who _____

Is anyone fleeing from felony prosecution, an outstanding felony warrant or jail? ☐Yes ☐No

If yes, who _____

Your Family's Health Coverage

Complete this page if you are applying for cash or medical benefits**.**
Is anyone enrolled in health coverage now from any of the following? If **YES**, check the type of coverage and write their names next to the coverage they have**.**

- ☐ Medicaid _____
- ☐ CHIP _____
- ☐ Medicare _____
- ☐ Tricare (Don't check if you have Direct Care or a Line of Duty) _____
- ☐ Veteran's Health Insurance Program _____
- ☐ Peace Corps Health Insurance _____
- ☐ Employer Insurance _____

  Name of Insurance _____

  Policy Number _____

  Is this a retiree health plan? ☐ Yes ☐ No

  Is this COBRA coverage? ☐ Yes ☐ No
- ☐ Other _____

  Is this a limited-benefit plan (such as a school accident policy)? ☐ Yes ☐ No

  Is anyone listed on this application offered health coverage from a job? ☐ Yes ☐ No

  Check **YES** even if the coverage is from someone else's job, such as a parent's or spouse's.

  If **YES**, complete Page 11.

Tell us about the job that offers coverage:

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____

Employer Identification Number (EIN): _____

Who can we contact about employee health coverage at this job? _____

Phone Number: _____ E-Mail address: _____

Can you get coverage now or sometime in the next 3 months? ☐ Yes ☐ No

If yes, when?: _____

List the name of anyone who can get coverage from this job:

_____

Your Family's Health Coverage

Complete this page if you are applying for cash or medical benefits and anyone listed on this application is offered health coverage from a job.

Does the employer offer a health plan that pays at least 60% of the total costs of benefits? (The minimum value standard for health plans) ☐Yes ☐No

For the lowest-cost minimum value plan offered to the employee ONLY (don't include family plans):

Does the employer offer wellness programs? ☐Yes ☐No

If yes, what premium would the employee pay if he or she got the maximum discount for a tobacco cessation program? $_____

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐Weekly ☐Every two weeks ☐Twice a month ☐Quarterly ☐Yearly

What changes will the employer make for the new plan year, if you know?

☐ Employer won't offer health coverage.

☐ Employer will start offering health coverage to employees.

☐ Employer will change the premium for the lowest-cost plan minimum value plan available to the employee only.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐Weekly ☐Every two weeks ☐Twice a month ☐Quarterly ☐Yearly

You must answer for all household members age 19 or younger:
Did anyone lose health insurance from a job within the past three months? ☐Yes ☐No

If yes, answer the questions below:

a. Name of household member: _____

b. When did the insurance end? _____

c. Reason insurance ended: _____

RESOURCE INFORMATION

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

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

Owner	Address	Type	Value	Amount Owed
			$	$
			$	$

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

Owner	Type	Make/Model/Year	Value	Amount Owed
			$	$
			$	$

Does anyone own any life insurance? ☐Yes ☐No

Owner	Insurance Company	Policy Number	Face Value	Cash Value
			$	$
			$	$

Does anyone have an insurance policy that pays when he or she is in a nursing home? ☐Yes ☐No

If yes, list the following:

Policy Number: _____

Name of Company: _____

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

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

☐ Other List, If other: _____

Owner(s)	Type of Resource	Account/Policy #	Value	Name of Bank, Company, etc.
			$	
			$	

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

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

Resource:	Value:	Name and relationship of Other Person(s) Holding the Resource:
Property in Illinois:	$	
Property in another state:	$	
Checking/Savings account:	$	
Certificate of Deposit:	$	
Stocks/Mutual Funds:	$	
Other:	$	

Employment and Employment Related Expenses

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

Employed person's name: (1) _____

Amount received before deductions (gross amount): $ _____

How often paid: ☐Weekly ☐Every two weeks ☐Bi-Monthly ☐Monthly

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

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

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

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

How does this person get to and from work? ☐Own car ☐Bus ☐Other Please list. if other: _____

If this person uses his/her own car, how many miles to and from work? _____

If this person person takes the bus, what is the fare to and from work? $ _____

If other transportation is used, enter type and cost. Attach proof. _____

Must this person pay union dues, group life insurance premiums, group health insurance premiums, or retirement plan withholding as a condition of employment? ☐Yes ☐No Monthly amount: $ _____

Employed person's name: (2) _____

Amount received before deductions (gross amount): $ _____

How often paid: ☐Weekly ☐Every two weeks ☐Bi-Monthly ☐Monthly

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

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

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

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

How does this person get to and from work? ☐Own car ☐Bus ☐Other Please list. if other: _____

If this person uses his/her own car, how many miles to and from work? _____

If this person person takes the bus, what is the fare to and from work? $ _____

If other transportation is used, enter type and cost. Attach proof. _____

Must this person pay union dues, group life insurance premiums, group health insurance premiums, or retirement plan withholding as a condition of employment? ☐Yes ☐No Monthly amount: $ _____

SNAP - CLIENT RIGHTS AND RESPONSIBILITIES

Read carefully before signing this application on page 18. Ask your caseworker to explain anything you do not understand.

Because the SNAP program requires a Social Security Number (SSN) for every member of your household who is applying for SNAP benefits, we are explaining how your SSN is used by DHS.

What does DHS do with your Social Security Number?

The SSN will be used in the administration of the SNAP program to check the identity of household members, prevent duplicate participation, and to facilitate making mass changes. If you or any member of your household wants to apply for SNAP benefits, but does not have a SSN, we can help you apply for one. The SSN (or any other information in this application) may be used in computer matching and program reviews or audits and to make sure the household is eligible for SNAP benefits, other Federal assistance programs, and Federally assisted state programs, such as school lunch, TANF, and Medicaid. This may result in criminal or civil action or administrative claims against persons fraudulently participating in the SNAP program. We do not require a Social Security Number for any member of your household who is not eligible for the SNAP program or who does not wish to apply.

Why does DHS collect your Social Security Number?

DHS will only use your SSN for the purpose for which it was collected. DHS will not: Sell, lease, loan, trade, or rent your SSN to a third party for any purpose; publicly post or publicly display your SSN; print your SSN on any card required for you to access our services; require you to transmit your SSN over the internet, unless the connection is secure or your SSN is encrypted; or print your SSN on any materials that are mailed to you, unless State or Federal law requires that number to be on documents mailed to you, or unless we are confirming the accuracy of your SSN.

Right to appeal.

A fair hearing may be requested either orally or in writing if there is a disagreement with any action taken on this case. The SNAP unit's case may be presented at the hearing by any person chosen by the SNAP unit.

Non-Discrimination.

In accordance with Federal Law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution prohibits discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the department. If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. You may also contact the Department of Human Services (DHS) at Department of Human Services, Bureau of Civil Affairs, 401 South Clinton St, 2nd Floor, Chicago, Illinois, 60607. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the DHS Helpline Number at 1-800-843-6154 or (800)447-6404 (TTY). DHS and USDA are equal opportunity providers and employers.

SNAP - CLIENT RIGHTS AND RESPONSIBILITIES continued

Declaration Regarding Citizenship/Alien Status

I declare, under penalty of perjury, that the statements I have made regarding the citizenship or alien status of each person requesting assistance are true and correct. I understand that the alien status of each person requesting assistance who is not a citizen of the United States will be verified with the United States Citizenship and Immigration Services (USCIS). This will require the disclosure to USCIS of certain identifying information which I have provided. The information received from USCIS may affect eligibility for assistance and the benefit level.

I understand that documents may have to be provided to prove what I have said. I agree to do this. If documents are not available, I agree to give the name of the person or organization the FCRC may contact to obtain the necessary proof. The information on this form is subject to verification by Federal, State, and Local Officials. If any information is found to be inaccurate, I may be denied SNAP benefits, and/or be subject to criminal prosecution for knowingly providing false information.

I understand that a change that happens after the eligibility interview and before the notice of decision must be reported within 10 calendar days unless otherwise notified. If I have any doubt about whether to report a change, I will ask my Human Services caseworker.

I understand that if I am approved for SNAP benefits and I receive more benefits than I am entitled to, whether an error on my part or an agency error, the amount of overpaid benefits may be subtracted from my monthly benefit amount.

AT THE APPLICATION	
You Must Report	**You must report and <u>verify:</u>**
Child care expenses	Medical expenses
Rent or mortgage payment, property taxes and insurance and utility expenses.	Child support paid to a non-SNAP Unit member

Failure to report or verify above expenses will be seen as a statement by your SNAP Unit that you do not want to receive a deduction for the unreported expenses.

Child support payments are subject to verification by computer matching with the records of the Division of Child Support Enforcement.

Penalty Warning - **What are the SNAP Program Penalties?**

If you.....	**Then you will lose SNAP benefits**
* Hide or give wrong information on purpose to get SNAP benefits * Trade, steal or sell SNAP benefits, or resell food bought with SNAP benefits * Use SNAP benefits to buy non-food items like alcohol or tobacco. * Use someone else's SNAP benefits for yourself or someone else. * Throw away beverages purchased with SNAP benefits just to get money back from a container deposit.	*** 12 months first time** *** 24 months the second time** *** Permanently the third time**
Trade SNAP benefits for controlled substance, such as drugs.	*** 24 months first time** *** Permanently the second time**
Trade SNAP benefits for firearms, ammunition or explosives.	*** Permanently**
Buy, sell, steal or trade SNAP benefits of more than $500.00	*** Permanently**
* Give false information about who you are and where you live so you can get extra SNAP benefits.	*** 10 years**

You can also be fined up to $250,000 and put in prison up to 20 years or both. You can also be charged under other Federal Laws. Persons who are fleeing felons or probation/parole violators are ineligible for SNAP benefit.

Cash/Medical Assistance - CLIENT RIGHTS AND RESPONSIBILITIES

Read carefully before signing this application on page 18. Ask your caseworker to explain anything that you do not understand.

To receive benefits, a person must have a valid Social Security Number (SSN) or proof that he or she has applied for one, unless exempt. If you or any member of your household wants to apply for assistance, but do not have a SSN, we can help you to apply for one. State law requires us to explain how your SSN is used by the State of Illinois.

- ✓ **Your Social Security Number (**SSN) will be used in the administration of the cash and/or medical program to check the identity of household members, prevent duplicate participation, and to facilitate making mass changes to the cash and/or medical program.
    - The SSN (or any other information in this application) may be used in computer matching and program reviews or audits and to make sure the household is eligible for assistance, other federal assistance programs, and federally assisted state programs, such as school lunch, TANF, and Medicaid.
    - DHS secures and uses information about all clients through the income and eligibility verification system. This includes such information as receipt of social security benefits, unemployment insurance, unearned income and wages from employment.
    - Any information obtained will be used in determining eligibility for assistance and the amount of assistance provided for all programs.
    - When discrepancies are found, verification of this information may be obtained through contacts with a third party, such as employers, claims representatives, or financial institutions. This information may affect your eligibility for assistance and the amount of assistance provided.
    - DHS will only use your SSN for the purpose for which it was collected.
    - DHS will not: sell, lease, loan, trade, or rent your SSN to a third party for any purpose; publicly post or publicly display your SSN; print your SSN on any card required for you to access our services; require you to transmit your SSN over the Internet, unless the connection is secure or your SSN is encrypted; or print your SSN on any materials that are mailed to you, unless State or Federal law requires that number be on documents mailed to you, or unless we are confirming the accuracy of your SSN.
- ✓ When an application for cash or medical assistance is filed, a determination of eligibility under all of the programs administered by DHS will be made unless I do not want to be considered for a particular program(s). If I do not want to be considered for a particular program, DHS will not consider my eligibility for that program(s).
- ✓ The information provided on this form will be subject to verification by Federal, State, and Local officials. If any information is found to be inaccurate, I may be denied cash benefits and/or medical assistance. I understand that anyone who knowingly misuses the medical card issued by the State of Illinois may be committing a crime.
- ✓ All information related to the establishment of paternity and child support enforcement has been provided to the best of my knowledge.
- ✓ If my application is approved, I give the State of Illinois the right to recover under the terms of any private or public health care coverage any amount for which I or a member of my family may be eligible.
- ✓ I also authorize staff of the DHS to obtain information from my records or copy my records from the Social Security Administration (SSA). I authorize release of my records from SSA to the staff of DHS with respect to any claims for disability benefits and all related appeals. I certify that I understand that the materials requested may be protected under the Privacy Act. I authorize release of any material protected under the Privacy Act to the staff of DHS.

Cash/Medical Assistance - CLIENT RIGHTS AND RESPONSIBILITIES continued

- ✓ I understand that the State of Illinois will release information concerning medical services that I have received for any reason authorized by law.
- ✓ I understand that if the children I am applying for are approved for All Kids Share or All Kids Premium, then I am responsible for paying the premiums and copayment amounts.
- ✓ I understand that if the children I am applying for are approved for All Kids Rebate, then the State of Illinois is not responsible for additional premiums; deductibles or copayments required by the employer's or private health insurance policy.
- ✓ If I am approved for TANF Cash and/or medical benefits for myself and my children, and the State of Illinois pays medical bills for me, I give my right to collect medical support payments to the State of Illinois. I understand I must help to obtain medical support payments for members of my family unless I have a good reason not to. My children can get health insurance even if I do not help when the Department asks me to.
- ✓ As a condition of eligibility, if I am approved for TANF Cash and/or medical assistance for myself and my children, I understand that I may be required to cooperate with child support enforcement.
    - Cooperation includes establishment of paternity and/or support enforcement and modification of child support orders.
    - I assign and give all my rights, title and interest of child support and medical support to Healthcare and Family Services (HFS) as long as I receive TANF Cash/or medical assistance.
    - I understand and agree that any child support payments paid through the clerk of the circuit court and through the State Disbursement Unit (SDU) may be forwarded to the HFS as long as I receive TANF Cash.
    - I understand that if I apply for TANF Cash and/or medical assistance for my children only, I am not required to cooperate with child support enforcement, but I may request services.
- ✓ I declare under penalty of perjury, that the statements I have made regarding the citizenship or immigration status of each person requesting assistance are true and correct.
- ✓ I understand the Department will not share any information about immigration or any persons who do not have an Alien Registration Number.
- ✓ The Department will verify the immigration status of any person for whom I give an Alien Registration Number. To do that, the Department will check the number with the U.S. Citizenship and Immigration Service (USCIS). The Department may send other information to USCIS, such as copies of proof that I give of an Alien Registration Number and the person's Social Security Number, if they have one.
- ✓ If I am approved for **Aid to the Aged, Blind, or Disabled (AABD**) for cash and/or medical assistance, I understand that the DHS may have the right to place a lien on my home or other real property I own. The amount of the lien is the amount of assistance DHS has provided to me.
- ✓ I agree to inform the agency within 10 days of any change in my household's size, income, property, living arrangements, school attendance, or address.
- ✓ I understand that if approved for cash benefits, and I receive more benefits than I am entitled to, whether it be an error on my part or an agency error, the amount of overpaid benefits are subject to recoupment/recovery.
- ✓ I understand that a person convicted of a Class X or Class I felony or a comparable federal law, for acts that occurred on or after 08/22/96 involving possession, use, or distribution of a controlled substance is ineligible to receive Cash assistance. I understand that a person convicted of drug-related felony, other than a Class X or Class I, under Illinois or any comparable federal law an act that occurred on or after 08/22/96, is ineligible for Cash assistance for 2 years following the date of the conviction, unless they are in drug treatment or aftercare, or successfully participated in and completed drug treatment and/or aftercare subsequent to their conviction.

Cash/Medical Assistance - CLIENT RIGHTS AND RESPONSIBILITIES continued

✓ **Right to Appeal** I understand that if I am not satisfied with the action taken on my application that I have the right to a fair hearing. I understand that I can ask for a fair hearing by getting in touch with the office where I applied or by writing to: Illinois Department of Human Services, Bureau of Assistance Hearings, 401 South Clinton Street, 6th Floor, Chicago, Illinois 60607, or by calling 1-800-435-0774.

✓ I understand that if I am mentally and physically able to apply and I want someone else to apply for cash and/or medical benefits for me, I must attach a written statement that gives the person permission. The statement must include the person's name, address, and phone number. The statement must say that I am still responsible for the information provided by the person.

✓ I understand that by signing this application form, I consent to any investigation made by the Department to verify or confirm the information I have given or any other investigation made by them in connection with my request for public assistance. I understand that I must cooperate in these efforts to verify information.

Applicant Signature

I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil or both. I certify under the penalty of perjury that the information I have provided on this application form is the truth to the best of my knowledge.
I declare under penalties of perjury that I have examined this form and all accompanying statements or documents pertaining to the income and resources of myself (the applicant) or any member of my family (the applicant's family) included in this application for aid, or pertaining to any other matter having bearing upon my (the applicant's) eligibility for aid, and to the best of my knowledge and belief the information supplied is true, correct, and complete.

Applicant: _____ Date _____

Spouse: _____ Date _____

Signature: Applicant Makes a Mark (X)

☐ If you have made your mark (X) instead of signing your name, one witness must sign here:

Signature of Witness: _____ Date _____

Signature: Applicant Blind

☐ Applications based on blindness must be attested to by two witnesses.

Signature of Witness: _____ Date _____

Signature of Witness: _____ Date _____

APPROVED REPRESENTATIVE SIGNATURE

If the application is initiated by someone else for the applicant, they must sign below. If an approved representative completes and signs this application, written authorization from the applicant is required.

I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil or both. I certify under the penalty of perjury that the information I have provided on this application form is the truth to the best of my knowledge.

Signature of Approved Representative: _____ Relationship: _____

Home Address: _____ Apt. Number: _____

Phone Number: _____

ILLINOIS VOTER REGISTRATION APPLICATION

Suggested, August 2008, SBE
R-19

FOR ILLINOIS RESIDENTS ONLY
TO VOTE YOU MUST:

- Be a United States citizen
- Be at least 18 years old
- Live in your election precinct at least 30 days
- Not be convicted and in jail
- 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. (click here for County Clerk/Election Board listings) or go to 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, pay check, 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 at a voting place or by absentee ballot. 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.

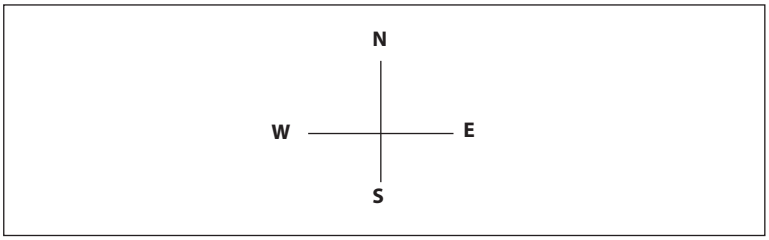
If you have questions about completing this form, please call the State Board of Elections at (217)782-4141 or (312)814-6440 (or webmaster@elections.il.gov).

TO COMPLETE THIS FORM:

- 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-If you have never registered before, leave blank. If you do not remember your former address; provide as much information as possible.
- Box 5-If you have not changed your name, leave blank.
- Box 9-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.
- 10-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 neighbors names.



TYPE OR PRINT CLEARLY IN BLACK OR BLUE INK

Are you a citizen of the United States of America? (check one) ◯ Yes ◯ No

Will you be 18 years of age on or before election day? (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 (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 | Zip Code | County | Township

4. Former Registration Address: (include City and State and Zip Code) | Former County | 5. Former Name: (if changed)

6. Date of Birth: MM/DD/YYYY

7. Sex (check one) ◯ Male ◯ Female

8. Home Telephone number including area Code (optional)

9. 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 SSN _____
☐ I have none of the above-listed identification numbers

10. Voter affidavit - Read all statements and sign within the box to the right.

This is my signature or mark in the space below.

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;
- 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.

Today's Date: _____

11. 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. _____

YOUR ADDRESS

PUT
FIRST
CLASS
STAMP
HERE

MAIL TO:

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																				

State of Illinois
Department of Healthcare and Family Services

Application for Health Coverage & Help Paying Costs

Use this application to apply for health coverage.

- Health coverage means Medicaid, All Kids, or insurance you buy from the Health Insurance Marketplace.
- You can get comprehensive benefits to help you stay well.
- You may qualify for low-cost coverage under Medicaid or All Kids or you may qualify to get a tax credit to help pay your premiums for health insurance from the Health Insurance Marketplace.

Do not use this application if you want to apply for SNAP or cash assistance at the same time. By using this application, you are stating that you only want to apply for health coverage and you do not want to apply for SNAP or cash assistance.

Apply faster online.

You can apply faster online at **ABE.Illinois.gov**.

Who should use this application?

- Use this application to apply for health coverage for children, parents or other caretaker relatives raising dependent children, pregnant women and other adults older than 19, but younger than age 65.
- If someone is helping you fill out this application, you may need to complete Appendix C.
- Immigrants can apply. You can apply for your children even if you do not qualify for coverage. Applying will not affect your immigration status or your chances of becoming a permanent resident or citizen.

Seniors, persons on Medicare and people who receive SSI or SSDI payments from Social Security should apply online at **ABE.illinois.gov** or use a different paper application, Form 2378H. You can get it at: http://www2.illinois.gov/hfs/SiteCollectionDocuments/hfs2378h.pdf or call the number below.

What you may need to apply.

- Social Security numbers or document numbers for any legal immigrants who need health coverage.
- Employer and income information for everyone in your family. You can get this from paystubs, W-2 forms, or wage and tax statements.
- Policy numbers for any current health insurance.

Information about any job-related health insurance you can get.

Why do we ask this information?

We ask for the information to decide what health coverage you qualify for and to decide if you can get any help to pay for it.

The law requires that we have to keep all the information you give us private.

What happens next?

Fill out your application, sign it and send it to the address on page 14.

If you cannot answer all the questions, sign your application and send it anyway. We will contact you if we need more information. We will send you a notice when we decide if the people you apply for qualify for Medicaid or All Kids. If anyone does not qualify for Medicaid or All Kids, we will send the information from the application to the Health Insurance Marketplace to see if they can get help to buy insurance.

Get help with this application.

- Online: Log onto **GetCoveredIllinois.gov/get-help/**
- Phone: Call the ABE Customer Call Center at 1-800-843-6154.
- In person: to find a local office near you log-on to: https://www.dhs.state.il.us/page.aspx?module=12&officetype=&county

Step 1: Tell us about yourself. (We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name & Suffix

_____

2. Home address (Leave blank if you don't have one.) 3. Apartment or suite number

_____ _____

4. City 5. State 6. Zip 7. County

_____ _____ _____ _____

8. Mailing address (if different from home address) 9. Apartment or suite number

_____ _____

10. City 11. State 12. Zip 13. County

_____ _____ _____ _____

14. Phone number 15. What is the best number to reach you during the day?

(_____) - _____ - _____ (_____) - _____ - _____

16. Do you want to get information from us by e-mail? ☐ Yes ☐ No

E-mail address: _____

17. Preferred spoken or written language (if not English) ☐ Spanish ☐ Other _____

Step 2: Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't have to file taxes to get health coverage.)

DO Include:

- Yourself
- Your spouse
- Your children under 19 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 19 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 19)
- Other adult relatives who file their own tax return

The amount of assistance and type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, and then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status of a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information to check if you're eligible for health coverage.

PERSON 1 (Start with yourself)

Complete PERSON 1 for yourself. See page 3 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

_____

2. Relationship to you?

SELF

3. Date of birth (mm/dd/yyyy)

_____/_____/_____

4. Sex ☐ Male ☐ Female

5. Social Security Number (SSN): _____ - _____ - _____

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES** **If yes**, please answer questions a - c. ☐ **NO** **If no,** SKIP to question c

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, name of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant or have you been pregnant in the last 3 months? ☐ Yes ☐ No

If yes, how many babies are expected: _____

8. **Do you need health coverage?**

(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES** **If yes,** answer all the questions below**.** ☐ **NO** **If no,** SKIP to the income questions on page 5.

9. **Do you live in a medical facility or nursing home or do you need support services to help you stay in your home to prevent going into a nursing home or other facility?**

☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national**?** ☐ Yes ☐ No

11. **If you aren't a U.S. citizen or U.S. National,** do you have eligible immigration status**?**

☐ Yes Fill in your document type and ID number below.

a. Immigration document type: _____

b. Document ID number: _____

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

e. What is the date of entry into the United States? _____

12. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

14. Were you in foster care at age 18 or older? ☐ Yes ☐ No

15. Are you a full-time student? ☐ Yes ☐ No

16. **If Hispanic/Latino, ethnicity (OPTIONAL - check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

17. **Race (OPTIONAL - check all that apply.)**

☐ White ☐ Black or African American ☐ Asian

☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native

☐ Other _____

Current Job & Income Information

Employed
If you're currently employed, tell us about your income. Start with question 18.

Not employed
Skip to question 28.

Self-employed
Skip to question 27.

Current Job 1:

18. Employer name and address:

_____

19. Employer phone number (_____) - _____ - _____

20. Wages/tips before taxes: ☐ Hourly ☐ Weekly ☐ Every 2 weeks

$ _____ ☐ Twice a month ☐ Monthly ☐ Yearly

21. Average hours worked each week: _____

Current Job 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address:

_____

23. Employer phone number (_____) - _____ - _____

24. Wages/tips before taxes: ☐ Hourly ☐ Weekly ☐ Every 2 weeks

$ _____ ☐ Twice a month ☐ Monthly ☐ Yearly

25. Average hours worked each week: _____

26. **In the past year, did you:**

☐ Change Jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

27. **If self-employed, answer the following questions:**

a. Type of work: _____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

28. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it. **NOTE:** You don't need to tell us about child support, veteran's payment, or supplemental security income (SSI).

☐ None

☐ Unemployment	**$**	_____	How often?	_____
☐ Net farming/fishing	**$**	_____	How often?	_____
☐ Pensions	**$**	_____	How often?	_____
☐ Net rental/royalty	**$**	_____	How often?	_____
☐ Social Security	**$**	_____	How often?	_____
☐ Retirement accounts	**$**	_____	How often?	_____
☐ Alimony recieved	**$**	_____	How often?	_____
☐ Other	**$**	_____	How often?	_____

If other, type: _____

29. DEDUCTIONS: Check all that apply, and give the amount and how often you get it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b.)

☐ Alimony paid: **$** _____ How often? _____

☐ Student loan interest: **$** _____ How often? _____

☐ Other deductions: **$** _____ How often? _____

If other, type: _____

30. YEARLY INCOME: Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year: $** _____

Your total income **next year** (If you think it will be different)**: $** _____

THANKS! This is all we need to know about you.

PERSON 2

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 3 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you. **If you have more than two people to include, make a copy of Person 2 (pages 7 through 10) and complete.**

1. First name, Middle name, Last name, & Suffix

2: Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

_____/_____/_____

5. Social Security Number (SSN): _____

We need this if you want health coverage and have an SSN. Providing an SSN can be helpful if PERSON 2 doesn't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-800-325-0778.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES** **If yes,** please answer questions a - c. ☐ **NO** **If no,** SKIP to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant or have they been pregnant in the last 3 months**?**

☐ Yes ☐ No

If yes, how many babies are expected: _____

9. **Does PERSON 2 need health coverage?**

(Even if PERSON 2 has insurance, there might be a program with better coverage or lower costs.)

☐ **YES** **If yes,** answer all the questions below. ☐ **NO** **If no,** SKIP to the income questions on page 9, Step 2, PERSON 2.

10. **Does PERSON 2 live in a medical facility or nursing home or does this person need support services to prevent them going into a nursing home or other facility?**

☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national**?** ☐ Yes ☐ No

12. **If PERSON 2 isn't a U.S. citizen or U.S. National,** do they have eligible immigration status**?**

☐ Yes Fill in their document type and ID number below.

a. Immigration document type: _____

b. Document ID number: _____

c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No

d. Is PERSON 2 or their spouse or parent a veteran or an active-duty member of the U.S. military?

☐ Yes ☐ No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is 20 or younger:

16. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. **If yes,** end date: _____

b. Reason the insurance ended: _____

17. Is PERSON 2 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL - check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

19. **Race (OPTIONAL - check all that apply.)**

☐ White ☐ Black or African American ☐ Asian

☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native

☐ Other _____

Current Job & Income Information for PERSON 2

Employed
If PERSON 2 is currently employed, tell us about their income. Start with question 20.

Not employed
Skip to question 30.

Self-employed
Skip to question 29.

Current Job 1:

20. Employer name and address:

_____

21. Employer phone number (_____) - _____ - _____

22. Wages/tips before taxes:

$ _____

☐ Hourly ☐ Weekly ☐ Every 2 weeks

☐ Twice a month ☐ Monthly ☐ Yearly

23. Average hours worked each week: _____

Current Job 2: (If PERSON 2 has more jobs and needs more space, attach another sheet of paper.)

24. Employer name and address:

_____

25. Employer phone number (_____) - _____ - _____

26. Wages/tips before taxes:

$ _____

☐ Hourly ☐ Weekly ☐ Every 2 weeks

☐ Twice a month ☐ Monthly ☐ Yearly

27. Average hours worked each WEEK: _____

28. **In the past year, did PERSON 2:**

☐ Change Jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work: _____

b. How much net income (profits once business expenses are paid) will PERSON 2 get from this self-employment this month?

$ _____

30. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often PERSON 2 gets it. **NOTE:** There is no need to tell us about child support, veteran's payment, or supplemental security income (SSI).

☐ None

☐ Unemployment	**$**	_____	How often?	_____
☐ Net farming/fishing	**$**	_____	How often?	_____
☐ Pensions	**$**	_____	How often?	_____
☐ Net rental/royalty	**$**	_____	How often?	_____
☐ Social Security	**$**	_____	How often?	_____
☐ Retirement accounts	**$**	_____	How often?	_____
☐ Alimony recieved	**$**	_____	How often?	_____
☐ Other	**$**	_____	How often?	_____

If other, type: _____

31. DEDUCTIONS: Check all that apply, and give the amount and how often PERSON 2 gets it. If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** Don't include a cost that is already considered in the answer to net self-employment (question 29b).

☐ Alimony paid: **$** _____ How often? _____

☐ Student loan interest: **$** _____ How often? _____

☐ Other deductions: **$** _____ How often? _____

If other, type: _____

32. YEARLY INCOME: Complete only if PERSON 2's income changes from month to month. If you don't expect changes to PERSON 2's monthly income, skip to the next section and complete.

PERSON 2's total income **this year: $** _____

PERSON 2's total income **next year** (If you think it will be different)**: $** _____

THANKS! This is all we need to know about PERSON 2.

Step 3: American Indian or Alaska Native (AI / AN) family member(s)

1. Are you or is anyone in your family American Indian or an Alaska Native?

☐ NO. **If No**, skip to Step 4.

☐ YES. **If Yes**, go to Appendix B.

Step 4: Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ NO. ☐ YES. **If yes**, check the type of coverage and write the person(s) name(s) next to the coverage they have.

☐ Medicaid _____

☐ CHIP _____

☐ Medicare _____

☐ TRICARE (Don't check if you have direct care or Line of Duty)

_____

☐ VA health care programs _____

☐ Peace Corps _____

☐ Employer insurance _____

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other _____

Name of health insurance: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?**
Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ YES. **If yes,** you'll need to complete and include Appendix A.

Is this a state employee benefit plan? ☐ Yes ☐ No

☐ NO. **If no,** continue to Step 5.

Step 5: Other Questions

33. Is anyone on this application currently in jail or prison? ☐ Yes ☐ No

If yes, who? _____

If they have a release date, show it here: _____

34. Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No

Step 6: Read carefully and sign this application. These are your Rights and Responsibilities as an applicant for medical benefits.

1. We will keep what you tell us private as required by law.

2. Be sure to answer the questions correctly. We may check all information on your application. You must help us if we ask you to prove that your information is correct.

3. We will use the information you provided as well as information from other sources such as Social Security benefits, unemployment insurance, unearned income and wages from employment to decide if you qualify.

4. You agree the state may seek reimbursement for services the state covered for your family if those services should have been paid for by any other health coverage your family may have.

5. If we pay medical bills for you, you give your right to collect medical support payments to the State of Illinois. You must help us if we ask you to establish parentage or obtain medical support payments for members of your family. You may not have to do this if you have a good reason not to. Your children can get health insurance even if you do not help us when we ask you to help.

6. You must apply for other financial benefits for which you may qualify such as Social Security Benefits or Unemployment Insurance.

7. We will not share any information about immigration of any person who does not have an Alien Registration Number. We will verify the immigration status of any person if you gave us their Alien Registration Number. To do that, we will check the number with the U.S. Citizenship and Immigration Service (USCIS). We may send other information to USCIS, such as copies of proof you sent of an Alien Registration Number and the person's Social Security Number, if they have one.

8. If you are seeking benefits as a person with a disability, you authorize staff at the Illinois Department of Healthcare and Family Services (HFS) and the Illinois Department of Human Services (DHS) to obtain information from your records or copy your records from the Social Security Administration (SSA) with respect to any claims for disability benefits and all related appeals. You certify that you understand that the materials requested may be protected under state and federal privacy laws. You authorize release of any material protected under state and federal privacy laws to the staff of HFS and DHS.

9. Some families or individuals have to make a payment each month for this health insurance. This payment is called a premium. The amount of the premium depends on the family's income.

10. Some families or individuals have to pay part of the bill when they visit the doctor, go into the hospital or get a prescription filled. These payments are called co-payments. The amount of the co-payment depends on the family's income.

11. You must report changes within 10 days if any of the following happens:

- Your income changes.
- The number of people in your family who live with you changes.
- Your address or phone number changes.
- Someone who gets health benefits moves out of Illinois, dies, or goes to jail or prison.
- Someone becomes covered by other insurance.

12. You understand that anyone who knowingly misuses the medical card issued by or on behalf of the State of Illinois may be committing a crime.

13. You understand that if you have given false information or intentionally failed to disclose information, you may be subject to civil prosecution, criminal prosecution or both.

14. You may withdraw your application or cancel your benefits at any time.

15. The State of Illinois does not discriminate on the basis of race, color, national origin, sex, age, or disability, religion or political belief. The State of Illinois provides reasonable accommodations according to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

16. If you are not satisfied with the actions taken on your application, you have the right to a fair hearing. You can ask for a fair hearing by calling 1-800-435-0774 (TTY: 1-877-734-7429), by writing to the Department of Human Services, Bureau of Hearings. at 401 South Clinton Street, 6th Floor, Chicago, IL 60607, or by e-mailing your request to **DHS.BAHNewAppeal@illinois.gov**. The call is free. Use this phone number, e-mail and address only for appeal-related inquiries. All other inquiries should be directed to 1-800-843-6154 (TTY 1-800-447-6404.)

17. You understand that if you or anyone you have applied for is not eligible for Medicaid or All Kids, the state will send the information from the application to the Health Insurance Marketplace. The Health Insurance Marketplace needs detailed information about health coverage that your employer may offer even if you do not take it. The information requested on Appendix A may be required if the state sends your application to the Health Insurance Marketplace.

18. If you qualify to buy health insurance from the Marketplace, to make it easier to determine your eligibility for help paying for it in the future years, you agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send you a notice, let you make any changes, and you can opt out at any time. Indicate below if you agree and for how many years. Check only 1 box.

☐ 5 years - This is the maximum number of years allowed, or check

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ Do not use information from tax returns to renew my coverage.

Sign this application. The person who filled out Step 1 should sign this application. If you are an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

_____ _____/_____/_____

Signature Date (mm/dd/yyyy)

Step 7: Mail completed application.

Mail your signed application to:

Illinois Department of Healthcare and Family Services
P.O. Box 19122
Springfield, IL 62794-9122

If you want to register to vote, you can complete a voter registration form at **www.elections.il.gov**.

Appendixes:

Appendix A - Health Coverage from Jobs
Appendix B - American Indian or Alaskan Native Family Member (AI / AN)
Appendix C - Assistance with Completing this Application

APPENDIX A Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)

_____

2. Employee Social Security number

_____ - _____ - _____

EMPLOYER Information

3. Employer

_____

4. Employer Identification Number (EIN)

_____ - _____ - _____

5. Employer address

_____

6. Employer phone number

(_____) - _____ - _____

7. City

_____

8. State

_____

9. Zip

_____

10. Who can we contact about employee health coverage at this job?

_____

11. Phone number (if different from above)

(_____) - _____ - _____

12. E-mail address

_____

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage?

_____/_____/_____
Date (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

_____ Name

_____ Name

_____ Name

☐ **No** (Stop here and go to Step 5 in the application.)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much will the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

_____

Date of change (mm/dd/yyyy)

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed health benefit costs covered by the plan is no less than 60 percent of such costs. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security Number in boxes 1 and 2 and ask the employer to fill out the rest of the form.

EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)

_____

2. Employee Social Security number

_____ - _____ - _____

EMPLOYER Information

Ask the employer for this information.

3. Employer

_____

4. Employer Identification Number (EIN)

_____ - _____ - _____

5. Employer address (the Marketplace will send notices to this address)

_____

6. Employer phone number

(_____) - _____ - _____

7. City

_____

8. State

_____

9. Zip

_____

10. Who can we contact about employee health coverage at this job?

_____

11. Phone number (if different from above)

(_____) - _____ - _____

12. E-mail address

_____

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?

_____/_____/_____
Date (mm/dd/yyyy)

☐ **No** (Stop and return this form to the employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return the form to the employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much will the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return the form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

_____/_____/_____

Date of change (mm/dd/yyyy)

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed health benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986.)

APPENDIX B American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native Family Member(s)

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. NAME	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name ☐ No	☐ Yes **If yes**, tribe name ☐ No
3. Has the person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:	$ _____ How often?	$ _____ How often?

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties.
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations.
- Money from selling things that have cultural significance.

If you need help, visit GetCoveredIllinois.gov or call 1-800-843-6154. If you use a TTY call 1-800-447-6404.
Tenemos esta solicitud en español. For other languages, call 1-800-843-6154.

APPENDIX C Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

_____

2. Address

_____

3. Apartment or suite number

_____

4. City

_____

5. State

_____

6. ZIP code

_____

7. Phone number

(_____) - _____ - _____

8. Organization name

_____

9. ID number (if applicable)

_____

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

_____

10. Signature

_____/_____/_____

11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

_____

2. First name, Middle name, Last name & Suffix

_____

3. Organization name

_____

9. ID number (if applicable)

_____

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION

☐ Paper Application ☒ Online Application

TRANSMITTAL NUMBER:	**STATE:**
13-0017-MM2	Illinois

Through December 31, 2015, the state is using an interim alternative single streamlined application. After December 31, 2015, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.