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

00041
IMR7AZE
00-IMR2BR1E-5
LTC - EN
HH_NAME (LTC_ENGLISH)
ADDRESS LINE1
ADDRESS LINE2
CITY ST

9040101

February 12, 2014

Case ID: 044044010011Y

Dear HH_NAME (LTC_ENGLISH),

It is time to renew your medical coverage!

It's time for renewal, also known as "redetermination" or "re-de."

Here's what to do:

1. Answer all questions on this form.
2. Make sure all the information is correct. If any information is wrong, cross it out and write in the correct information.
3. Sign this form at the bottom of **page 4**. If someone helped you, have them sign it too.
4. Attach proof documents for income and expenses and other proofs we ask for.
5. Send your signed form and all proofs by **February 25, 2014**.

Send your form and proofs to us one of these ways:

→ **Fax** your form and proofs to 1-866-661-7025

→ **Mail** your form and proofs in the envelope that we sent you

→ **E-mail** your form and proofs to www.medredes.hfs.illinois.gov

Your medical benefits may end if you do not send your proofs by February 25, 2014.

Call us at 1-855-458-4945 (TTY: 1-855-694-5458) if you cannot send everything on time or if you have questions. We may be able to help you get the proofs you need.

Thank you,

Illinois Medicaid Redetermination

Questions? Call **1-855-458-4945** (TTY: 1-855-694-5458). The call is free!
Monday to Friday from 7 a.m. to 7:30 p.m. and Saturday from 8 a.m. to 1 p.m.
E-mail us at **www.medredes.hfs.illinois.gov** or send a fax to 1-866-661-7025.
Tenemos información en español. ¡Servicio de intérpretes gratis!
Llame al 1-855-458-4945.

State of Illinois
Department of Healthcare and Family Services
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Illinois Medicaid Redetermination

Long Term Care Renewal Form

9040101

Case ID: 044044010011Y

If you have questions about this form:

Please call us at **1-855-458-4945** (TTY: 1-855-694-5458). You can call Monday to Friday from 7 a.m. to 7:30 p.m. and Saturday from 8 a.m. to 1 p.m. The call is free! Tenemos información en español. ¡Servicio de intérpretes gratis! Llame al 1-855-458-4945.

Section A: Income	**Check Your Answer**		**Amount / Month**
1. Do you get money from any of the following sources?	Yes	No	
a. Social Security	☐	☐	
b. Supplementary Security Income	☐	☐	
c. Veterans Benefits	☐	☐	
d. Railroad Retirement	☐	☐	
e. Pension	☐	☐	
f. Income from Property	☐	☐	
g. Black Lung Benefit	☐	☐	
h. Contribution	☐	☐	
i. Other _____	☐	☐	
2. Do you get paid for working?	☐	☐	

If YES, complete the following information:

Employer Name
(If self-employed, enter self) _____

Address: _____

How often paid _____

HFS 1229A (R-6-13)

02-05-1

Section B: Resources

	Check Your Answer		Value
1. Do you have any of the following resources?	Yes	No	
a. Cash	☐	☐	
b. Savings Account	☐	☐	
c. Checking Account	☐	☐	
d. Nursing Home Resident Account	☐	☐	
e. Burial Funds	☐	☐	
f. Mutual Funds, Stocks, Bonds	☐	☐	
g. Certificates of Deposit	☐	☐	
h. Annuities	☐	☐	
i. Trust Funds	☐	☐	
j. IRA or Keough Account	☐	☐	
k. Oil, Coal, Gas or Mineral Rights	☐	☐	
l. Promissory Notes	☐	☐	
m. Inheritance	☐	☐	
n. Business or Farm Income Producing Property	☐	☐	
o. Other _____	☐	☐	
2. Do you own or pay on a house or mobile home?	☐	☐	
If YES:			
a. Do you regard the property as your home and intend to return to it?	☐	☐	
b. Does your spouse, minor child, disabled child, adult child who provided care and lived in the home for 2 years, or your brother or sister live in the property?	☐	☐	
c. Is the property vacant?	☐	☐	
d. Does the property produce income?	☐	☐	
e. Is the property listed for sale?	☐	☐	
3. Do you own or pay on any other land or buildings?	☐	☐	
If Yes:			
a. Is the property listed for sale?	☐	☐	
b. Does the property produce income?	☐	☐	
4. Do you have life insurance?	☐	☐	

Name of Company _____

Policy Number _____ Face Value $ _____

Name of Company _____

Policy Number _____ Face Value $ _____

	Yes	No
5. Do you have health insurance?	☐	☐
Does it cover long term care?	☐	☐

Name of Company _____ Policy Number _____

Premium Amount $ _____ How Often Paid _____

Section B: Resources (continued) Yes No

6. Do you have other insurance? ☐ ☐
   Does it cover long term care? ☐ ☐

Name of Company _____ Policy Number _____

Premium Amount $ _____ How Often Paid _____

Section C: Transfer of Resources

During the preceding year, have you:

- Consulted with a financial planner or an attorney? Yes ☐ No ☐
- Sold or given away any resources such as cash, house, land, insurance, stocks, certificates of deposit, etc.? Yes ☐ No ☐
- Closed any savings, checking or other financial institution accounts? Yes ☐ No ☐
- Changed the way any resource is held? This includes, but is not limited to, adding a name to a house or deed or creating a trust. Yes ☐ No ☐

If YES to any of the above, enter the following information about each transfer:

1. Person who transferred the resources: _____

   Description of resources: _____

   Date transferred: _____ Value: _____ Amount Received: _____

   Action taken (check only one):

   Resources Sold ☐ Resources Given Away ☐ Change in Ownership ☐

   If ownership changed, describe the change in the way the resource is held:

   _____

   _____

   Reason for transfer: _____

2. Person who transferred the resources: _____

   Description of resources: _____

   Date transferred: _____ Value: _____ Amount Received: _____

   Action taken (check only one):

   Resources Sold ☐ Resources Given Away ☐ Change in Ownership ☐

   If ownership changed, describe the change in the way the resource is held:

   _____

   _____

   Reason for transfer: _____

If more transfers were made, please attach an additional page.

Section D: Income Diversion

This section does not affect your eligibility for medical assistance. It will affect the amount you must pay the facility where you live.

Are you giving a part of your monthly income like Social Security or a pension to your spouse in the community, your children or other dependent family members living with your spouse in the community, or children under age 21 not living with your spouse? Yes ☐ No ☐

1. **If the answer is no**, do you want to **start** giving part of your income to these family members? Yes ☐ No ☐
2. **If the answer is yes**, do you want to **continue** to give a part of your income to these family members? Yes ☐ No ☐
3. **If the answer is yes to #2**, after we complete a current calculation, do you want to increase the amount diverted to your family if more is available to do so? Yes ☐ No ☐

If the answer to 1, 2 or 3 is "yes", please provide the information below about your spouse or other dependent family members in the community.

Name of Person	Amount You Want to Give

You must give us verification of the income of the person(s) you name above if you want to start or increase the amount of your income you give them.

Section E: Customer Statement and Signature

If the state pays your medical bills, you agree to give your right to collect medical support payments to the State of Illinois.

When you sign this form, you certify the information given is true and correct to the best of your knowledge and that you have read this statement and understand it. You understand that giving false information can result in referral for prosecution for fraud. You are required to report any future changes to the information given on this form to your caseworker within ten (10) calendar days. **Check to be sure you answered all of the questions. It is very important for you to complete and return this form.**

Signature of person completing this form _____ Date _____

Your relationship to the customer _____ Phone number where we can call you _____

Your Address:

Street _____ City _____ State _____ Zip Code _____

Voters Registration Information

If you want to apply to register to vote, fill out all the enclosed Voter Registration Application SBE (R-19) and return it to your local Department of Human Services (DHS) Family Community Resource Center (FCRC) or your local election official. If you would like assistance or need translation services, contact your DHS FCRC.

You may also call the Helpline at 1-800-843-6154, or 1-800-447-6404 (for TTY).

For information online, see

 or 

www.dhs.state.il.us www.elections.il.gov/

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

Distribution: Original to customer
Copy to community spouse, if applicable
Copy to representative, if applicable
File

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 Comissioners** 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:

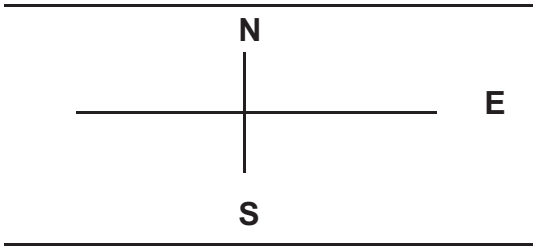
- If you do not have a driver's license, State Identification Card or social security number, and this form is submitted by mail, and you have never registered to vote in the jurisdiction you are now registering in, then you must send, with this application, either (i) a copy of a current and valid photo identification, or (ii) a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows the name and address of the voter. If you do not provide the information required above, then you will be required to provide election officials with either (i) or (ii) described above the first time you vote 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.

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.



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

TYPE OR PRINT CLEARLY IN BLACK OR BLUE INK

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

Office Use

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

1. Last Name | First Name | Middle Name or Initial | Suffix (Circle One) Jr. Sr. II III IV

2. Address where you live (House No., Street Name, Apt. No.) | City/Village/Town | Zip Code | County | Township

3. Mailing address (P.O. Box) | City/Village/Town, State | Zip Code

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

5. Former Name: (if changed)

6. Date of Birth: MM/DD/YY

7. Sex (circle one) M F

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 Social Security Number
   - ☐ I have none of the above-listed identification numbers.

10. Voter Affidavit – Read all statements and sign within the box to the right.

I swear or affirm that

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

This is my signature or mark in the space below.

Today's Date: _____/_____/_____

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																			