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

AGENCY USE ONLY
Date Received

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Case Number

Mail-In Application For Payment of Medicare Premiums, Deductibles and Coinsurance

This application is available in Spanish.
Esta solicitud está disponible en español.

Apply now. Print in ink. Answer all the questions. If you wish, you may have someone help you complete this application. If you need more space for any answers, use an extra sheet of paper.

Note: This is NOT an application for medical assistance, cash assistance, or food stamps. If you want to apply for these programs, contact your local Department of Human Services (DHS) Family Community Resource Center (FCRC) or visit their website at **www.dhs.state.il.us**.

If you are interested in registering to vote, please go to **www.elections.il.gov/** or call the Department of Human Services Helpline at 1-800-843-6154 (TTY: 1-800-447-6404). If you would like assistance or need translation services, please contact your FCRC.

PERSONAL INFORMATION

Name
(Last, First) _____

Do you live in a nursing home or assisted living facility? ☐ Yes ☐ No

If yes, write the name of the home or facility: _____

Street Address
(Where you currently live) _____

City _____ State _____ Zip _____

County _____ Phone _____

Mailing Address
(If different from above) _____

Date of Birth _____ Social Security Number _____ Sex of Applicant ☐ Male ☐ Female

What language do you use the most?

☐ English ☐ Spanish ☐ Other (Specify) _____

List all persons living with you. Include your spouse and children under the age of 18.

Name	Date of Birth	Relationship
1)	1)	1)
2)	2)	2)
3)	3)	3)

Are you a U.S. Citizen?

☐ Yes ☐ No

If no, write alien registration number: _____

Send in copy of your registration card.

Your answers to these questions will not affect our decision.

Are you Hispanic or Latino?

☐ Yes ☐ No

What is your race? (Mark all that apply)

☐ White
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ Native American Indian or Alaska Native
☐ Asian
☐ Other _____

HEALTH INSURANCE You must report all health insurance you have now.

Medicare Coverage (Send in copy of Medicare card with the application.)

Do you have Medicare Part A? ☐ Yes ☐ No

If yes, when did your coverage begin? _____

Do you have Medicare Part B? ☐ Yes ☐ No

If yes, when did your coverage begin? _____

Medicare Claim Number: _____

List private health insurance, group health insurance, or a plan through your most recent employer.

Do you have health insurance? ☐ Yes ☐ No If yes, list the name of the insurance.

Name of Insurance Company: _____ Certificate/Policy #: _____

If insurance is through employer/union, enter employer or union.

Name: _____ Street: _____

City: _____ State: _____ Zip: _____

Check all the following benefits provided:

☐ Major Medical ☐ Dental ☐ Vision ☐ Long Term Care ☐ Prescriptions

ASSETS

List any property that you or your spouse own. Do not list the house you live in.

Address	Current Value	If you are still paying for this item, how much do you owe?
1)	$	$
2)	$	$

List any car, truck, motorcycle, boat, trailer, or other vehicle that you or your spouse owns.

Owner(s)	Year	Make/Model/Type	Current Value	If you are still paying for this item, how much do you owe?
1)			$	$
2)			$	$

Tell us if you or your spouse pays child support or spousal support.

Name of Person	How much do you pay?	How often do you pay?
1)	$	
2)	$	

Do you or your spouse own any of the following assets? Check all that apply. ☐ Yes ☐ No

- ☐ Checking Account
- ☐ Savings
- ☐ Mutual Funds
- ☐ Trust Funds
- ☐ Annuity Deposits
- ☐ Funeral/Burial Plans
- ☐ Government Bonds
- ☐ Certificate of Deposit
- ☐ Burial Plots
- ☐ Nursing Home Accounts
- ☐ Money Market Accounts
- ☐ Stocks/Bonds
- ☐ Mineral/Oil Rights
- ☐ IRA
- ☐ Other List, if other:

Owner	Type of Asset	Account/Policy #	Value	Name of Bank, Company, etc.
1)	1)	1)	$	1)
2)	2)	2)	$	2)
3)	3)	3)	$	3)
4)	4)	4)	$	4)

Do you or your spouse have life insurance?

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value
1)	1)	1)	$	$
2)	2)	2)	$	$

INCOME AND EARNINGS

Tell us about the money that you or your spouse gets from any source. List the income amount before deductions (such as taxes or insurance). Income includes, but is not limited to:

Social Security	**SSI**	**Wages/Self-Employment**
Railroad Retirement Benefits	**Veteran's Benefits**	**Trust or Annuity Payments**
Pensions/Retirement Benefits	**Rental Income**	**Royalties, Oil/Mineral Rights**

Name of Person Who Receives Income	Type of Income	Employer or Source of Income	Amount	How Often Received?	Claim Number (if applicable)
1)	1)	1)	$	1)	1)
2)	2)	2)	$	2)	2)
3)	3)	3)	$	3)	3)

If you or your spouse get money from a job, answer the following questions or send us pay stubs received during the last month. You can get certain deductions if you tell us about them. These deductions may help you become eligible. If you do not provide this information to us, we will make the decision from the information you provided.

What are your earned income deductions?		What are your spouse's earned income deductions?	
Federal Tax	**$**	**Federal Tax**	**$**
State Tax	**$**	**State Tax**	**$**
FICA	**$**	**FICA**	**$**
Medicare	**$**	**Medicare**	**$**
Retirement	**$**	**Retirement**	**$**
Union Dues	**$**	**Union Dues**	**$**
Insurance	**$**	**Insurance**	**$**

If you or your spouse gets money from a job or self-employment answer the following questions:

Do you buy or bring lunch to work?	☐ Yes	☐ No
Does your spouse buy or bring lunch to work?	☐ Yes	☐ No
Do you buy uniforms or special tools for work? **If yes, how much monthly: $** _____	☐ Yes	☐ No
Does your spouse buy uniforms or special tools for work? **If yes, how much monthly: $** _____	☐ Yes	☐ No
Do you pay for child care so you can work? **If yes, how much monthly: $** _____	☐ Yes	☐ No
Does your spouse pay for child care so they can work? **If yes, how much monthly: $** _____	☐ Yes	☐ No

How do you get to and from work?	**How does your spouse get to and from work?**
☐ **Bus** **Amount: $** _____ **How often paid:** _____	☐ **Bus** **Amount: $** _____ **How often paid:** _____
☐ **Taxi** **Amount: $** _____ **How often paid:** _____	☐ **Taxi** **Amount: $** _____ **How often paid:** _____
☐ **Train** **Amount: $** _____ **How often paid:** _____	☐ **Train** **Amount: $** _____ **How often paid:** _____
☐ **Car** **Weekly miles:** _____	☐ **Car** **Weekly miles:** _____
☐ **Other (describe):** _____ **Amount: $** _____ **How often paid:** _____	☐ **Other (describe):** _____ **Amount: $** _____ **How often paid:** _____

Read and Sign

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

If we pay medical bills for you, you give your right to collect medical support payments to the State of Illinois. You agree the state may seek reimbursement for services the state covered for you if those services should have been paid for by any other health coverage you may have.

You agree that the state may release information about medical services that you have received through any program paid for by medical assistance for any purpose authorized by law.

You must tell your caseworker within 10 days if any of the following happens:

- Your income or assets change.
- The number of people in your family who live with you changes.
- You move to a new home in Illinois.
- You move out of Illinois.

Anyone who misuses your medical benefits may be committing a crime.

I declare under penalty of perjury that I have read all statements on this form and the information I give is true, correct and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information.

Applicant's Signature: _____ Date: _____

(If unable to sign, make a mark and have a witness sign next to your mark.)

If someone completed this application for you, they must sign and complete the information below.

Signature: _____ Date: _____

Name (print): _____ Relationship to Applicant _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____

Final Checklist - Keep this page for your records.

✓ Did you answer all the questions?

✓ Did you sign and date the application?

✓ Do you have copies of all the proofs we said you would need?

✓ Mail your application along with copies to your local Family Community Resource Center. You may call 1-800-843-6154 (TTY 1-800-447-6404) to find the office near you. The call is free.

Next Steps

- If any information changes after you send in the application, call 1-800-843-6154 (TTY 1-800-447-6404). The call is free.
- We will review your application as quickly as possible.
- If we find something missing, we will send you a letter telling you what else to send.
- Please allow 45 days for us to make a decision.

If you are not satisfied with the actions taken on this 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) or by writing to the Department at 401 South Clinton Street, 6th Floor, Chicago, IL 60607. The call is free. Use this address only to ask for a fair hearing. **DO NOT SEND APPLICATION TO 401 SOUTH CLINTON.**

Medical benefits programs comply with all state and federal laws, rules and regulations pertaining to equal access regardless of sex, race, disability, national origin, religion, or age. The State of Illinois is an equal opportunity employer that practices affirmative action. 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.

To file a complaint of discrimination, contact any or all of these offices:

Illinois Department of Human Services (DHS)
Bureau of Civil Affairs
401 South Clinton Street, 4th Floor
Chicago, Illinois 60607

Illinois Department of Healthcare and Family Services (HFS)
EEO/AA Office
401 South Clinton Street, 7th Floor
Chicago, Illinois 60607

U.S. Department of Health and Human Services (HHS)
Director, Office for Civil Rights
Room 506-F,
200 Independence Avenue, S.W.
Washington, D.C. 20201
Call
(202) 619-0403 (voice) or
(202) 619-3257 (TTY)

OTHER BENEFIT PROGRAMS OFFERED BY THE STATE OF ILLINOIS

You may also qualify for these programs:

- **Home and Community Based Services -** You or your family members may also qualify for one of the Illinois home and community based services programs. These programs allow eligible individuals to either remain in their own home or live in a community setting, rather than an institutional setting such as: a hospital, nursing home or intermediate care facility for the developmentally disabled. For more information, visit **www.hfs.illinois.gov/hcbswaivers/**

- The **Low Income Home Energy Assistance Program (LIHEAP)** helps qualified households pay for winter energy services. The amount of the benefit depends on income, household size, fuel type and geographic location. For more information, visit **www.liheapillinois.com**

- The **Illinois Department of Human Services' Child Care Program** provides low-income, working families with access to quality, affordable child care. Parents can learn about childcare in their community and see if they qualify for a subsidy by contacting their local Child Care Resource and Referral agency (CCR&R). Visit **www.ilchildcare.org** or call 1-800-649-1884 to find your local CCR&R. The call is free.

Here are other medical programs your friends or neighbors might use:

- **Veteran's Care** offers access to affordable, comprehensive healthcare to veterans across Illinois. Veterans pay an affordable monthly premium and receive medical, dental and vision coverage. For additional information, please visit **www.illinoisveteranscare.com** or call 1-877-4VETS-RX (TDD: 1-877-504-1012). The call is free.

- **Illinois Cares Rx** provides a safety net for seniors and persons with disabilities so they won't have to pay more out out of pocket under the Medicare drug plan. To find out more, visit **www.illinoiscaresrx.com** or call the Illinois Health Benefits hotline at 1-800-226-0768 (TTY: 1-866-675-8440). The call is free.

- The **Illinois Rx Buying Club** provides an average discount of 24% at many Illinois pharmacies. To get more information or to enroll visit **www.illinoisrxbuyingclub.com** or call 1-866-215-3462 (TTY: 1-866-215-3479). The call is free.

- **Health Benefits for Workers with Disabilities** is a comprehensive healthcare program for employed persons with disabilities. Working individuals between the ages of 16 and 64 may be eligible. To download an application, visit **www.hbwdillinois.com** or call 1-800-226-0768 (TTY: 1-866-675-8440). The call is free.

- The **Illinois Breast and Cervical Cancer Program (IBCCP)** provides cancer screening and treatment for eligible women between 35 and 64 years old (younger women may be eligible in some cases). To find out if you qualify visit **www.cancerscreening.illinois.gov** or call the Women's Health Line 1-888-522-1282 (TTY: 1-800-547-0466). The call is free.

- The **Illinois Healthy Women (IHW)** program provides family planning and related services for women between 19 and 44 years old. To find out if you qualify, visit **www.ihwillinois.com** or call the Health Benefits hotline at 1-800-226-0768 (TTY: 1-866-675-8440). The call is free.