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

Mail-In Application for Medical Benefits

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

Medical benefits are available to eligible persons who need help paying their medical bills. Anyone who wants to apply for medical benefits may use this application.

This is **NOT** an application for cash assistance or food stamps. If you want to apply for those programs, contact your local Department of Human Services (DHS) office.

WHAT MEDICAL SERVICES ARE COVERED?

Most needed medical services are covered. Payment will not be made for services that are free or paid for by another source, like health insurance. The following services are covered:

- hospital care
- nursing facility care
- doctor services
- prescription drugs
- shots and check-ups for children
- care at clinics
- physical occupational and speech therapy
- laboratory tests and x-rays
- help for alcohol and substance abuse
- medical equipment, supplies and appliances
- medical transportation
- hospice care
- home health care services
- renal dialysis
- family planning
- eye care
- podiatry care
- dental care
- chiropractic care
- audiology services
- mental health care

WHERE CAN YOU GET THESE MEDICAL SERVICES?

You may go to any medical provider who accepts payment from the Department of Healthcare and Family Services.

HOW LONG DOES THE APPLICATION PROCESS TAKE?

If you are applying because you have a disability, DHS will send you a notice to tell you if you are eligible for medical benefits within 60 days of the date you apply. If you do not have a disability, the notice will be sent within 45 days.

WHERE DO YOU SEND THIS APPLICATION?

Mail the application to your local DHS office. If you do not know the address, call toll-free 1-800-843-6154. Persons using a teletypewriter (TTY), call toll-free 1-800-447-6404.

INSTRUCTIONS: Read the application carefully and follow all instructions.

1. A separate application must be completed for each person who is blind, has a disability or is age 65 or older.

2. **Complete pages 1 - 5 of the application.** Depending on your situation, also complete the attached **Forms A through H**. Be sure to mail all documents together. Answer questions completely and accurately. If you cannot answer all of the questions, fill out as much as you can. If you need more space to answer questions, attach an extra sheet. If you have questions, call your local Department of Human Services (DHS) office or call toll-free 1-800-843-6154. Persons using a TTY can call toll-free 1-800-447-6404.

   - Complete **Form A** if anyone applying for medical benefits has Medicare or other health insurance.
   - Complete **Form B** if anyone applying is blind, has a disability or is age 65 or older.
   - Complete **Form C** if anyone applying lives in a long term care facility or a supportive living facility or intends to move to a long term care facility or a supportive living facility, or receives or has applied for services through the Department on Aging's Community Care Program. Complete **Form D** if the person is married.
   - Complete **Form E** if anyone applying is blind, has a disability or is age 65 or older and is employed **or** if a responsible relative living with the person is employed. A responsible relative is a spouse or a parent of a child younger than 18.
   - Complete **Form F** if anyone applying is married, but does not live with his or her spouse.
   - Complete **Form G** if you have a disability, and the Social Security Administration has not decided the person is disabled.
   - Complete **Form H** (Rebate Form for All Kids or FamilyCare) if you are applying for a child or caretaker relative including a parent who is already covered by health insurance or for whom you have arranged for health insurance to begin soon.

3. Sign the application.

4. Attach copies of any required documents to the application. See pages 3 and 4.

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 (if using TTY: 1-877-734-7429) or by writing to : Illinois Department of Human Services, Bureau of Assistance Hearings, 401 South Clinton Street, 6th Floor, Chicago, IL 60607.

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)
EEO/AA Office
401 South Clinton Street, 3rd Floor
Chicago, Illinois 60607

Illinois Department of Healthcare and Family Services (HFS)
EEO/AA Office
401 South Clinton Street, 3rd 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)

INFORMATION TO INCLUDE WITH THE APPLICATION

To get medical benefits, you must provide proof for some of the information you give. Please attach copies of the following documents with this application. Do not send originals. Include all that apply.

- **Income** - Send proof of each type of income listed on the application. If the person applying lives with his or her spouse, include the spouse's income. This may include:
  - Copies of pay stubs for earnings and proof of tips received during the last month. If anyone is self-employed, provide detailed business records that include income and expenses for the last month.
  - Copies of checks for the last month or award letters for Unemployment Benefits, Social Security Benefits and Veteran's Benefits.
  - Copies of checks for the last month or a support order for spousal or child support.
  - Proof of other income including income from trusts, pensions, rental property, etc. Also send proof of expenses tied to rental income.
- **Support Paid** - To get credit for spousal or child support paid, provide proof of payments made in the last month.
- **Child Care Expenses** - If anyone applying for medical benefits pays for child care so they can work, provide proof of payments made in the last month so that they can get credit for those expenses.
- **Documents for U. S. Citizens** - For anyone who is a U.S. citizen and requesting medical benefits, provide one of the following documents: U.S. Passport, Certificate of Naturalization (N-550 or N-570), Certificate of Citizenship (N-550 or N-561). If these are not available, provide one of each of the following:

Place of Birth

- Certified copy of a birth certificate from the state of county where the person was born;
- Final Adoption decree;
- Official military record that shows a place of birth, or
- Papers showing the persons was employed by the U.S. government before 1976.

and

Identity

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

If you receive Medicare or Supplemental Social Security, you do not need to provide proof of your U.S. citizenship or identity.

- **Immigration Documents for Non-Citizens** - If anyone applying for medical benefits is not a U.S. Citizen, provide proof of their immigration status. Proof is a copy of any one of the following:

  - Alien Registration Receipt Card/Permanent Resident Card/Green Card (INS-3A); or
  - Passport with the following stamps or attachments: Arrival-Departure Record with the stamp showing status (I-94), or Resident Alien Form (I-151 or I-551), or Temporary Resident Card (I-688); or
  - A court ordered notice for Asylees; or
  - INS documents with an A-number; or
  - Other proof of lawful immigration status.

  A pregnant woman is not required to provide proof of immigration status.

  Other adults who want medical benefits must provide proof of their immigration status. We will contact the U.S. Bureau of Citizenship and Immigration Services to check their status. Adults must also have been in the U.S. for at least five years. The state can only cover medical care provided in an emergency if we cannot verify an adult's legal immigration status or they have been in the U.S. less than five years.

- **Proof of Pregnancy** - If anyone applying for medical benefits is pregnant, provide a signed statement from her doctor or health clinic that includes the date she is expected to deliver and the number of babies expected.

- **Proof of Application for a Social Security Number** - If anyone applying for medical benefits does not have a Social Security Number, provide a signed statement from the Social Security Administration that application for a number has been made.

- **Medicare or Other Health Insurance** - If anyone applying has Medicare or other health insurance, complete the attached **Form A** or provide a copy (front and back) of the Medicare card or health insurance card. If anyone can get free health insurance through a job or union, provide information about the plan and qualifications.

Persons who are blind, have a disability or are age 65 or older, see next page.

INFORMATION TO INCLUDE WITH THE APPLICATION (cont.)

If anyone applying is blind, has a disability or is age 65 or older, provide proof of the following information if it applies.

- **Age** - If anyone applying for medical benefits is age 65 or older, provide proof of age. This may include a copy of the person's birth certificate, Social Security records, passport or Veteran's Administration records.

- **Disability** - If anyone applying for medical benefits has a disability, provide proof of disability and complete **Form G**. If they get Supplemental Security Income (SSI), or Social Security Disability Insurance (SSDI) benefits, they do not have to provide other proof of disability. If the person does not get SSI or SSDI benefits, provide a current medical report.

- **Employment Expenses** - If anyone applying for medical benefits is employed, complete **Form E.** Also complete **Form E** for an employed spouse or parent of a child under age 18 if they live together. We will deduct the following from earnings if you provide proof of:

  - Federal, State, or City income taxes,
  - Social Security tax,
  - Transportation to work expenses at the most reasonable rate. We allow 24 cents per mile if you use your own car,
  - Special tools and uniforms required for the type of work performed,
  - Union dues, group life insurance premiums, group health insurance premiums and retirement plan withholding, if required as a condition of employment, and
  - For persons with disabilities, special work expenses, such as special transportation to work or a telecommunication device for the hearing impaired, that allow them to work. To be allowed as a deduction, the expenses must be paid by the applicant and not be reimbursed by an agency or other person.

- **Assets** - Send proof of each asset listed on **Form B**. If the person lives with his or her spouse, include the spouse's assets. This may include, but is not limited to, copies of current bank statements, certificates of deposit, life insurance policies, vehicle titles, prepaid burial contracts, trust documents, property deeds, and property tax bills.

- **Assets and Income of Spouse** - Provide proof of a spouse's assets and income, if anyone applying wants to transfer assets and give income to his or her spouse and the person applying:

  - lives in or intends to move to a long term care facility, or
  - lives in or intends to move to a supportive living facility, or
  - receives or has applied for services through the Department on Aging's Community Care Program.

  If any apply, complete **Form D**.

MAIL-IN APPLICATION FOR MEDICAL BENEFITS

AGENCY USE ONLY
Date Received
Recycle Instruction pages 1 through 4 upon receipt of this application.
Case Number

If this application is submitted by a health care facility, enter the date of the applicant's admission to the facility ____________________, the actual or expected discharge date ______________________ and facility name ____.

Answer questions completely and accurately.

1. **APPLICANT -** The applicant is usually the person filling out this Form like the aged or person with a disability; a child's parent, guardian or other relative the child lives with; or a pregnant woman. The information you provide on this application is confidential and may only be used for purposes directly connected with the administration of the medical benefits programs.

Name (Last, First, Middle Initial)			Daytime phone and best time to call you	
			( )	
Street	**City**	**State**	**Zip**	**County**
Mailing Address (If different from above)			**Other phone number**	
			( )	

Language Preference	Race or Ethnic Group
❒ English ❒ Spanish ❒ Other___________	❒ White ❒ Black ❒ Hispanic ❒ Asian or Pacific Islander ❒ American Indian or Alaska Native ❒ Other: ______________

2. PERSONAL INFORMATION

Enter the following for the person applying for medical benefits and all persons living with them. You do not have to give the Social Security Number or the U.S. citizenship status for a pregnant woman or anyone who does not want medical benefits. Attach an extra sheet if more space is needed.

A. Name (Last, First, Middle Initial)	Sex	Birth Date	Relationship to Applicant (wife, son, etc.)	Wants Medical Benefits	U.S. Citizen	Social Security Number
	❒ M ❒ F		Applicant	❒ Yes ❒ No	❒ Yes ❒ No	
	❒ M ❒ F			❒ Yes ❒ No	❒ Yes ❒ No	
	❒ M ❒ F			❒ Yes ❒ No	❒ Yes ❒ No	
	❒ M ❒ F			❒ Yes ❒ No	❒ Yes ❒ No	

2. PERSONAL INFORMATION (cont.)

B. Enter the mother's full name and father's full name for each person under age 18 applying for medical benefits. If a parent does not live with the child, also enter the parent's address.

Child's Name	Mother's Name and Address	Father's Name and Address

C. Is anyone applying a veteran or a spouse, child, widow(er) or parent of a veteran?	❒ Yes ❒ No
If yes, enter the person's name and relationship to the veteran.	

D. Is anyone applying blind or have a disability?	❒ Yes ❒ No
If yes, enter the person's name and complete Form H.	

E. Does everyone applying live in Illinois?	❒ Yes ❒ No
If no, enter the person's name.	

F. If anyone applying is a U.S. citizen, enter their name and the city and state where they were born. Send proof of their identity and their citizenship. See page three of the instructions for more information.

Name	City	State

G. If anyone applying is not a U.S. citizen, enter their name. If the person has a valid Alien Registration Number, enter it also. Send a copy of proof of the Alien Registration Number. See page four of the instructions for more information.

Name	Valid Alien Registration Number

2. PERSONAL INFORMATION (cont.)

H. Does anyone applying live in a long term care or supportive living facility?	❒ Yes ❒ No
If yes, enter the person's name.	
Was the person a resident in the facility prior to 07/01/96?	❒ Yes ❒ No ❒ Unknown
Enter the facility's name, address and telephone number.	

I. Does anyone applying receive or has anyone applied for services through the Department on Aging's Community Care Program?	❒ Yes ❒ No
If yes, enter the person's name.	

J. Is this an application to pay bills for someone who has died?	❒ Yes ❒ No
If yes, enter the person's name and date of death.	

K. Does anyone applying have a legal guardian?	❒ Yes ❒ No
If yes, who has the guardian?	
Name of guardian. Attach copy of guardianship papers.	

L. Is anyone applying pregnant or has anyone been pregnant within the last 3 months?	❒ Yes ❒ No
If yes, enter the person's name, due date and number of babies expected.	

M. Did anyone applying receive any medical service during the 3 months before the month of this application?	❒ Yes ❒ No
If yes, do you want us to decide if they can get help to pay these bills?	❒ Yes ❒ No
If yes, what months?	

N. Is anyone applying covered by Medicare or other health insurance? If yes, complete Form A.	❒ Yes ❒ No

2. PERSONAL INFORMATION (cont.)

O. Does anyone applying have a high cost medical condition?	❒ Yes ❒ No
If yes, enter the person's name:	
Does the person have health insurance for the medical condition or can they get health insurance through a recent employer or through a relative's policy?	❒ Yes ❒ No

P. Can anyone applying get free health insurance through a job or union?	❒ Yes ❒ No
If yes, enter the person's name.	

3. SUPPORT PAID

Does anyone pay support for a person for whom they are legally responsible or for whom there is a court order for support? Attach proof.					❒ Yes ❒ No
If yes, enter the person's name who pays support.					
Amount paid:		How often paid:		Court ordered:	❒ Yes ❒ No

4. INCOME AND BENEFITS

Enter all money that anyone applying for medical benefits receives. If married and living with spouse, also enter any money the spouse receives. If under age 18 and living with a parent, also enter any money the parent receives. Enter the amount before deductions like taxes or insurance. Attach proof. Check all that apply and enter details below:

- ❒ Social Security
- ❒ Pensions/Retirement Benefits
- ❒ Wages/Self-Employment
- ❒ SSI
- ❒ Veterans Benefits
- ❒ Railroad Retirement Benefits
- ❒ Trust or Annuity Payments
- ❒ Child Support
- ❒ Dividends or Interest
- ❒ Royalties, Oil/Mineral Rights
- ❒ Worker's Compensation
- ❒ Rental Income
- ❒ Alimony
- ❒ Contributions
- ❒ Farm Income
- ❒ Disability Benefits
- ❒ Unemployment Benefits
- ❒ Other: ____________________

Person Who Receives Income	Source of Income. If work, enter employer's name.	Amount	How Often?	If Social Security, enter Claim Number

5. CHILD CARE

Do you or does anyone living with you pay for child care so they can work? Attach proof.			❒ Yes ❒ No
If yes, complete the following:			
Child's Name	Care Giver Name	Monthly Amount	Person Paying for Care

For more information call 1-800-843-6154, for persons using TTY, 1-800-447-6404.

Read and Sign

Read carefully, then sign and date the application below.

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

2. Some families 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 income.

3. Some families 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 co-payment depends on the family income.

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

6. 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. Bureau of Citizenship and Immigration Service (USCIS). We may send other information USCIS, such as copies of proof you sent of an Alien Registration Number and the person's Social Security Number, if they have one.

7. You must tell you caseworker within 10 days if any of the following happens.
   - Your income changes.
   - The number of people in your family who live with you changes.
   - You move.
   - Someone who gets health benefits moves out of Illinois, dies, or goes to jail or prison.

8. 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 paternity 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.

9. Anyone who misuses our health insurance card 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 ________________________________
(Make a mark and have another adult sign next your mark if you cannot sign your name.)

If you completed this application on behalf of the Applicant, sign and complete the following.

Signature _____________________________________ Date _______________________ Phone (_____)____________

Name (print) ___________________________________ Relationship to applicant _________________________________

If application is initiated by someone on behalf of the applicant, identify a relative, or other person, who can answer questions about the applicant's financial situation:

Name ____ Home Address _______________________________________

Relationship _______________________________________ Phone ____

FORM A
MEDICARE AND OTHER HEALTH INSURANCE

MEDICARE

Complete for anyone who has Medicare or attach a copy (front and back) of the Medicare card.		
Name	**Medicare Claim Number**	**Effective Date**
		Part A________ Part B ________
		Part A________ Part B ________

HEALTH INSURANCE

Complete for anyone covered by private health insurance or group health insurance, including a plan through their most recent employer or attach a copy (front and back) of the insurance card.

Name of Covered Person: ____

Policy Holder Name: ______________________ Policy Holder's SSN (optional) ___________

Insurance Company ______________________ Certificate/Policy # ________________________

Medical Claims Mailed To:

Name _____________ Street ________________ City ___________ State _____ Zip ______

Prescription Claims Mailed To:

Name _____________ Street ________________ City ___________ State _____ Zip ______

Dates of Coverage: Begin Date _________________ End Date ________________

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

Name _____________ Street ________________ City ___________ State _____ Zip ______

Check all the following benefits provided:

❒ Major Medical ❒ Dental ❒ Vision ❒ LTC ❒ Prescription

Monthly Premium Amount $________________

Name of Covered Person: ____

Policy Holder Name: ______________________ Policy Holder's SSN (optional) ___________

Insurance Company ______________________ Certificate/Policy # ________________________

Medical Claims Mailed To:

Name _____________ Street ________________ City ___________ State _____ Zip ______

Prescription Claims Mailed To:

Name _____________ Street ________________ City ___________ State _____ Zip ______

Dates of Coverage: Begin Date _________________ End Date ________________

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

Name _____________ Street ________________ City ___________ State _____ Zip ______

Check all the following benefits provided:

❒ Major Medical ❒ Dental ❒ Vision ❒ LTC ❒ Prescription

Monthly Premium Amount $________________

FORM B
ASSET 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 assets the spouse owns. If yes to any of the following, enter the details below. Attach proof.

Does anyone own any property such as a home, land or building?				❒ 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 own any of the following assets? Check all that apply:				
❒ checking account ❒ savings ❒ stocks, bonds ❒ mutual funds	❒ trust funds ❒ annuity ❒ funeral/burial plans	❒ government bonds ❒ certificates of deposits	❒ burial plots ❒ nursing home account ❒ money market account	❒ mineral/oil rights ❒ IRA ❒ other _____________
Owner	**Type of Asset**	**Account/Policy #**	**Value**	**Name of Bank, Company, etc.**

FORM C
TRANSFER OF ASSETS

Complete only for persons who live in a long term care facility or a supportive living facility or who intend to move to a long term care facility or a supportive living facility, or who receive or have applied for services through the Department on Aging's Community Care Program.

Have you or your spouse within the past 36 months sold or given away any assets; closed any bank accounts; or made any changes in the way an asset is held (such as, adding a name to a house deed or creating a trust or annuity)?	❒ Yes ❒ No
Have you or your spouse within the past 60 months: 1) Made any transfers from a revocable trust, or 2) created an irrevocable trust that does not permit payment to you? Do you or your spouse have an irrevocable trust that has stopped payment within the past 60 months?	❒ Yes ❒ No
If yes, enter details below. If you need more space, attach an additional page.	

What asset was transferred?				
Who transferred asset?	**Amount Received**	**To whom?**	**Date of Transfer**	**Market Value**
Describe the transfer. For example, was the asset sold, given away, or was there a change in the way the asset was held?				
Why was the asset transferred?				

What asset was transferred?				
Who transferred asset?	**Amount Received**	**To whom?**	**Date of Transfer**	**Market Value**
Describe the transfer. For example, was the asset sold, given away, or was there a change in the way the asset was held?				
Why was the asset transferred?				

FORM D
TRANSFER OF ASSETS AND INCOME TO SPOUSE

Complete only for persons who are married and live in a long term care facility or a supportive living facility or who intend to move to a long term care facility or a supportive living facility, or who receive or have applied for services through the Department on Aging's Community Care Program.

Do you want to transfer assets to your spouse?	❐ Yes ❐ No
If yes, attach copies of your spouse's assets.	

Do you want to give income to your spouse?	❐ Yes ❐ No
If yes, attach copies of your spouse's income.	

Does your spouse live in a long term care facility or a supportive living facility?	❐ Yes ❐ No

Does your spouse receive or has your spouse applied for services through the Department on Aging's Community Care Program?	❐ Yes ❐ No

Does your spouse receive medical benefits through the Department of Human Services or the Department of Healthcare and Family Services?	❐ Yes ❐ No
If yes, enter case number:	

FORM E
EMPLOYMENT 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:			
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 the person buy or bring lunch to work?	❒ Buy Lunch ❒ Bring Lunch		
Does the person buy uniforms or special tools?	❒ Yes ❒ No		
If yes, enter the items bought, how often, and cost. Attach proof.			
How does the person get to and from work?	❒Own Car ❒ Bus ❒ Other		
If person uses own car, how many miles to work?			
If person takes bus, what is the fare to work?			
If other, enter type and cost. Attach proof.			
Must the 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:			
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 the person buy or bring lunch to work?	❒ Buy Lunch ❒ Bring Lunch		
Does the person buy uniforms or special tools?	❒ Yes ❒ No		
If yes, enter the items bought, how often, and cost. Attach proof.			
How does the person get to and from work?	❒Own Car ❒ Bus ❒ Other		
If person uses own car, how many miles to work?			
If person takes bus, what is the fare to work?			
If other, enter type and cost. Attach proof.			
Must the 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:$___________		

FORM F
ABSENT SPOUSE INFORMATION

Enter the following information for each absent spouse.

Absent Spouse's Name			Spouse of Whom?		
Street	**Apt. No.**	**City**	**State**	**Zip**	**County**
Social Security Number					
Monthly Gross Income					
Source of Income (Include employer's name and address)					

Absent Spouse's Name			Spouse of Whom?		
Street	**Apt. No.**	**City**	**State**	**Zip**	**County**
Social Security Number					
Monthly Gross Income					
Source of Income (Include employer's name and address)					

FORM G

Complete this form only for persons who have a disability if the Social Security Administration has not decided the person is disabled.

Name of Person Who Has a Disability

EDUCATION

Highest Grade Completed	At What Age?	Date	Technical or Vocational Training?
			❒ Technical ❒ Vocational
Special Education Classes While in School? If yes, please list.			
❒ Yes ❒ No			
Is the person able to read and write English?			❒ Yes ❒ No
Is the person able to speak English?			❒ Yes ❒ No
If no, what language is spoken?			

WORK HISTORY

Has the person ever worked?					❒ Yes ❒ No
Major activity, if never worked.					
Has the person ever worked?					
Give history of last 3 jobs.					
Job Title and Duties	Dates of Employment			Full Time or Part Time	Reason For Leaving
1.	From:	To:			
2.	From:	To:			
3.	From:	To:			

MEDICAL PROVIDERS TREATING THIS PERSON

Name of Doctor	Doctor’s Phone Number	Doctor’s Address

FORM H

Rebate Form for All Kids and FamilyCare

Use this form if you want All Kids or FamilyCare Rebate.

A rebate is a monthly amount we will pay you if you already pay for health insurance for yourself, your spouse or your children. If you choose to get rebates, you will use your current insurance card to

Only families who have health insurance can get rebate payments. Also, only families with a certain amount of income can get rebates. You may be able to get rebates if your family is like one in the list below:

- ☐ You are the **only** person in your family ➪ You may qualify for rebates if the income you get each month is between $1,087 and $1,633.
- ☐ You have **two** people in your family ➪ You may qualify for rebates if the income you get each month is between $1,464 and $2,200.
- ☐ You have **three** people in your family ➪ You may qualify for rebates if the income you get each month is between $1,841 and $2,767.
- ☐ You have **four** people in your family ➪ You may qualify for rebates if the income you get each month is between $2,218 and $3,333.

To ask for rebates, you must send this form **with** the rest of your application.

Part A

The main person whose name is on the insurance must sign this part of the form. Often this person is called the policyholder. This person may get the health insurance from a job.

Policyholder's name ____
Last First

Home Address ______________________________________ **Apt. #** __________

City ____________________________________ **State** _________ **Zip** ___________

SSN ___ ___ ___-___ ___-___ ___ ___ ___ **Phone** (_____) ______________________________

We must have the SSN (Social Security Number) so we can pay the rebate to this person.

Policy Number ___________________________ **Group Number** ____________________

Tell us the names of the family members you want rebates for.

____

____

I agree to call All Kids/FamilyCare right away if this health insurance ends, someone is added or taken off the health insurance, the amount paid for the insurance changes, covered benefits change or someone else becomes the policyholder.

I authorize my employer, plan administrator and insurance company to provide the information requested in Part B on the next page for the purpose of determining whether I qualify for All Kids/FamilyCare. I also authorize my employer, plan administrator and insurance company to verify my coverage and any of the information below for any time when I get All Kids/FamilyCare Rebate.

Signature of Employee/Policyholder ____________________________________

Need help? Visit www.allkidscovered.com or call 1-866-All-Kids (1-866-255-5437). The call is free.
If you use a TTY, call 1-877-204-1012.

For more information call 1-800-843-6154, for persons using TTY, 1-800-447-6404.

Part B

This part of the form must be completed by the employer providing the health insurance or the insurance agent.

Note to Employer/Insurance Agent: The employee/policyholder named on the front of this form is applying for help to cover the cost of their family's health insurance premiums. Please assist them by completing the information below and returning the form to the employee/policyholder as soon as possible. (As used below, "employee" applies to an employee or private policyholder.) For help in completing this form, call 1-877-805-5312. The call is free.

Employer (if employer policy) ____

Employer address ____

City ______________________ **State** __________________ **Zip** ___________

Person completing this form ____

Phone (______)______________________ **Fax** (______)______________________

Insurance Company__________________ **Policy Number** ______________ **Group Number** ______________

What benefits are covered? ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ monthly ☐ every 2 weeks ☐ quarterly ☐ semi-annually ☐ annually

Persons covered by the employee premium contribution

____

____

Does the employer pay 100% of the cost of the employee's coverage? ☐ Yes ☐ No

If no, how much of the amount listed above is for coverage of the employee only (single rate)?

$____________________ Include amounts for dental, vision and prescription coverage.
Enrollment period for policy ____
Date the premium listed above began or begins ______________________________
Date of next scheduled change in premium __________________________________

Authorized signature of employer/agent ____________________________ **Date** ____________________

Return the completed Rebate Form to the employee for submission with the All Kids / FamilyCare application.

Need help? Visit www.allkidscovered.com or call 1-866-All-Kids (1-866-255-5437). The call is free.
If you use a TTY, call 1-877-204-1012.