

NUTS & BOLTS OF THE MEDICAID APPLICATION PROCESS AND APPEALS

Materials Prepared by:

Catherine E. Lenert

Constance Burnett Renzi

Elder Law Center, P.C./Mickey Wilson Weiler Renzi & Andersson, P.C.

Megan Kinney

Land of Lincoln Legal Assistance Foundation, Inc.

Susan Dawson-Tibbits

Johnson, Bunce & Noble, P.C.

Presented by:

Susan Dawson-Tibbits

Catherine E. Lenert

I. OVERVIEW:

Whether you are a seasoned elder law attorney or an attorney who has recently begun practicing in the area of elder law, reviewing the ever-evolving procedures for filing a Medicaid application is a must. Since January, 2012, there have been numerous changes to the Medicaid eligibility policies, rules, and laws which have significantly impacted the application process for long-term care Medicaid. The Illinois Department of Human Services (IDHS) and Illinois Department of Healthcare and Family Services (IDHFS) have also restructured the internal procedures for the processing of long-term care applications, introduced a new system for on-line filings, and begun a campaign to encourage electronic filings as the primary and preferred filing method. As such, the tried and true methods utilized by attorneys preparing and filing long-term care Medicaid applications should be reviewed and will, more likely than not, require updating. This presentation also provides an overview of the appeal process, which can be very complicated for individuals to navigate. Thus, clients, more than ever, will turn to attorneys for assistance in pursuing long-term care Medicaid benefits.

II. WHERE TO FIND THE APPLICABLE LAWS & POLICIES IMPACTING APPLICATIONS

- A.** Medicaid is a joint federal and state program, and as such, is governed by both federal and state laws and regulations. For Illinois applicants, the following laws and regulations are in place:
- 1.** Federal statutes governing Medicaid are included in Title XIX of the Social Security Act, 42 U.S.C. §1396, *et seq.*
 - 2.** The Centers for Medicare and Medicaid Services (CMS) is responsible for promulgating the rules and regulations interpreting the law, which can be found at 42 C.F.R. part 430, *et seq.*
 - 3.** The Illinois Medicaid Code located at 305 ILCS 5/1-1, *et seq.*, contains the Illinois statutes governing Medicaid in Illinois.
 - 4.** Illinois regulations governing Medicaid are found in 89 Ill. Admin. Code, part 120, *et seq.*
 - 5.** The Illinois Department of Human Services, IDHS, is responsible for administering the program in Illinois.
 - a.** The website for IDHS can be found at: <http://www.dhs.state.il.us/>
 - 6.** The Illinois Department of Healthcare and Family Services, IDHFS, is in charge of day-to-day administration for the program.
 - a.** The website for IDHFS can be found at: <http://www2.illinois.gov/hfs/>

- B.** Practically speaking the nuts and bolts related to preparing an application for long-term care including the timing of the filing and the procedures for filing an application will be found via the resources available on the websites for both IDHS and IDHFS, including but not limited to: the Combined Policy Manual (PM); the Worker's Action Guide (WAG); and Notices, Memorandums, Manual Releases, and other updates posted on these websites.
1. Specifically, The Department's Combined Policy Manual and Worker's Action Guide can be found online at:

<https://www.dhs.state.il.us/page.aspx?item=4107>
 2. Practitioners are strongly encouraged to regularly monitor both of these websites for the posting of Notices; Memoranda; and Manual Releases related to Medicaid for long-term care.

III. ELIGIBILITY REQUIREMENTS & BACKGROUND INFORMATION.

- A.** In order to qualify for long-term care Medicaid, there are some basic requirements that your client needs to meet:
1. The individual must be a resident of Illinois and a U.S. citizen or a non-citizen living in the U.S. with a specific type of Immigration and Naturalization Service status or residing under the color of law.
 2. The individual must be age 65 or over, blind or disabled.
 3. The individual must be within certain resource and income limitations.
 - a. To be eligible, an applicant's non-exempt resources cannot exceed \$2,000.00 (\$3,000.00 for a couple). (89 Ill.Admin. Code 120.382(a)).
 - b. Certain resources are considered **exempt** and do not affect one's eligibility. See PM Section 07-02-04(a) through 07-02-19 of the Illinois Combined Policy Manual and the corresponding sections of the Worker's Action Guide; and see 89 Ill. Admin. Code 120.381 for the complete list of exempt resources.
 - c. The applicant's monthly income must be less than the nursing home's private pay rate.
 - d. The applicant must generally pay all income to his/her facility less specific deductions (89 Ill.Admin. Code 120.61(f))

4. There are special rules for married applicants, namely resource and income allowances to prevent the impoverishment of the Community Spouse.
 - a. The "Community Spouse Resource Allowance" (CSRA) is the amount of non-exempt resources the "resident spouse" is permitted to transfer to the "community spouse" without affecting the resident spouse's eligibility. (Combined Policy Manual PM 07-02-21). The current CSRA is \$109,560.00. (89 Ill.Admin. Code 120.379(d)(1); PM 07-02-22.)
 - b. In addition, the community spouse is entitled to a contribution of monthly income from the resident spouse to bring the community spouse's monthly income up to what is known as the "Minimum Monthly Maintenance Needs Allowance" (MMMNA). The current MMMNA is \$2,739.00. (305 ILCS 5/5-4(a); 89 Ill.Admin. Code 120.379(e)(1)(A)).
5. While an in-depth review of the Medicaid eligibility rules is beyond the scope of this presentation, any practitioner preparing an application for a client should have a thorough understanding of the rules.

B. In addition to knowledge of the basic eligibility requirements, it is helpful for practitioners to be aware of recent events that have impacted the application process.

1. Effective January 1, 2012, Illinois amended the necessary sections of the Illinois Administrative Code to comply with the federal changes required by the Deficit Reduction Act of 2005, which significantly altered the Medicaid eligibility rules. Six months later, the Illinois Legislature passed, and the Governor signed into law, the SMART Act (Save Medicaid Access and Resources Together), which, again, harshly amended the Illinois Medicaid eligibility rules for long-term nursing home care.
2. In the wake of the new DRA-compliant rules and the SMART Act, IDHS updated its own Policy Manual via the following Manual Releases:
 - a. MR #12.18 contains a list of "triggers" (see section IV(G) below) that will cause an application to be sent to the Office of the Inspector General's (OIG) Long-Term Care Asset Discovery Investigation (LTC-ADI) Unit.
 - b. On February 6, 2014, MR# 14.05 was released, which clarified certain changes implemented by the DRA and SMART Act, such as: verifying resources and transfers during the lookback period,

transfers to the community spouse, annuities, medical expenses, two-step eligibility, penalty periods, medical backdating, homestead property, non-homestead property, income, resources for self-support, prepaid burial contracts, requests for hardship waiver, liens and estate claims, billing, redetermination. (See Exhibit A, which is a copy of MR # 14.05.)

- i.** Many of the clarifications impact various aspects of the application process, including the timing of the filing applications and the required documentation to support an application.
- ii.** MR # 14.05, also, notes that when all of the IDHFS forms are revised and developed, an Information Memorandum with a complete list will be published, and that the workers should continue to check the forms library to make sure they are using the current version of each form.

- C.** Thus, not only must practitioners who are preparing Medicaid applications be familiar with the eligibility rules, it is also critical that they carefully monitor the policy manual and departmental forms, to ensure that they have the most up-to-date information prior to filing the application.

IV. Application Process

- A.** The preparation of the application for Medicaid coverage for a long-term nursing home stay can be a daunting task.
- B.** Applicants must complete an extensive application, a copy of which is available online, and is attached hereto as Exhibit B. It may be submitted in person or by mail.
- C.** The Department's online application system, Application for Benefits Eligibility ("ABE") has been available to applicants since October of 2013.
 - 1.** Long-term care facilities must submit their applications for long-term care benefits online via ABE.
 - 2.** Paper applications have NOT been eliminated and will remain an option for applicants and attorneys filing applications on behalf of applicants. However, information being disseminated by the IDHFS and IDHS makes it clear that filing on-line is preferred and should result in quicker processing

times.

3. Regardless of whether an on-line application or a paper application is filed, HFS 3654 (Additional Information for Long-term Care Applicants) MUST be filed. Until this form is incorporated on-line, those filing on-line applications will either have to upload this form with the on-line application or mail it in, once a caseworker is assigned.

D. Applicants must answer questions on the application regarding the following:

1. citizenship;
2. information regarding family members;
3. income information (social security, pensions, etc.);
4. information on Medicare and health insurance;
5. resource information (bank accounts, life insurance, real property, etc.);
6. information on transfers of assets within the five years prior to the application date. (See Exhibit C for a sample list that can be provided to clients)

E. In addition to the application, applicants will be required to submit numerous supporting documents, including 60 months of financial records, to verify the answers provided in the application.

1. All attachments to the application should be organized to follow the order of the application, with cover sheets for each category of documents being submitted.
2. HFS form 3654, attached hereto as Exhibit D, must be attached.
3. Finally, a cover letter should be included detailing any special information of which the caseworker should be aware, any special requests, and that includes a list of ALL of the documents being submitted with the application. (See Exhibit E)

F. Once the application has been completed, it must be submitted to IDHFS. Previously, there were two hubs receiving and processing long-term care applications; however, effective May 10, 2017, applications for long-term care benefits submitted online or via mail must now be submitted to one of three hubs:

- 1.** Medical Field Operations-North (#200): This hub, which formerly accepted all applications north of Interstate 80 and Kankakee, now only accepts applications from Region 1, which is comprised solely of Cook County.
- 2.** Medical Field Operations-Central (#244): This is the new hub, which accepts applications from Regions 2 and 3, comprised of the following counties:
 - a.** Region 2: Boone, Carroll, DeKalb, DuPage, JoDaviess, Kane, Kankakee, Kendall, Lake, Lee, McHenry, Ogle, Stephenson, Whiteside, Will and Winnebago Counties;
 - b.** Region 3: Bureau, Champaign, Ford, Fulton, Grundy, Henderson, Henry, Iroquois, Knox, LaSalle, Livingston, Marshall, Mason, McDonough, McLean, Mercer, Peoria, Putnam, Rock Island, Stark, Tazewell, Vermilion, Warren and Woodford Counties.
- 3.** Medical Field Operations-Downstate (#163): This hub formerly accepted all applications south of Interstate 80, excluding Kankakee, and it now accepts applications from Regions 4 and 5, comprised of the following counties:
 - a.** Region 4: Adams, Brown, Calhoun, Cass, Christian, Clark, Coles, Cumberland, DeWitt, Douglas, Edgar, Effingham, Green, Hancock, Jersey, Logan, Macon, Macoupin, Menard, Montgomery, Morgan, Moultrie, Piatt, Pike, Sangamon, Schuyler, Scott and Shelby Counties.
 - b.** Region 5: Alexander, Bond, Clay, Clinton, Crawford, Edwards, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson, Lawrence, Madison, Marion, Massac, Monroe, Perry, Pope, Pulaski, Randolph, Richland, Saline, St. Clair, Union, Wabash, Washington, Wayne, White and Williamson Counties.
- 4.** It is recommended that applications submitted by mail be submitted via a method that ensures delivery to the appropriate office (such as FedEx, or some other similar type of delivery service that requires a signature for the receipt of the package.) Attached as Exhibit F is a provider notice that contains the addresses and contact information for each hub.
- 5.** If an application is being delivered in person, rather than submitted by mail, it can still be delivered to the local office, as opposed to one of the three hubs.

G. Once the application has been submitted, it will be assigned to and reviewed by an IDHFS caseworker; unless the caseworker sends the application to OIG LTC-ADI.

- 1.** The presence of any of the following triggers will cause the case to be transferred to OIG:
 - a.** any case with a trust,
 - b.** transfers over \$5,000,
 - c.** annuities,
 - d.** home-equity line of credit,
 - e.** promissory notes,
 - f.** reverse mortgages,
 - g.** personal care contracts,
 - h.** use of a lawyer/financial planner in connection with the Medicaid application, and
 - i.** where OIG suspects the client failed to answer Form 3654 or where OIG suspects unreported transfers.
- 2.** The OIG has verbally advised practitioners that the use of a lawyer will no longer constitute a trigger, and it has further advised that only cases with transfers over \$10,000, rather than \$5,000, will trigger a transfer to OIG; however, to date, there are no written documents confirming these changes.
- 3.** The sequence of a Medicaid application review containing the above issues is as follows: first, the application is submitted to the local field office. From there it is transferred to OIG's LTC – ADI division if one of the above triggers is present. The OIG LTC-ADI staff will perform an investigation and analysis of the applicant's assets, and provide direction to the local office. Then, the application is sent back to the local office for the issuance of a notice of decision.

H. In order to ensure the fastest processing time possible, practitioners need to pay careful attention to the organization of their applications. The Office of the Inspector has shared the following information and/or tips with practitioners:

- 1.** Practitioners can help with the process of expediting new applications and reducing the backlog by: carefully examining the applicant's records

during the five-year look back period and identifying and providing explanations for each transfer of over \$1,000. Practitioners were also encouraged to identify and explain repetitive transfers, provide explanations with regard to expenditures that are not obvious and/or were made in the process of handling routine client affairs; provide plausible explanations that are factually correct so that the analyst has the discretion to approve; and consider the use of affidavits where cancelled checks or receipts are unavailable.

2. The preference is that, ultimately, applications and supporting documentation will be submitted electronically via ABE.
3. When filing an application, attorneys are encouraged to bring to OIG's attention very simple cases by including a cover letter with the submission of the application, which notes the same. Likewise, a similar approach may also help expedite cases which have been pending for a very long time.
4. The preferred order for submitting the applications and additional documentation is: 1) application; 2) HFS 3654 form; 3) correspondence; 4) authorized representative form; and 5) the required 5 years of supporting documentation, categorized by each asset.
5. Finally, to minimize the effect of OIG staff turnover and/or changes, a universal mailbox is utilized for receiving comments and documentation from practitioners. The universal mailbox address is as follows: HFS.OIG.LTC-ADI@illinois.gov.

V. STARTING POINTS & TIPS FOR FILING AN ON-LINE APPLICATION:

A. As ABE is the preferred method, as well as the only means by which Nursing Homes will be filing applications, it is important for practitioners to have a familiarity with the system. There are some variations between the online application and the paper application, and thus practitioners who are considering switching to ABE from the paper application should consider the following tips as they familiarize themselves with the process:

1. Familiarize yourself with the on-line application and the Guide for Completing an ABE Application, which is 36 pages long and includes sample pages from the online application, along with instructions, and can be found at:

<http://www.dhs.state.il.us/page.aspx?item=33698>

- 2.** Practice an application using sample information. (Caution: DO NOT HIT SUBMIT OR YOU WILL BE COMMITTING A FRAUD.)
- 3.** Once you are ready to file your first on-line application be sure to have ALL required Information readily accessible to you as you are completing the application, such as:
 - a.** Applicant's personal information: birth date; social security number, etc.
 - b.** Income information (Per IDHFS training seminar, Social Security information can be obtained by the caseworker electronically.)
 - c.** Resource information—will need current balances to complete the form. (Query: How many months to upload and/or mail-in to caseworker, as MR # 14.05 says 12 months required for the application, and the caseworker/reviewer will determine whether additional months, up to 60 months must be produced.)
 - d.** Immigration information for individuals who are not U.S. citizens.
 - e.** Documents that you plan to upload with the application, such as: Form 3654, Verifications of Income and Resource information, etc.
- 4.** Decisions that you will need to make prior to and/or when filing the application:
 - a.** Who will be designated as the person completing the application? The possible options are:
 - i.** the applicant
 - ii.** friend or family member of the applicant
 - iii.** staff person or volunteer at an agency that helps people
 - iv.** approved representative (which could be the attorney)
 - v.** legal guardian
 - vi.** applicant's agent pursuant to a durable power of attorney
 - vii.** none of the above
 - b.** Consider having the applicant's family, friend, agent, or guardian be the person submitting the application on behalf of the applicant. This means

that this individual will need to review the application and be the electronic signer of the application at the time of submitting. This will, of course lead to other issues for consideration, such as:

- i.** Logistics of completing and reviewing with the individual.
 - ii.** Still having an Approved Representative form completed and on hand for submission, if need be, later in the process. (See Exhibit G).
 - iii.** What address to be used as the contact address—the individual signing the application or the attorney’s address?
- c.** Have a plan as to how you will create User names and Passwords for each applicant.
- i.** Adopting a uniform approach (so that it will be easier to remember) is recommended.
- d.** As you begin the application, remember the following tips:
- i.** Until the application is ready to submit, always use the “Save & Exit” option so that any completed information will be saved until signing back in and completing the application.
 - ii.** Do NOT use the back arrow button on the browser to go back to the previous section. Use the “Back” button on ABE or other button designed to return to a particular section of the application.
 - iii.** Remember when an applicant is residing in a nursing home (unless spouses are residing together at the long-term care facility), there is only “1” person in the household, which is where the applicant is located. This is important to ensure that the application goes to the correct hub for processing, as the office assigned is dependent upon the location of the long-term care facility. (Note: Completing the application in this manner, however, will not trigger the screen to provide “community spouse” information. Thus, one may prefer to err on the side of responding “2” persons to trigger the screens for including the spouse’s information. If so, make sure to use the proper address for the applicant to ensure that the proper hub is assigned.)
 - iv.** The answers given to particular questions will impact the screens to be completed.

- v. Be sure to answer “yes” to the question regarding needing assistance with daily living skills, which is critically important for an applicant who is less than 65 years old.
- vi. “RSDI” is basic Social Security that one receives when he/she retires.
- vii. Be sure to carefully review the Resource Review page before moving on. If there are errors and/or missing information which are not being corrected or completed before moving on, then be sure to do so before submitting the application.
- viii. If requesting assistance with prior medical expenses/bills (up to 6 months can be deducted), then have these on hand when completing application and consider uploading after submitting the application.
- ix. Before finalizing and submitting, complete the “Additional Information” section that you want the caseworker to know and/or consider. For example, consider including the following information here:
 - Date of Admission and private pay rate (per letter from long-term care facility)
 - Community spouse (if answered only “1” person in the household)
 - Other pertinent information to be highlighted or not otherwise asked for on the application.
- x. On final page of the application the assigned office appears. If the correct office does not appear, more likely than not the question regarding where the applicant is residing was not accurately answered, and the application should be corrected before being submitted or the processing will be slowed down in getting it to the proper office.
- xi. The person completing the electronic signature is accepting responsibility for the information submitted and liability for incorrect information, etc. Thus, a final review of the application PRIOR to pressing the “Submit” button by that person is recommended.
- xii. Once the application has been fully completed, reviewed, and electronically signed, then press the “Submit” button and it will be officially submitted.

- xiii.** Once the application is submitted, a confirmation page will appear on the screen which will include a Temporary Identification number. This page will also include an option to print the application. (Note: The application can be viewed at any time by logging back in, as such some may consider printing the application unnecessary. Also, by logging back in, one will be able to view the status of the processing of the application. However, the application cannot be changed, and once a caseworker begins processing, documents can no longer be uploaded.)
- xiv.** To speed up the processing of the application, DHFS recommends uploading all anticipated required documents/verifications, such as:

 - Proof of all non-Social Security income;
 - Proof of, at least, 12 months of resources or as many months that one anticipates will be required;
 - Completed Form HFS 3654 (Additional Information for Long-term Care Applicants);
 - Letter from the long-term care facility stating date of admission and private pay rate;
 - Any medical expenses/bills to be considered;
 - Other documents relevant to the application being filed: marriage certificate, identification information, trust, deed, pre-paid funeral plan, etc. (Note: Per IDHFS, rarely is proof of citizenship required.)
- e.** When uploading documents the system is only equipped to handle approximately 35 pages at a time.

 - i.** Thus, breaking up the documents to be uploaded into logical groups of 35 pages or less is recommended.
 - ii.** Consider including cover sheets for each category of documents being uploaded, similar to the process for organizing documents submitted with a paper application.
- f.** Uploading documents is NOT required. Some may prefer waiting until contacted by the assigned caseworker and then sending all requested documents in one complete packet to the caseworker.

 - i.** IDHFS does NOT recommend this approach, as it will slow down the process.

c. the first day of the month, after the month of application, in which the person meets non-financial and financial eligibility requirements. (89 Ill.Admin. Code 120.61(b)).

3. If curing the penalty with an annuity or a promissory note, it is critical that the annuity/promissory note payments are timed so as to properly cover the penalty period. Thus, the payments must be scheduled to start the same month as eligibility begins, as that is when the penalty will begin to run.

a. Example 3 in WAG 07-02-20-d outlines a scenario where the applicant, Mr. E., gifts \$2,400 to his daughter on 4/08/12, enters a facility on 04/12/12 and applies for Medicaid on that date. The WAG directs the caseworker to start the 12 day penalty on 05/01/15. This example suggests that filing the application in the same month that a gift is made will cause the penalty to begin on the first day of the next month (assuming the client is otherwise eligible).

b. However, some practitioners have reported receiving decisions in which the first month of eligibility is determined to be the month in which the application was *filed*, even if the applicant was over-resourced at the beginning of the month (due to annuity purchase and/or gift), contrary to the example provided above.

i. In some of these cases, IDHFS has assessed a spenddown due to the applicant being over-resourced in the month in which the application was filed, rather than a penalty, which further delays the date of eligibility, as the applicant will have to spend down those excess resources, as well as income, each month (while receiving annuity or promissory note payments) before Medicaid will start paying.

ii. In other cases, IDHFS has assessed a spenddown *and* imposed a penalty when the application is filed in the same month as a gift is made and/or the annuity or promissory note is purchased/executed, the effect of which can cause a substantial delay in eligibility and often negate the effects of the annuity/promissory note strategy.

c. Thus, it is best practice to ensure that all gifts, spenddowns, annuity purchases, etc. are made in the month prior to the month in which the application is filed and eligibility is sought.

4. As with many other aspects of the application process, the practitioner should carefully consider all possible scenarios and outcomes when determining when to file the application.
- C. Clients must also be properly advised regarding spenddowns.
1. As discussed above, the timing of an application can also affect whether or not a spenddown will be assessed.
 2. Beginning with the month of eligibility, excess resources can be spent on medical expenses only. (89 Ill.Admin. Code. 120.384(b); PM 15-08-05)).
 3. Thus, pre-paid funeral plans, attorney's fees, and other non-medical expenses should be paid prior to the month in which eligibility is sought.
 4. As with filing, when you expect a penalty, the most conservative course of action is to wait and file one month after all expenditures (other than medical) are made.
- D. It is good practice to always have your client complete the form designating you as an authorized representative, even if you are not completing the application for the client
1. This will make it easier for you to respond to information requests from IDHFS or OIG.
 2. In the event that the client passes away, this designation may be necessary to pursue an appeal.

VII. APPEAL PROCEDURES & HARDSHIP WAIVERS

- A. In the event your client's application is denied, or the notice of decision contains inaccuracies, imposes a penalty, or is otherwise unfavorable, it may be necessary to file an appeal and/or a request for a hardship waiver.
- B. Note, however, that where an application is denied due to the failure to provide information or verification, MR# 14.09, released March 21, 2014, mandates that IDHS must allow the client the opportunity to provide missing information within 60 days after the date of Notice of Denial of a medical application. MR #14.09 further states the following:
1. When an application is denied for failure to provide required information or verification, the local office must not require an appeal or new application to be filed to reopen the case, if the information was provided within the 60 days following the date of Notice of the Denial.

2. If the information/verifications are provided within 60 days and if the applicant is determined eligible, the local office must re-register a denied medical case using the original application date (including any back dating).
- C. Similarly, if the reason for the denial is due to the failure of the applicant to comply with procedural requirements, such as failure to produce acceptable proof of eligibility, or failure to request more time to obtain such proof, the denial shall be rescinded at any time before the decision on the appeal is made, if the appellant complies with the procedural requirements necessary to process the application. 305 ILCS 5/11-8.1)
- D. The Administrative rules governing Public Assistance Appeals can be found at 89 Ill.Admin. Code 104.1-104.80 (for recipients of certain programs, including Aid to the Aged, Blind, or Disabled (AABD)); 89 Ill.Admin. Code 14.1-14.80 (for recipients of assistance under IDHS) and 89 Ill.Admin. Code 102.80-83.
- E. Applicants have the right to appeal decisions (or a lack of decision) relating to the application under the following circumstances:
 1. Refusal to accept an application or reapplication;
 2. Failure to act on an application within the mandated time period;
 3. A decision to deny an application;
 4. A decision to reduce, suspend, terminate or in any way change the amount of assistance/food stamps or manner in which it is provided;
 5. Failure to make a decision or take appropriate action on any request which the client makes;
 6. A decision affecting the basis of issuance of food stamps with which the client disagrees;
 7. A decision to deny the payment for a medical service or item that requires prior approval;
 8. A decision granting prior approval request for a lesser or different medical service or item than was originally requested;
 9. An issue of Department policy, if the client is aggrieved by its application;
 10. The determination of the amount of a premium that may be charged to a client under any medical assistance program. The Department's

determination of the amount of a premium shall remain in force during the appeal process;

- 11.** Imposition of a penalty period under 89 Ill. Adm. Code 120.387 or 120.388; or
- 12.** A denial of a request for a hardship waiver under 89 Ill. Adm. Code 120.379(i), 120.385(c)(3) or 120.388(r). (89 Ill.Admin. Code 102.80(a)).

F. The following basic procedural rules apply to appeals filed due to the denial of an application:

- 1.** The appeal must be in writing, (89 Ill.Admin. Code 104.10(a)(1); 89 Ill.Admin. Code 14.10(a)) and it must be filed by the applicant or the applicant's approved representative (89 Ill.Admin. Code 102.80(b); 89 Ill.Admin. Code 14.10(e)). (See Appeal Request Form (IL 444-0103) attached as Exhibit H).
 - a.** If Appeal Request Form is signed by applicant's authorized representative, then attach written authorization (e.g. Power of Attorney document, Letters of Office, or written consent) upon submission of Appeal Request Form.
 - b.** Appeal can be submitted via email to: DHS.BAH@illinois.gov.
- 2.** The appeal must be filed within 60 calendar days of the date of DHFS's action to notify the client. (89 Ill.Admin. Code 102.82).
 - a.** Notice of the appeal should be sent to the Bureau of Assistance Hearings, the respective local IDHFS office, and the OIG, if applicable.
- 3.** Upon IDHFS's receipt of appeal, pre-hearing conference should be scheduled within 10 days by IDHFS/OIG (however, this timing is usually not followed, and practitioners may wish to contact caseworker/OIG re: scheduling the conference prior to appeal hearing if they are not contacted).
- 4.** DHS must prepare a statement of facts after the pre-hearing meeting. The applicant must receive the statement of facts at least two workdays prior to the hearing. (PM 01-07-07-a).
- 5.** Prior to the hearing the appellant shall have the opportunity to examine their case record and obtain copies of case record material. Copies of the parts of the case record relevant to the hearing shall be provided free if requested by the appellant. (89 Ill.Admin. Code 14.12).

a. If OIG is involved in the case, it is useful to request the OIG analysis of the case, showing how and why a penalty was assessed, for example.

6. If appeal is not resolved at a pre-hearing conference, it will proceed to a hearing. The applicant and any authorized representative must receive notice of the time, date and place of the hearing at least 10 days prior to said hearing. (89 Ill.Admin. Code 104.12; 89 Ill.Admin. Code 14.15).

a. The hearing must be held in the county in which the applicant resides, or in another county acceptable to the applicant. (89 Ill.Admin. Code 104.20(a); 89 Ill.Admin. Code 14.20(a)).

i. In practice, most appeals are now conducted by telephone. The Notice of Hearing will list the number on which the Administrative Law Judge will contact the applicant, and if the applicant would like to be contacted at a different number, he/she will need to notify the BAH of same.

ii. An applicant can still request to have a hearing at the local office—which for long-term care cases, means one of the three hubs. As telephonic appeals are now the default manner in which hearings are held, applicants who wish to appear in person must notify the BAH of their request no later than 10 days prior to the hearing date.

iii. As the rules technically provide that the hearing shall be held in the county in which the applicant resides, if the applicant wants an in-person hearing, he/she should submit a request to BAH to have the hearing held in the county where the applicant resides, or in another county acceptable to the applicant, to avoid having to travel to one of the three hubs. This could include a DHS/FCRC office or, in some instances, the hearing can be held at the nursing home. However, in practice, telephonic hearings will be most convenient for practitioners and their clients.

b. Impartial hearing officers shall conduct the hearings. (89 Ill.Admin. Code 104.20(b); 89 Ill.Admin. Code 14.20(c)).

c. The applicant may, but is not required to have legal representation present at the hearing. (89 Ill.Admin. Code 104.21; 89 Ill.Admin. Code 14.21).

withdrawal. Request a copy of the withdrawal after it is signed by DHS.

8. Under the Illinois Power of Attorney Act, if the applicant dies while his/her application or appeal is pending, and has no executor of his/her estate, a Health Care Power of Attorney agent is authorized to continue to pursue an application or appeal for government benefits if those benefits were applied for during the life of the principal. (755 ICLS 45/4-10).

G. Hardship Waivers

1. A Hardship Waiver may be filed where the imposition of a penalty period due to unallowable transfers would create an undue hardship.
2. There are two types of hardship waivers:
 - a. Traditional Hardship waiver: IDHFS shall waive a penalty period or a portion thereof if the application of the penalty would deprive the applicant of medical care, endangering the person's health or life; or of food, clothing, shelter or other necessities of life. (89 Ill.Admin. Code 120.388(r)(1)).
 - i. A hardship waiver may be requested by any person residing in a nursing home, SLF, or receiving DoA HCBS waiver services, or by the person's authorized representative. A long term care facility may submit a claim of undue hardship on behalf of the applicant if they have written authorization from the person or their authorized representative. WAG 01-08-00.
 - ii. The person has the burden of proof that **actual**, not just potential, hardship exists, and must provide written evidence to clearly substantiate the circumstances supporting the hardship claim. WAG 01-08-00.
 - b. Hardship waiver for transfers made prior to November 1, 2011: if an applicant signs an attestation stating that the penalized transfer was made in reliance on the administrative rules in effect at the time of the transfer, and that, without a waiver, the imposition of a penalty would cause an undue hardship (i.e. that without the waiver, the person would be deprived of medical care endangering health or life, food, clothing, shelter or other necessities of life) IDHFS will grant a hardship waiver and waive penalty period. (89 Ill.Admin. Code 120.388(r)(3)). Note that, because November 1, 2011 is now outside the look-back period, this hardship waiver is essentially

obsolete; however, practitioners who have older cases that are still pending may still be able to utilize this strategy.

- 3.** Per the direction of IDHFS and OIG, requests for Hardship Waivers should be filed only after a decision has been issued and a penalty imposed.
 - a.** Although practitioners may seek to file hardship waivers with the application, IDHFS and OIG have taken the position that a hardship waiver cannot be granted until a decision has been issued assessing a penalty.
 - b.** Thus, request for hardship will need to be filed after notice of decision is received, often with an appeal.
 - c.** However, care must be taken to ensure that proper form is used to request the hardship waiver:
 - i.** Form HFS 2378WA for traditional hardships. (Attached as Exhibit J).
 - ii.** Form HFS 2379WA for pre November 1, 2011 transfer hardship. (Attached as Exhibit K).

H. Possibility of Changes in the law.

- 1.** The law in this area is constantly evolving, and will likely continue to do so. Practitioner's should be aware of this, and closely monitor proposed amendments to the laws and regulations governing long-term care Medicaid.
- 2.** By way of recent example, on May 29, 2015, IDHS issued proposed amendments to the administrative rules governing appeals and hearings. Many of the proposed changes violated Federal due process requirements.
- 3.** There were strong objections to these rules, from members of the public, agencies and organizations that provide assistance to the disabled and the elderly, and Elder Law practitioners, led by Illinois NAELA. Fortunately, the Department did not pursue these changes, likely in large part due to the opposition mounted the aforementioned groups.
- 4.** Practitioners are encouraged to continually monitor the Department's filings with the Joint Committee on Administrative Rulemaking, to ensure that a proper response can be formulated should the Department attempt to propose similarly harsh rules in the future.

VIII. CONCLUSION

As a result of events over the past couple of years which have led to a significant backlog of pending applications for long-term care, along with the introduction of ABE, it is likely that the utilization of on-line applications for benefits will become the norm. Thus, it is critical for attorneys filing applications and appeals for long-term care Medicaid to stay abreast of ABE and the evolving new developments related to same. In addition, it is good practice for all practitioners to diligently monitor proposed rule changes and updates to IDHS's and IDHFS's publications and forms to ensure compliance with the most current rules and policies.



MR #14.05: Clarification and Explanation of LTC and Community AABD Changes made in response to the DRA of 2005 and the Illinois SMART Act



02/06/14

Summary:

This manual release clarifies and further explains changes in community AABD and long term care policy resulting from the federal Deficit Reduction Act of 2005, the Illinois SMART Act (**PA 097-0689**), and other improvements to conform with federal and state regulations. [Also see **MR #12.18.**] Topics clarified and further explained include:

- verifying resources and transfers during the lookback period;
- transfers to the community spouse;
- annuities;
- medical expenses;
- two-step eligibility;
- penalty periods;
- medical backdating;
- homestead property;
- non-homestead property;
- income;
- resources for self-support;
- prepaid burial contracts;
- requests for hardship waiver;
- liens and estate claims;
- billing;
- redetermination.

The policies and workers' action guides listed and linked under Manual Revisions (below), but not otherwise referenced within this release, were revised in minor ways including terminology changes, updated form names, address changes, etc.

When all of the HFS forms revised and developed in response to the DRA and the SMART Act have been completed and made available for use, an Information Memorandum with a complete list will be published. It is important to check the forms library and use the current version of each form, including those referenced in this release.

Verifying resources and transfers

WAG 01-02-01-a and **PM 07-02-21** were revised to provide better direction about when to have the customer or authorized representative complete HFS Form 3654, Additional Financial Information for Long Term Care, to identify all current and transferred resources.

PM 07-02-20-a is clarified to describe a reasonable process for verifying resource though all LTC applicants and customers in community cases that move into LTC must report all of resources during the entire 60-month lookback period, it is customary and permissible to request detailed bank records and other documentation for only the 12-month period immed



application unless there is reason to require records and verifications for older transfers.

Other sections of the Policy Manual, including **PM/WAG 07-02-20-b**, were revised to clarify the process for referral to LTC-ADI.

Transfers to the community spouse

PM 15-04-04-a is revised to better explain the Community Spouse Maintenance Needs Allowance (CSMNA).

PM 07-02-22, **PM 07-02-22-a** and **PM/WAG 19-02-03-b** now include better direction regarding the Community Spouse Resource Allowance (CSRA) and review of resources at redetermination. The community spouse's resources are not reviewed at annual redetermination except to verify transfer up to the CSRA, if applicable, at the first redetermination.

PM 07-02-22 was also revised to clarify which resources received after initial determination of eligibility are available to the LTC spouse and which are not. If the community spouse acquires a resource (such as an inheritance) after initial eligibility is determined, it does not affect the CSRA which was previously established and the new resource is not available to the LTC spouse. If the LTC spouse receives a resource after eligibility is determined, it cannot be transferred to the community spouse even if the transfer would bring resources of the community spouse up to the maximum CSRA amount. If, after eligibility is determined, a resource is received by the couple (not legally owned by one or the other alone), half of the resource belongs to the community spouse and the other half is available to the LTC spouse.

Annuities

Purchasing an annuity that does not meet the requirements detailed in policy is considered a transfer for less than fair market value (FMV). Changing the terms of an annuity subsequent to purchase may also cause it to be considered a transfer for less than FMV. The purchase of an annuity that pays out over a period less than the person's life expectancy may be considered an allowable transfer if it meets all of the other requirements listed in **PM 07-02-20-b**. Also see revisions to **WAG 07-02-17**.

Medical expenses

Policy regarding allowable medical expenses is clarified in **PM 15-08-05**. Allow premiums for dental coverage and eye care only if the plan covers services not covered by the medical card. Due to changes which became effective 07/01/12, emergency extraction is the only adult dental service covered by the medical card so dental insurance premiums for additional services are allowed.

If a community spouse is paying for health insurance of the LTC spouse, allow the portion of the premium paid for the LTC customer's coverage if it can be separately identified.

For NH or SLF cases, long term care charges at the private pay rate can only be applied to the person's credit or spenddown for the month the services are provided and only if the bill has been paid by the customer. LTC costs during a penalty period or for services provided by a terminated, barred or suspended facility cannot be used toward meeting spenddown. Contact the HFS Bureau of Comprehensive Health Services with questions about ineligible providers.

When considering medical expenses for services or items covered under Illinois' Medicaid Program, only allow receipts for services where the cost was the responsibility of the customer or someone included in the medical standard. Only bills that continue to be the responsibility of the customer or someone included in the standard are allowed. Expenses (bills or receipts) that will be covered by the medical card or by other health coverage are not allowed.

After eligibility is determined, the purchase of a funeral or burial contract may not be applied to reduce the group care credit or to meet spenddown. The purchase of the contract is considered an allowable transfer for LTC as long as the customer receives fair market value (FMV) but does not reduce the portion of the customer's resources that were originally determined available to pay for the customer's care.

Two-step eligibility

Use of income in determining two-step eligibility and spenddown is clarified in **PM/WAG 15-04-04**. Under Step 1, application of anticipated LTC charges used to meet spenddown no longer specifies "at the state payment rate." The private payment rate is used to determine spenddown. Spenddown

calculation is also clarified in [PM 15-02-03-b](#) and [WAG 15-08-01-c](#).

Penalty periods

[PM/WAG 07-02-20-d](#) was revised to clarify calculation and application of a penalty, including partial months. The changes include additional direction for determining the date the penalty begins, how to code certain cases, and improved examples.

Medical backdating

The manual now includes additional information about medical backdating. When backdating is requested for AABD medical cases, use the verified amount of nonexempt resources available on the first day of each individual month before any income is added or expenses paid out of the person's account(s). Examples are provided in [WAG 07-02-00](#) and a new workers' action guide ([WAG 15-04-01](#)).

Homestead property

[PM 07-02-04-a](#) was revised to comply with Illinois law by adding that homestead property transferred to a trust is not exempt unless the person provides evidence that his or her spouse, minor child or child with a disability resides in the property.

[PM 07-02-04-a](#) was further revised to include additional detail regarding how to determine the value of homestead property in various regions of Illinois and the home equity limit was changed to \$536,000 based on the increase in the CPI. For homestead property that includes farmland, send an inquiry to HFS.OIG.LTC-ADI@illinois.gov including the name of the county in which the property is located and the year for which value is needed. LTC-ADI will return a per-acre value via email that the caseworker will multiply by the number of acres to determine FMV of the farmland acreage. The FCRC adds that value to the FMV of the home and other buildings of the farm to determine the total FMV of the property. Equipment, tools, livestock, grain in storage and other farm resources are not part of the property value and must be valued and applied toward the resources for self-support (see [PM 07-02-11](#)).

Instructions for processing applications and cases of customers with excess home equity were added to [WAG 07-02-04-a](#).

Non-homestead property

[PM/WAG 07-02-04-b](#) were revised to formalize the process for requesting an extension of the time limit for selling non-homestead property. The criteria for exempting the equity value of non-homestead was also revised. Requests for guidance on cash cases are sent to the DHS Bureau of Program and Performance Management (formerly the Bureau of Research & Analysis). For medical only cases, send Form 2150 to the HFS Bureau of Medical Eligibility & Special Programs (BMESP).

Income

Nonexempt income is only available to the extent and in the amount actually received by the customer. See revisions to [PM 08-02-00](#).

Resources for self-support

[PM 07-02-11](#) has been revised to clarify the circumstances in which an exemption may apply to resources used for self-support. Allow the exemption for rental property resources whether the income is earned or unearned and also when considering the resources of the spouse. At redetermination (see [PM 19-02-03](#)), review the current value of resources for self-support and exempt up to \$6,000 only if the customer's circumstances meet policy requirements.

Prepaid burial contracts

To be exempt, an irrevocable prepaid burial contract funded by assignment of life insurance to a trust and established on or after 07/01/12 must name the State of Illinois as remainder beneficiary to the extent the state provides medical assistance. This specific time frame was added to [PM 07-02-08-d](#) along with instructions to submit a check for the remainder, when appropriate, to the HFS Bureau of Collections and payable to *Treasurer, State of Illinois, HFS*.

Requesting a hardship waiver

When medical benefits are denied due to excess home equity or a penalty is applied for a non-allowable transfer, the Notice of Decision on Application for Medical Assistance (HFS 458LTC) informs the customer of the denial or the penalty, the right to appeal and the opportunity to request a hardship waiver.

WAG 01-08-00 was revised to clarify that the FCRC does not enclose an application for hardship waiver. A customer or his/her representative who decides to request a hardship waiver contacts the Benefits Hotline and hotline staff send the Application for Hardship Waiver (HFS 2378WA). The customer or his/her representative completes the form and returns it to the mailing address or the fax provided at the bottom of the form. The OIG reviewer will contact the FCRC to request additional information, if necessary, by emailing the LOA and copying the ROA. The inquiry will specify the information needed and identify the case by name, number and caseload. A scanned copy of the waiver request will also be attached. The FCRC will send the requested information to OIG via fax or by scanning and emailing the documents and information.

If the penalty period resulted from a transfer for less than FMV made before 11/01/11, the OIG reviewer will send the customer or his/her representative a Statement of Hardship - Waiver of Penalty Period (HFS 2379WA). The form must be completed and returned to the mailing address or the fax at the bottom of the form before the penalty will be waived.

Liens and estate claims

PM 23-02-00 was clarified regarding recalculation of NH/SLF credits and adjustment of spenddown amounts for active medical cases. These actions are not considered reports of overpayment. **PM 23-09-00**, **PM 23-09-02**, **PM/WAG 23-09-02-c** and **PM 23-09-02-e** were revised to clarify the circumstances under which the state is entitled to recover money spent on AABD customers and the processes used to complete the lien or claim.

Billing

Time frames for billing are revised in **PM 20-04-01-c**. Providers must submit most bills for service within 180 days. Medicare cross-over claims must be submitted within 24 months. LTC admissions must be submitted electronically within 5 working days and the supporting documentation must be submitted to the FCRC within 30 days.

Redetermination

In addition to the redetermination issues presented elsewhere in this release, **PM 19-02-03** now includes a reminder to review current home equity and assess eligibility according to **PM 01-08-02** for LTC cases. Also review annuities, loans and contracts for deed to assure requirements in **PM 07-02-20-b** are met and that such financial instruments have been referred to the Bureau of Collections using Form IL444-0008 ("DPA 8").

Manual Revisions

PM 01-08-00

PM 01-08-02

PM 07-02-00

PM 07-02-04-a

PM 07-02-04-b

PM 07-02-08-d

PM 07-02-11

PM 07-02-17

PM 07-02-20-a

PM 07-02-20-b

PM 07-02-20-d

WAG 01-02-01-a

WAG 01-08-00

WAG 01-08-01

WAG 01-08-02

WAG 07-02-00

WAG 07-02-04

WAG 07-02-04-a

WAG 07-02-04-b

WAG 07-02-08-d

WAG 07-02-17

WAG 07-02-20

PM 07-02-21

WAG 07-02-20-a

PM 07-02-22

WAG 07-02-20-b

PM 07-02-22-a

WAG 07-02-20-d

PM 08-02-00

WAG 07-02-21

PM 09-02-04-b

WAG 15-04-01

PM 15-02-03-b

WAG 15-04-04

PM 15-04-04

WAG 15-07-00

PM 15-04-04-a

WAG 15-08-01-c

PM 15-08-05

WAG 17-01-04

PM 19-02-03

WAG 17-01-04-e

PM 19-02-03-b

WAG 17-02-04

PM 20-04-01-c

WAG 17-04-02

PM 20-08-04-a

WAG 19-02-03-b

PM 20-08-14

WAG 20-08-04-a

PM 23-02-00

WAG 20-08-14

PM 23-09-00

WAG 23-09-01-c

PM 23-09-02

WAG 23-09-01-d

PM 23-09-02-c

WAG 23-09-02-c

PM 23-09-02-e

Forms referenced:

- HFS 3654
- IL 444-2498
- HFS 458LTC
- HFS 2378WA
- HFS 2379WA
- IL 444-0008

[signed copy on file]

MICHELLE R.B. SADDLER

Secretary, Illinois Department of Human Services

JULIE HAMOS

Director, Illinois Department of HealthCare and Family Services



State of Illinois

Department of Healthcare and Family Services
Department of Human Services

Instructions for 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.

This is **NOT** an application for cash assistance, food stamps, or the other programs listed on page 6 of these instructions. If you want to apply for cash assistance or food stamps, contact your local Department of Human Services (DHS) Family Community Resource Center (FCRC).

Voter's Registration Information

If you want to apply to register to vote, fill out the enclosed Illinois Voter Registration Application SBE (R-19) and return it to your DHS 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 www.dhs.state.il.us or www.elections.il.gov/

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

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

WHERE CAN YOU GET THESE MEDICAL SERVICES?

You may go to any medical provider who accepts the HFS medical card.

WHEN WILL YOU KNOW IF YOU QUALIFY?

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.

WHAT IF YOU DISAGREE WITH THE 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 THIS APPLICATION TO 401 SOUTH CLINTON.**

For more information call 1-800-843-6154, (TTY: 1-800-447-6404). The call is free



INSTRUCTIONS: Read the application carefully and follow all instructions.

1. **Complete pages 1 - 6 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 DHS FCRC office or call 1-800-843-6154 (TTY: 1-800-447-6404). This call is free.
 - 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 or intends to move to a nursing home facility or a supportive living facility, or receives or has applied for services through the Department on Aging Community Care Program.
 - Complete **Form D** if the person is transferring income and assets to spouse.
 - 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 the Social Security Administration has not yet decided if the person has a disability.
 - 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.
2. Sign the application.
3. Attach copies of any required Forms A through H and documents to the application. Failure to submit required forms or documents could result in denial of your application. See instructions pages 3 and 4.
4. Mail the application to your local DHS FCRC office. If you do not know the address visit the DHS website at www.dhs.state.il.us or call 1-800-843-6154, (TTY: 1-800-447-6404). The call is free.

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, 2nd Floor
Chicago, Illinois 60607

Illinois Department of Healthcare
and Family Services (HFS)
EEO/AA Office
401 South Clinton Street, 5th 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)

For more information call 1-800-843-6154, (TTY: 1-800-447-6404). The call is free

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. Include all that apply. Please see the information on the next page about providing documents for U.S. citizens.

- **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 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.

- **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.

For more information call 1-800-843-6154, (TTY: 1-800-447-6404). The call is free

INFORMATION TO INCLUDE WITH THE APPLICATION (cont.)

- **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/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.

Pregnant women and children under age 19 who do not have proof of their immigration status may still qualify for medical benefits. However, you should provide proof if you have it.

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 cover medical care provided in an emergency for adults whose legal immigration status can not be verified, or if they have been in the U.S. less than five years, only if they meet all other medical program requirements.

- **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) or Certificate of Citizenship (N-560 or N-561). If these are not available, provide one document from each of the two categories listed below:

Place of Birth

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

and

Identity

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

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

- If you or your representative bring this application to your local FCRC office in person, or can come into the office after sending the application in, please bring original or certified copies of citizenship and identity documents.
- If you mail in copies with this application, we may ask you to show the original documents at a later time.

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

For more information call 1-800-843-6154, (TTY: 1-800-447-6404). The call is free

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 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 with holdings, 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.
- **Resources** - Send proof of each resource listed on **Form B**. If the person lives with his or her spouse, include the spouse's resources. 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.
- **Resources and Income of Spouse** - Provide proof of a spouse's resources and income, if anyone applying wants to transfer resources or income to his or her spouse and the person applying:
 - lives in or intends to move to a nursing home facility,
 - 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**.

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 facility, supportive living facility 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 in Illinois:

- **Veteran's Care** offers access to affordable, comprehensive healthcare to veterans across Illinois. Veterans pay an affordable monthly premium of \$40 or \$70 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.
- **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 35 and older (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.iwillinois.com or call the Health Benefits hotline at 1-800-226-0768 (TTY: 1-866-675-8440). The call is free.

For more information call 1-800-843-6154, (TTY: 1-800-447-6404). The call is free



State of Illinois

Department of Healthcare and Family Services
Department of Human Services

AGENCY USE ONLY
Date Received

Mail-In Application For Medical Benefits

If the applicant is in a health care facility, enter the date of the applicant's admission to the facility:
the actual or expected discharge date
and facility name

Recycle any instruction pages sent with this application.

Case Number

Answer questions completely and accurately.

APPLICANT - The applicant is usually the person filling out this form or who has someone complete the form for them. The applicant can also be the parent, guardian or other relative a child lives with. 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. See Instructions 3 to 5 for a list of documents you may need to send with this application.

Name (Last, First, Middle Initial)
Daytime phone and best time to call you

Address (Please list Street, City, State, Zip and County)

Mailing Address (if different than above)
Other phone number

If you are living in a nursing home, list the two places you lived prior to moving to the nursing home. If you have not yet moved to a nursing home, list the last two places where you lived prior to your current residence.

Address City State Zip Address City State Zip

Language Preference

- English
Spanish
Other (please list)

Race / Ethnic Group (for information purposes only)

Are you Hispanic or Latino? Yes No

Race (Mark all that apply)

- White Black or African American Asian
American Indian or Alaska Native
Native Hawaiian or Other Pacific Islander
Other (please list)

1. 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.

Table with 7 columns: A. Name, Sex, Birth Date, Relationship To Applicant, Wants Medical Benefits, U.S. Citizen, Social Security Number. Rows 1-4 for family members.

2. PERSONAL INFORMATION (continued)

B. For each person under age 18 applying for medical benefits, tell us about their parents. If a parent does not live with the child, also enter the parent's address.

First Child's Name	Second Child's Name	Third Child's Name
<p>Mother's full name: _____</p> <p>SSN: _____</p> <p>Mother's Employer: _____</p> <p><input type="checkbox"/> Full-time <input type="checkbox"/> Part-time</p> <p>Address if other: _____</p>	<p>Mother's full name: _____</p> <p>SSN: _____</p> <p>Mother's Employer: _____</p> <p><input type="checkbox"/> Full-time <input type="checkbox"/> Part-time</p> <p>Address if other: _____</p>	<p>Mother's full name: _____</p> <p>SSN: _____</p> <p>Mother's Employer: _____</p> <p><input type="checkbox"/> Full-time <input type="checkbox"/> Part-time</p> <p>Address if other: _____</p>
<p>Father's full name: _____</p> <p>SSN: _____</p> <p>Father's Employer: _____</p> <p><input type="checkbox"/> Full-time <input type="checkbox"/> Part-time</p> <p>Address if other: _____</p>	<p>Father's full name: _____</p> <p>SSN: _____</p> <p>Father's Employer: _____</p> <p><input type="checkbox"/> Full-time <input type="checkbox"/> Part-time</p> <p>Address if other: _____</p>	<p>Father's full name: _____</p> <p>SSN: _____</p> <p>Father's Employer: _____</p> <p><input type="checkbox"/> Full-time <input type="checkbox"/> Part-time</p> <p>Address if other: _____</p>

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: _____

Complete Form G if the Social Security Administration has not yet decided if the person has a disability.

E. Does everyone applying live in Illinois? Yes No

If no, enter the person's name: _____

2. PERSONAL INFORMATION (continued)

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 4 of the instructions for more information.

Name	City	State
1) _____	1) _____	1) _____
2) _____	2) _____	2) _____
3) _____	3) _____	3) _____

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 4 of the instructions for more information.

Name	Valid Alien Registration Number
1) _____	1) _____
2) _____	2) _____
3) _____	3) _____

H. Does anyone applying live in a nursing home facility or supportive living facility? Yes No

If yes, you must complete forms **B, C and D**.

If yes, enter the person's name: _____

Was the person a resident in the facility prior to 07/01/96? Yes No Unknown

Facility Name: _____

Facility Street Address: _____

City, State, Zip Code: _____ **Facility Telephone Number and Area Code:** _____

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: _____

Date of Death: _____

2. PERSONAL INFORMATION (continued)

K. Does anyone applying have a legal guardian? Yes No

If yes, enter the guardian's name: _____

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 or delivery date: _____ , and number of babies expected or delivered: _____ .

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, list months: _____

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

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: _____

Q. Is anyone applying enrolled in the Illinois Comprehensive Health Insurance Plan (ICHIP) program? 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. Attach proof. Enter the amount before deductions like taxes or insurance. Check all that apply and enter details below:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Social Security | <input type="checkbox"/> Pensions/Retirement Benefits | <input type="checkbox"/> Wages/Self-Employment | <input type="checkbox"/> SSI |
| <input type="checkbox"/> Veterans Benefits | <input type="checkbox"/> Railroad Retirement Benefits | <input type="checkbox"/> Trust or Annuity Payments | <input type="checkbox"/> Child Support |
| <input type="checkbox"/> Dividends or Interest | <input type="checkbox"/> Royalties, Oil/Mineral Rights | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Rental Income |
| <input type="checkbox"/> Disability Benefits | <input type="checkbox"/> Unemployment Benefits | <input type="checkbox"/> Farm Income | <input type="checkbox"/> Alimony |
| <input type="checkbox"/> Contributions | <input type="checkbox"/> Other: List additional income and benefits not shown here: _____ | | |

Person Who Receives Income	Source of Income. If work, enter employer's name.	Amount	How Often?	If Social Security, enter Claim Number
1) _____	1) _____	\$ _____	1) _____	1) _____
2) _____	2) _____	\$ _____	2) _____	2) _____
3) _____	3) _____	\$ _____	3) _____	3) _____

5. CHILD CARE

Do you or does anyone living with you pay for child care so they can work? Yes No

If yes, complete the following:

Child's Name	Care Giver Name	Monthly Amount	Person Paying for Care
1) _____	1) _____	\$ _____	1) _____
2) _____	2) _____	\$ _____	2) _____
3) _____	3) _____	\$ _____	3) _____

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. Some individuals have to incur medical expenses to qualify for a medical card. This is called a spenddown. This is similar to a health insurance deductible.
5. 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.
6. 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.
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. Bureau of Citizenship and Immigration Services (USCIS). We may send USCIS other information such as copies of proof you sent of an Alien Registration Number and the person's Social Security Number, if they have one.
8. You must tell your 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 or change your mailing address; or
 - Someone who gets health benefits moves out of Illinois, dies, or goes to jail or prison.
9. 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.
10. Anyone who misuses the 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.

The undersigned hereby consents and authorizes the Department of Human Services and Healthcare and Family Services to investigate, obtain and verify all information necessary in connection with the request for public assistance. Such information shall include, but not be limited to, documents of financial institutions, trusts, insurance, stocks/ mutual funds, real estate, pension, SSI/SSA, and any other type of financial resources. Failure to cooperate or provide documentation or information necessary to determine the applicant's eligibility may result in the denial of assistance.

Applicant's signature: _____ Date: _____

(Make a mark and have another adult sign next to 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 someone initiates this application on behalf of the applicant, identify the 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	
1) _____	1) _____	Part A _____	Part B _____
2) _____	2) _____	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 #1: _____

Policy Holder Name: _____ Policy Holder Social Security Number (Optional): _____

Insurance Company: _____ Certificate/Policy Number: _____

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 #2: _____

Policy Holder Name: _____ Policy Holder Social Security Number (Optional): _____

Insurance Company: _____ Certificate/Policy Number: _____

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 - 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
1) _____	1) _____	1) _____	\$ _____	\$ _____
2) _____	2) _____	2) _____	\$ _____	\$ _____

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

Owner	Type	Make/Model/Year	Value	Amount Owed
1) _____	1) _____	1) _____	\$ _____	\$ _____
2) _____	2) _____	2) _____	\$ _____	\$ _____

Does anyone own any life insurance? Yes No

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

Do you have an insurance policy that pays when you are 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:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Business | <input type="checkbox"/> Savings | <input type="checkbox"/> Money Market Account | <input type="checkbox"/> Stocks, Bonds |
| <input type="checkbox"/> Checking Account | <input type="checkbox"/> Funeral/Burial Plans | <input type="checkbox"/> Life Estate | <input type="checkbox"/> Deferred Comp |
| <input type="checkbox"/> Annuity | <input type="checkbox"/> Nursing Home Account | <input type="checkbox"/> Trust Funds | <input type="checkbox"/> Inheritance |
| <input type="checkbox"/> Burial Plots | <input type="checkbox"/> IRA / 401 K | <input type="checkbox"/> Certificates of Deposit | <input type="checkbox"/> Reverse Mortgage |
| <input type="checkbox"/> Mineral/Oil Rights | <input type="checkbox"/> Mutual Funds | <input type="checkbox"/> Other | List, if other: _____ |
| <input type="checkbox"/> Promissory Note/Loan | <input type="checkbox"/> Government Bonds | | |

Owner(s)	Type of Resource	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 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:.....	\$ _____	_____

FORM C - TRANSFER OF RESOURCES AND INCOME

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

1. Have you filed a State or Federal Income Tax Return in the last 5 years? Yes No

If YES, which years? _____

If YES, you are required to provide a copy of each of your tax returns, including all attachments, filed the last 5 years.

Have you or your spouse within the past 60 months sold or given away any resources; closed any bank accounts; or made any changes in the way a resource 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? Yes No

Do you or your spouse have an irrevocable trust that has stopped payment within the past 60 months? Yes No

2. Has someone else been helping you handle your money and general financial affairs? Yes No

This would include helping you handle things such as checking and savings account; handling your life and health insurance payments; handling financial investments such as IRAs and Certificate of Deposit; handling your income such as Social Security checks, pension checks or annuity payments. This could be a family member, a friend, or a financial advisor or attorney, or power of attorney (POA).

If YES, list the name, address, phone number and relationship of each person who assists you with any of these matters:

Name: _____

Name: _____

Address _____

Address _____

City _____ State _____ ZIP _____

City _____ State _____ ZIP _____

Relationship: _____

Relationship: _____

Phone: _____

Phone: _____

Is this person your POA? Yes No

Is this person your POA? Yes No

If YES, for: _____ Property _____ Health

If YES, for: _____ Property _____ Health

3. Within the last 60 months, did you talk with a financial planner, attorney, family member or anyone else about your need to reside in a nursing home and discuss any of the following issues? Yes No

- How you can use your resources and income to pay for nursing care.
- How you might become eligible for Medicaid if you are unable to pay for the cost of nursing home care from your own resources.
- Estate Planning - that is, developing a plan to divide any of your resources between your spouse, members of your family, friends, church or any other organization or placing your resources in a trust for any of these persons.

If YES, who did you talk to? (This may include a financial planner, attorney, banker, family member, friend, community or service organization, other.)

Name: _____

Name: _____

Address _____

Address _____

City _____ State _____ ZIP _____

City _____ State _____ ZIP _____

Relationship: _____

Relationship: _____

Phone: _____

Phone: _____

If yes, enter details below. If you need more space, attach an additional page.

FORM C - TRANSFER OF RESOURCES AND INCOME (cont.)

4. In the last 5 years (60 months), did you transfer any of the things you own or any of your income? Yes No

What was transferred? _____

Who made the transfer?	Amount Received	To Whom?	Date of Transfer	Market value on the date of transfer. Attach proof of how you determined the market value.
------------------------	-----------------	----------	------------------	--

_____ \$ _____

Describe the transfer. For example, was it sold, given away, or was there a change in the way it was held?

Why was the transfer made?

What other transfers were made? _____

If you need more space, please attach an additional page.

Who made the transfer?	Amount Received	To Whom?	Date of Transfer	Market value on the date of transfer. Attach proof of how you determined the market value.
------------------------	-----------------	----------	------------------	--

_____ \$ _____

Describe the transfer. For example, was it sold, given away, or was there a change in the way it was held?

Why was the transfer made?

5. In the past 60 months, did you take out a reverse mortgage on your home? Yes No

If yes, how did you receive the money? Lump sum payout: \$ _____ Line of credit: \$ _____

Explain how the money was used: _____

FORM D - TRANSFER OF RESOURCES OR INCOME TO SPOUSE

Complete only for persons who are married and live in a nursing home facility or a supportive living facility or who intend to move to a nursing home 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 resources to your spouse?

Yes No

If yes, attach copies of your spouse's resources.

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 nursing home 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: (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 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 Please list, if other: _____

If person uses own car, how many miles to and from work? _____

If a person takes the bus, what is the fare to and from 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: (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 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 Please list, if other: _____

If person uses own car, how many miles to and from work? _____

If a person takes the bus, what is the fare to and from 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?

(1)

Street

Apt. No. City

State

Zip

County

Social Security Number:

Monthly Gross Income: \$

Source of Income:

(If employed, include employer's name and address below.)

Name:

Address:

Absent Spouse's Name

Spouse of Whom?

(2)

Street

Apt. No. City

State

Zip

County

Social Security Number:

Monthly Gross Income: \$

Source of Income:

(If employed, include employer's name and address below.)

Name:

Address:

FORM G

Eligibility Worker:
Form G is a required
part of the 183 packet
that goes to CAU, unless
a completed 183 B is sent.

Complete this form only for persons who believe they have a disability, but the Social Security Administration has not made the disability determination.

Name of person who is requesting
a disability determination: _____

EDUCATION

Highest Grade Completed	At What Age?	Date	Technical or Vocational Training?
_____	_____	_____	<input type="checkbox"/> Technical <input type="checkbox"/> Vocational

Special Education Classes While in School? Yes No

If yes, please list: _____

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

If no, how does the person support his or her self? _____

Give History of last 3 jobs.	Employment Dates	Full or Part Time	Reason for Leaving
Job Title (1): _____	From: _____	<input type="checkbox"/> Full Time	_____
Duties (1): _____	To: _____	<input type="checkbox"/> Part Time	_____
Job Title (2): _____	From: _____	<input type="checkbox"/> Full Time	_____
Duties (2): _____	To: _____	<input type="checkbox"/> Part Time	_____
Job Title (3): _____	From: _____	<input type="checkbox"/> Full Time	_____
Duties (3): _____	To: _____	<input type="checkbox"/> Part Time	_____

FORM G (cont.)

MEDICAL PROVIDERS TREATING THIS PERSON

Name of Doctor	Doctor's Phone Number	Doctor's Address
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has this person received treatment for this medical problem in the last three months?

Yes No

Has this person been hospitalized or used community health services for this problem in the last 12 months?

Yes No

If yes, where? _____



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 get health care.

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:

- Four checkbox items with arrows pointing to income qualification ranges for 1, 2, 3, and 4 family members.

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 (list last name, then first name):

Home Address: Apt. #:

City: State: Zip:

Social Security Number (Required): Phone Number:

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

Policy Number: Group Number:

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

Blank line for family member names

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.allkids.com or call 1-866-All-Kids (1-866-255-5437). If you use a TTY, call 1-877-204-1012. The call is free.

FORM H (cont.)

Part B

This part of the form must be completed by 1) the employer providing the health insurance, or 2) 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? Check all that apply. Physician Services Hospital Inpatient Services

Amount of premium (for physician and hospital inpatient) paid by employee: \$ _____

Include amounts paid for dental, vision and prescription coverage.

Premiums are paid:

- Weekly Every 2 weeks Twice a month Monthly Every 2 months Quarterly Semi-annually Annually

List the 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 physician and hospital inpatient coverage of the employee only (single rate)?

\$ _____ Include single rate 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 this completed form to the employee for submission with the application.

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

SUSAN DAWSON-TIBBITS
ATTORNEY AT LAW

JOHNSON, BUNCE & NOBLE, P.C.
7800 N. Sommer Street, Suite 425
Peoria, IL 61615
Telephone: (309) 691-9650 Fax: (309) 691-9651
Email: susan@peorialawyers.com

ITEMS REQUIRED FOR MEDICAID APPLICATION

The Medicaid application **requires** verification of U.S. citizenship, health insurance (if any), all income, and all assets. Please bring the following documents with you to your meeting with the attorney. You can either supply a copy, or bring in the originals and we will copy them for you here. **If the Medicaid applicant is married, we need all documents for both the applicant and his/her spouse.** If you have any questions regarding any of the items listed, please call.

1. IDENTIFICATION

- a. proof of age (i.e. birth certificate, baptismal certificate, etc.)
- b. driver's license or other photo identification card
- c. Social Security card (both sides)
- d. Medicare card (both sides)
- e. all health, hospitalization and/or prescription drug insurance cards (both sides)
- f. Marriage license, divorce decree, death certificate, military service records (if applicable)

2. LEGAL DOCUMENTS

- a. wills, codicils, trust agreements
- b. Power of Attorney for Property
- c. Power of Attorney for Health Care
- d. Guardianship documents, if you or someone else has been appointed as the legal guardian of the applicant or spouse

3. INCOME

- a. check or award letter for Social Security, SSI, Veterans' Benefits, Worker's Compensation, or any other government benefits
- b. check or award letter for all pensions or other retirement benefits
- c.
- d. check or other statement of trust and/or annuity payments



- e. check or paystub from employment
- f. documents showing farm income received
- g. proof of money received from any other source (i.e. maintenance (alimony), loans, gifts from family or friends, rental income, boarders, etc.)

4. **ASSETS**

- a. deeds, tax bills, and current mortgage statement for all real estate owned
- b. titles and payment book for all motor vehicles owned (i.e. cars, trucks, boats, trailers, motor homes, etc.)
- c. all individual and group life insurance policies
- d. a current cash value statement for each life insurance policy with a cash value
- e. long-term care insurance policies
- f. statements for **all** bank and credit union accounts **for the last five years** (i.e. checking, savings, money market, certificates of deposit, etc.)
- g. statements for **all** brokerage accounts **for the last five years**
- h. statements for all IRA and other retirement accounts **for the last five years**
- i. annuity contract and statements **for the last five years**
- j. trust fund documentation and statements **for the last five years**
- k. all savings bonds, treasury bills, or any other type of government bond
- l. proof of ownership and value of burial lots, burial merchandise, prepaid funerals, or prepaid burial contracts
- m. notes or mortgages receivable by you (meaning they are payable to you)
- n. Information regarding **any other asset owned by you of whatever type**

5. **OTHER**

- a. federal and state tax returns **for the last five years**
- b. unpaid doctor, hospital or dental bills, or unpaid prescription drug expenses for the last three months
- c. unpaid nursing home bills for the last three months

Please keep in mind that **ALL ASSETS** must be disclosed on the Medicaid application. Any non-disclosure can be prosecuted as Medicaid fraud.



ADDITIONAL FINANCIAL INFORMATION FOR LONG TERM CARE APPLICANTS

Read carefully and follow all instructions:

- For new applicants applying for Nursing Home Services, Supported Living Program or Department on Aging Home and Community based services, this form must be included with your paper application (see last page of this form for mail/fax information) or upload with your electronic application when you file through abe.illinois.gov.
- For current medical clients who are applying for Nursing Home Services or Supported Living Program or requesting Department on Aging Home and Community based services, this form must be completed and sent to DHS Family & Community Resource Center Long Term Care Hub (see last page of this form for mail/fax information) immediately when the need for these services begin.
- Answer ALL questions completely and accurately. Every question must be answered. Any false statements or concealment of material fact may be cause for prosecution or other appropriate legal action.
- Attach additional pages if more room is needed to completely answer any question(s)
- Sign the form.
- Provide documentation, of the resources you told us that you have changed, sold, or given away, with this form. This may enable your request to be processed more quickly. Verifications should be sent with the form or uploaded to abe.illinois.gov
- Documentation you do not provide with this form will be requested later.

HFS USE ONLY
DHS CASE No. _____
OIG USE ONLY
OIG CASE No. _____
DR: _____
DC: _____

APPLICANT

Last Name _____ First Name _____ Middle Initial _____

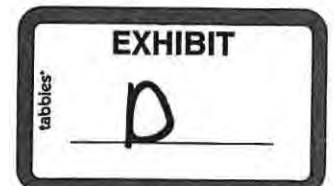
SS# _____ DOB _____

Name of nursing home or supported living facility (if applicable) _____

Date of Admission _____

Answer all questions about the resources of you or your spouse. Include any actions taken by someone else on your behalf. A transfer includes changing the ownership of the resource or reducing your share of the ownership.

1. Did you or your spouse give away, close, or transfer any of the following in the past 60 months? Yes No



Account Type	Institution Name	Date	Amount
Checking/Savings			
Christmas Club			
Certificate of Deposit			
Investment or Retirement account (money market, mutual fund, IRA, 401K, deferred comp, other)			
Stocks/Bonds			
Other			

2. Did you or your spouse give away, sell or transfer any property such as home, land or buildings (including farmland, mineral rights, life estate, mobile home) in the past 60 months? Yes No

If yes, date property given away, sold or transferred _____

Provide documentation of the sale of the property and the value when you transferred ownership. Examples of acceptable documentation to verify sale includes; settlement statement, deed (also acceptable for give away or transfer).

Examples of acceptable documentation to verify value includes; tax assessment that correlates with the year of the transaction, statement from reputable realtor, appraisal, market analysis.

3. Did you give away or sell any vehicles (including boats, trailers, motorcycles) in the past 60 months? Yes No

If yes, what did you give away or sell and for how much? _____

Date vehicle given away or sold _____

Provide copy of the bill of sale or signed statement from the buyer or the person you gave the vehicle to.

4. Did you or your spouse give away or sell a business (including a farm) or a partnership in a business in the past 60 months? Yes No

Date business given away or sold _____

Provide documentation of the sale of the business and the value when you transferred ownership. Documentation should include name of business, the value of you or your spouses' ownership interest in the business and the date of the transaction.

5. Did you or your spouse give away or sell any business equipment (including farm equipment, livestock, grain, wind turbines, etc.) in the past 60 months? Yes No

If yes, date business equipment given away or sold _____ Approximate value of equipment at time given away or sold _____

Provide documentation of the sale of the equipment. Documentation should include type of equipment, value of equipment and date of transaction.

6. Did you or your spouse receive rental income or income from a farm lease or cash rent in the past 60 months? Yes No
Date of most recent income received _____

7. Did you or your spouse get a loan or take out a reverse mortgage on your home in the past 60 months? Yes No
If yes, date loan was taken out _____ Amount of loan _____
Provide a copy of the loan/reverse mortgage papers.

8. Did you or your spouse make a loan, mortgage or promissory note agreement with anyone in the past 60 months? Yes No
Include anyone who owes you or your spouse money with an agreement to repay and any property sold contract for deed.
If yes, date loan was made _____ Amount of loan _____
Provide a copy of all promissory notes, loans, mortgage agreements or contracts for deed.

9. Have you or your spouse purchased any type of annuity in the last 60 months? Yes No
If yes, date of purchase _____ Provide a copy of all annuity contracts.

10. Do you have an insurance policy that pays for nursing home care when you are in a nursing home? Yes No
If yes, name of the insurance company _____
Who receives the payments from the insurance company? Nursing home You Someone else
Name of person _____ Provide a copy of your policy.

11. Did you or your spouse inherit (including refusal to accept inheritance) such as money, property, stocks, bonds, etc. within the last 60 months? Yes No
If yes, include a copy of the accounting of the estate settlement.
What is the amount or value you inherited? _____ On what date did you receive the inheritance? _____
Name and relationship of the deceased person _____ Date of death _____

12. Did you or your spouse have a trust or establish a trust in the last 60 months for yourself or someone else? Yes No
If yes, date trust established _____
Did you or your spouse add resources to an existing trust in the last 60 months? Yes No
If yes, date resources were added _____
If yes to either question, provide a copy of the trust agreement and include a list of all the assets held in the trust.

13. Do you or your spouse have an interest in a Time Share? Yes No

If yes, provide documentation about the time share.

14. Have you filed a federal income tax return in the last 60 months? Yes No

In which years? _____

Provide a copy of your tax return including all attachments filed in the last 60 months.
Provide copy of all 1099's for each year.

15. What is your current marital status? Single Married Divorced

Widowed Legally Separated

Provide information about your current or most recent spouse.

Name _____ Phone _____

Address _____

16. Provide the addresses of the last two places you lived in the past 60 months:

17. Within the last 60 months did you talk to a financial planner or attorney about your need to reside in a nursing home or discuss any of the following issues? Yes No

- How you can use your income and resources to pay for long term care
- How you might become eligible for medical assistance if you are unable to pay for long term care
- Estate planning to develop a plan to divide your resources between your family members or other heirs or placing your resources in a trust.

Provide information about the attorney(s) or financial planner(s)

Name		Name	
Address		Address	
Email Address		Email Address	
Phone		Phone	

18. Has someone been helping with you financial affairs other than named above? Yes No

This includes managing your savings or checking accounts, paying your bills or managing financial investments. This could be a family member, friend, investment advisor or Power of Attorney (POA).

Provide information about who has been helping you with your financial affairs.

Name		Name	
Address		Address	
Email Address		Email Address	
Phone		Phone	
Is this person your POA?		Is this person your POA?	
For Health? <input type="checkbox"/>	For Financial? <input type="checkbox"/>	For Health? <input type="checkbox"/>	For Financial? <input type="checkbox"/>

Provide a copy of financial POA papers.

I, the undersigned, hereby certify and swear, that all information on this form is true, accurate and complete. I understand that the information on this form may be used to determine eligibility for medical assistance and that payments will be made from state and federal funds. Any false statements, or documents, or concealment of material fact may be cause for prosecution or other appropriate legal action.

The undersigned hereby consents and authorizes Illinois Department of Healthcare and Family Services and Department of Human Services to investigate, obtain and verify all information necessary in connection with the request for public assistance. Such information shall include, but not be limited to, documents of financial institutions, trusts, insurance, stocks/mutual funds, real estate, pension, SSI/SSA, and any other type of financial resources. Failure to cooperate or provide documentation or information necessary to determine the applicant's eligibility may result in the denial of assistance.

SIGN YOUR NAME OR MAKE YOUR MARK:

Applicant

Date

Spouse

Date

****IF THIS FORM IS COMPLETED BY SOMEONE ON BEHALF OF THE APPLICANT, THAT PERSON MUST IDENTIFY** THEIR RELATIONSHIP (LEGAL GUARDIAN, POWER OF ATTORNEY, ETC.) TO THE APPLICANT AND SIGN BELOW.**

I, the undersigned, hereby certify and swear, that all information on this form in true, accurate and complete. I understand that the information on this form may be used to determine eligibility for medical assistance and that payments will be made from State and Federal funds. Any false statements, or documents, or concealment of material fact may be cause for prosecution or other appropriate legal action.

The undersigned hereby consents and authorizes Department of Human Services and Healthcare and Family Services to investigate, obtain and verify all information necessary in connection with the request for public assistance. Such information shall include, but not be limited to, documents of financial institutions, trusts, insurance, stocks/mutual funds, real estate, pension, SSI/SSA, and any other type of financial resources. Failure to cooperate or provide documentation or information necessary to determine the applicant's eligibility may result in the denial of assistance.

Print Name

Relationship (Legal Guardian, Power of Attorney, Etc.)

Signature

Date

Home Address

Telephone Number

CONTACT INFORMATION

1. If the person applying for medical assistance lives in one of the following counties (**Boone, Carroll, Cook, DeKalb, DuPage, Jo Davies, Kane, Kankakee, Kendall, Lake, Lee, McHenry, Ogle, Stephenson, Whiteside, Will, Winnebago**) send your application (including this form) to:

Medical Field Operations
1112 S. Wabash
Chicago, IL 60605-2351
Fax: 312-793-4566
DHS.MFOInfo@illinois.gov

2. If the person applying for medical assistance lives in **any of the remaining counties in Illinois** (other than listed above) send your application (including this form) to:

Macon County Long Term Care (LTC)
707 E Wood Street
Decatur, IL 62523
Fax: 217-362-6515
DHS.MaconLTC@illinois.gov

JOHNSON, BUNCE & NOBLE, P.C.

FREDERICK A. JOHNSON
JAMES P. JOHNSON
BRIAN F. JOHNSON
PATRICK T. CHAMBERS
SUSAN DAWSON-TIBBITS
ROBERT J. HILLS
JAMES F. KANE
WILLIAM W.P. ATKINS

FORMERLY SWAIN, JOHNSON & GARD
ESTABLISHED 1946
EXECUTIVE OFFICES – PARKWAY PLAZA
7800 N. SOMMER STREET, SUITE 425
PEORIA, ILLINOIS 61615-1994
TELEPHONE NUMBER:
(309) 691-9650
FACSIMILE NUMBER:
(309) 691-9651
WWW.PEORIALAWYERS.COM

ARBER JOHNSON
(1915-1982)
MISHAEL O. GARD
(1918-1996)
PARALEGALS:
WILMA J. BRINKER
DARCIE E. CURTO
NATASHA M. SLOMCZEWSKI
JACQUELINE M. EHRAT

March 27, 2017

Macon County Long Term Care (LTC)
707 E. Wood Street
Decatur, IL 62523

Re: [REDACTED]
Application for LTC Medicaid

To Whom It May Concern:

I represent [REDACTED], spouse and Power of Attorney for [REDACTED]. Mr. [REDACTED] is a resident at Manor Court of Peoria in Peoria, Illinois.

PLEASE DO NOT DESTROY THIS LETTER. IT PROVIDES AN EXPLANATION OF VARIOUS ITEMS ON THE APPLICATION. PLEASE SCAN THIS LETTER WITH THE OTHER DOCUMENTS SO THAT OIG WILL HAVE ACCESS TO IT.

Enclosed please find the following documents:

- A. Form IL444-2378B – Request for Medical Assistance
- B. Form HFS 3654 – Additional Financial Information for LTC Applicants
- C. Form IL 444-2998 – Approved Representative Consent Form
- D. Form IL444-3162 – Declaration Regarding Citizenship
- E. Supporting Documentation for the above (listed in order of production):
 1. Bank Accounts:
 - a. First Mid-Illinois Bank & Trust – Savings Account ending #2692:
 - (i) OPENED 4/07/2012



- (ii) statements from 4/07/2012 through 12/31/2016 enclosed
 - (iii) There are no transactions \geq \$1000 for this account.
 - c. First Mid-Illinois Bank & Trust Checking Account ending #7989:
 - (i) statements from 1/10/2012 through 02/10/2017 enclosed
 - (ii) List of transactions \geq \$1000 enclosed
 - (iii) Copies of checks \geq \$1000 enclosed
 - d. PNC Bank Checking Account # [REDACTED]:
 - (i) statements from 12/14/2011 through 2/13/2017 enclosed
 - (ii) List of transactions \geq \$1000 enclosed
 - (iii) Copies of checks \geq \$1000 enclosed
- 2. Certificates of Deposit: N/A
- 3. Annuities: N/A
- 4. Investment Accounts:
 - a. Morgan Stanley Account # [REDACTED]:
 - (i) statements from 1/01/2012 through 2/28/2017
 - (ii) List of transactions \geq \$1000 enclosed
- 5. Retirement Accounts: N/A
- 6. Stocks/Bonds: N/A
- 7. Life Insurance Policies:
 - a. Country Companies Whole Life Policy # [REDACTED]:
 - (i) This policy belongs to [REDACTED].
 - (ii) This policy has a face value of \$3,000.00.
 - (iii) This policy has a cash value of \$1,067.97.
 - b. Country Companies Life Insurance Policy # [REDACTED]:

- (i) This policy belongs to [REDACTED]
- (ii) This policy has a benefit value of \$1,331.97
- (iii) This policy has a cash value of \$816.35
- (iv) Copy of Annual Policy Statement dated November 28, 2016

c. AXA Equitable Life Account # [REDACTED]:

- (i) This policy belongs to [REDACTED]
- (ii) This policy has a death benefit of \$55,660.00
- (iii) This policy has a cash surrender value of \$41,220.79

d. AXA Equitable Life Account # [REDACTED]:

- (i) This policy belongs to [REDACTED]
- (ii) This policy has a death benefit of \$41,814.97
- (iii) This policy has a cash surrender value of \$28,864.77

8. Real Property:

a. Property located at [REDACTED], Peoria, IL 61615:

- (i) Copy of Warranty Deed, dated October 20, 1992, in which title was conveyed to Mr. & Mrs [REDACTED].
- (ii) Copy of 2015 Peoria County Real Estate Tax Bill

9. Pre-Need Burial Plan:

a. Pre-Need Burial Plan through Davison-Fulton-Woolsey-Wilton Funeral Home.

- (i) [REDACTED] A copy of the Guaranteed Insurance Funded Prearranged Funeral Agreement with Woolsey-Wilton Funeral Home for [REDACTED].
- (ii) A copy of the Guaranteed Insurance Funded Prearranged Funeral Agreement with Woolsey-Wilton Funeral Home for [REDACTED].

- (iii) The list of merchandise and services for [REDACTED] is listed on Scheudle A on page 4 of the Contract.
- (iv) The list of merchandise and services for [REDACTED] is listed on Scheudle A on page 4 of the Contract.

10. Safe Deposit Boxes:

- a. PNC Bank Downtown Bank Safe Deposit Box # [REDACTED]
 - (i) List of contents enclosed
- b. PNC Bank N. Ware Memorial Drive Safe Deposit Box # [REDACTED]
 - (i) List of contents enclosed
- c. First Mid-Illinois Bank & Trust Safe Depposit Box # [REDACTED]
 - (i) List of contents enclosed

11. Vehicles:

- a. 2010 Cadillac CTS Luxury
 - (i) VIN [REDACTED]
 - (ii) Purchased on 09/30/2014 for \$21,109.00. Copy of bill of sale enclosed
 - (iii) Trade in value received for 2007 Cadillac DTS Sedan for \$10,650.00
 - (iv) Balance of \$13,108.00 paid by check number 1810 of Morgan Stanley Account # [REDACTED], in the amount of \$13,008.00, and \$100 cash.
 - (v) Copy of Title enclosed

12: Trusts:

- a. Copy of [REDACTED] Trust Agreement dated October 10, 2014.
- b. Copy of [REDACTED] Trust Agreement dated October 10, 2014.
- c. Copy of Warranty Deed into Trust, recorded October 15, 2014, by which title was transferred into the [REDACTED].

- d. Copy of Bill of sale, dated October 10, 2014, by which the Stoneware Collection was transferred into the [REDACTED].
13. Inheritance: N/A
14. Income Tax Returns:
- a. 2011 federal and state tax returns (filed in 2011)
 - b. 2012 federal and state tax returns (filed in 2012)
 - c. 2013 federal and state tax returns (filed in 2013)
 - d. 2014 federal and state tax returns (filed in 2014)
 - e. 2015 federal and state tax returns (filed in 2015)
15. Nursing Home Correspondence: N/A
16. Spousal Verification:
- a. Copy of Marriage License
17. Income:
- a. Proof of Social Security – See bank statements
 - b. Proof of State of Illinois Pension monthly benefits – See bank statements
18. Other Notes/Points of Interest:
- a. Illinois Power of Attorney for Property, appointing [REDACTED] as agent for [REDACTED].
 - b. Birth Certificate of [REDACTED]
 - c. Birth Certificate of [REDACTED]
 - d. Illinois Driver's License/U.S Passport for [REDACTED]
 - e. Illinois Driver's License/U.S Passport for [REDACTED]
 - f. Social Security Cards for [REDACTED]
 - g. Medicare Cards for [REDACTED]
 - h. Humana Enhanced Prescription Drug Plan for [REDACTED]
 - i. United Healthcare Rx Card for [REDACTED]
 - j. Humana Medicare Supplement Plan Card for [REDACTED]
 - k. Copies of unpaid medical bills.

PLEASE CONTACT THE UNDERSIGNED IF ANY ADDITIONAL INFORMATION IS NEEDED TO MAKE A DETERMINATION ON THIS APPLICATION. Thank you for your cooperation in this matter.

Very truly yours,

JOHNSON, BUNCE & NOBLE, P.C.


Page 6

3/27/2017

JOHNSON, BUNCE & NOBLE, P.C.

By:

Susan Dawson-Tibbits
Attorney at Law

SDT/jme
Enclosures
cc: Mrs. 

Provider Notice Issued 05/10/2017

Department of Human Services Medical Field Operations Changes

Date: May 10, 2017

To: Long Term Care Facilities - Nursing Facilities (NF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Supportive Living Program (SLP) and Nursing Facilities eligible to be licensed Specialized Mental Health Rehabilitation Facilities (SMHRF)

Re: Department of Human Services Medical Field Operations Changes

The Departments of Healthcare and Family Services (HFS) and Human Services (DHS) continue to review operational procedures and identify ways to improve efficiency. This notice informs Long Term Care (LTC) providers of the addition of a third (3rd) DHS LTC office ("hub"). This office will provide experienced staff to increase productivity and more evenly distribute workflow. Work Operations (MFO) offices will be based upon the DHS Region of the county in which the

<p>Region 1 Medical Field Operations - North (#200) 1112 S Wabash Chicago, IL 60605 (312)793-8000 (312)793-4566 fax (866)214-8309 TTY DHS.MFOInfo@illinois.gov</p>	<p>Servi count Cook</p>
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<p>Region 2 (Effective May 1, 2017) Medical Field Operations - Central (#244) 1642 W 59th St, FL 1 Chicago, IL 60636 (773)863-6339 (773)863-6307 fax DHS.MFOCentral@illinois.gov</p>	<p>Serving facilities located in the following counties: Boone, Carroll, DeKalb, DuPage, JoDaviess, Kane, Kankakee, Kendall, Lake, Lee, McHenry, Ogle, Stephenson, Whiteside, Will and Winnebago</p>
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<p>Region 3 (<i>Effective April 1, 2017</i>) Medical Field Operations - Central (#244) 1642 W 59th St, FL 1 Chicago, IL 60636 (773)863-6339 (773)863-6307 fax DHS.MFOCentral@illinois.gov</p>	<p>Serving facilities located in the following counties:</p> <p>Bureau, Champaign, Ford, Fulton, Grundy, Henderson, Henry, Iroquois, Knox, LaSalle, Livingston, Marshall, Mason, McDonough, McLean, Mercer, Peoria, Putnam, Rock Island, Stark, Tazewell, Vermilion, Warren and Woodford</p>
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<p>Region 4 (<i>formerly known as Macon LTC Unit</i>) Medical Field Operations - Downstate (#163) 707 E Wood Decatur, IL 62523-1154 (217)362-6515 phone/fax (217)362-6659 fax (alternate) (866)847-6171 TTY DHS.MaconLTC@illinois.gov</p>	<p>Serving facilities located in the following counties:</p> <p>Adams, Brown, Calhoun, Cass, Christian, Clark, Coles, Cumberland, DeWitt, Douglas, Edgar, Effingham, Green, Hancock, Jersey, Logan, Macon, Macoupin, Menard, Montgomery, Morgan, Moultrie, Piatt, Pike, Sangamon, Schuyler, Scott and Shelby</p>
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<p>Region 5 (<i>formerly known as Macon LTC Unit</i>) Medical Field Operations - Downstate (#163) 707 E Wood Decatur, IL 62523-1154 (217)362-6515 phone/fax (217)362-6659 fax (alternate) (866)847-6171 TTY DHS.MaconLTC@illinois.gov</p>	<p>Serving facilities located in the following counties:</p> <p>Alexander, Bond, Clay, Clinton, Crawford, Edwards, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson, Lawrence, Madison, Marion, Massac, Monroe, Perry, Pope, Pulaski, Randolph, Richland, Saline, St. Clair, Union, Wabash, Washington, Wayne, White and Williamson</p>
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Felicia F. Norwood
 Director



APPROVED REPRESENTATIVE CONSENT FORM

APPROVED REPRESENTATIVE'S INFORMATION (PLEASE PRINT LEGIBLY OR TYPE)

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

CLIENT SECTION

I want the person named above to apply for cash, medical and/or Food Stamp benefits for me and/or my family. I understand that I am still responsible for the information that my representative gives to the Department.

Client's Signature (or mark): _____

Signature of Witness
(if client signed with a mark): _____

Date: _____

REPRESENTATIVE SECTION

I have talked to the client about why they are signing this form. I (or the company I represent) will submit to the Illinois Department of Human Services a request for cash, medical, and/or Food Stamp benefits on their behalf. I have also told this client that DHS needs to have certain facts to make a correct decision on their eligibility for benefits.

I have told the client that they need to cooperate with DHS to obtain any needed verification(s) for the eligibility decision.

Representative's Signature: _____

Relationship to Client: _____





APPEAL REQUEST FORM (SNAP, Medical Assistance, Cash Assistance, Child Care)

Use this form only if you want to file an appeal (this is a request for a hearing). Your Family Community Resource Center (FCRC or local office) may help you fill out this form. You may file this form with your FCRC or with the Bureau of Hearings at 69 W. Washington, 4th Floor, Chicago, IL 60602 or via email at DHS.BAH@Illinois.gov, Fax at (312) 793-3387 or by Telephone at (800) 435-0774.

Appellant First Name	Appellant Last Name	Telephone Number
Address (No. & Street, Apt. No.)	City, County	State, Zip Code
Name Case is Under	Case Number	Social Security Number

Will you need an interpreter in the hearing? Yes No If Yes, what language? _____

I am appealing action taken on: (check all that apply) SNAP Long Term Care Medical Assistance AABD Cash Assistance TANF Child Care

Application/Request Date: _____

Department Date of Notice from which you are appealing: _____

I AM REQUESTING A FAIR HEARING BECAUSE:

- ___ My application/request was denied and I disagree with this
- ___ IDHS says I am not disabled and I disagree with this
- ___ I was enrolled in spenddown and I disagree with this
- ___ A penalty period was imposed and I disagree with this
- ___ I disagree with the benefit amount
- ___ I disagree with the beginning eligibility date
- ___ My benefits were stopped or reduced and I disagree with this
- ___ I was charged with an overpayment and I disagree with this
- ___ My SNAP benefits were recouped for a previous overpayment claim(s) and I disagree with this
- ___ Money was recovered on an overpayment claim(s) and I disagree with this
- ___ A sanction was imposed and I disagree with this
- ___ I asked to be exempt from the Department's work and training activities and I was denied
- ___ I requested Crisis Assistance and I was denied
- ___ IDHS has not taken action on my application or a request

Other Reason _____





APPEAL REQUEST FORM (SNAP, Medical Assistance, Cash Assistance, Child Care)

Please Check One:

Under some programs, benefits may continue while the hearing decision is pending. If possible,

I WANT my benefits to continue until the hearing decision is made. I understand that if the decision is not in my favor, I may have to pay back the benefits. I want the following benefits to continue:

- Cash SNAP Cash and SNAP Medical Assistance

I DO NOT WANT my benefits continued while the hearing decision is pending.

Do you want someone else to represent you at the hearing? If yes, provide their information in the space below.

Approved Representative First Name, Last Name	Telephone Number	Email Address
Address (No. & Street, Apt. No.)	Representative's Firm (if applicable)	City, State, Zip Code

(If signed by a person other than the customer, you must attach written authorization to file an appeal on behalf of customer. Please note: the Bureau of Hearings does not have a standardized authorization form and the "Approved Representative Consent Form" (IL 444-2998) is not accepted for appeal representation, as its scope is limited to applying for benefits.)

Your Signature (or Signature of Approved Representative) _____ Date _____

(if signed by a person other than the customer, attach written authorization to file an appeal on behalf of customer)

Please Note: You are entitled by law to a final decision on your appeal and to full implementation of a decision favorable to you within 90 days from the time you requested the appeal, unless you have requested a delay of your hearing. For SNAP benefits only, you are entitled by law to a final decision on your appeal within 60 days and full implementation of a decision favorable to you within 10 days of receipt of the hearing decision.

For IDHS Office Use Only: To be completed by the FCRC or Hearings

Date Notice of Appeal Received:	Date of Postmark, if mailed (attach envelope):	Date of written request for hearing, if preceding this form:
Date of Decision Being Appealed:	Case Name:	Case Number:



APPEAL WITHDRAWAL AGREEMENT

If you need help in completing this form, your representative, if you have one, or your caseworker will assist you. Upon completion you can file your withdrawal at the FCRC (local office) or with the Bureau of Hearings at 69 W. Washington, 4th Floor, Chicago, IL 60602 or via email at DHS.BAH@Illinois.gov, Fax at (312) 793-3387.

Appellant First Name	Appellant Last Name	Telephone Number
Address (No. & Street, Apt. No.)	City, County	State, Zip Code
Name Case is Under	Case Number	Social Security Number

Program(s) Under Appeal (check all that apply):

- SNAP Medical Assistance AABD Cash Assistance TANF Child Care

Section 1: I filed an appeal requesting a fair hearing because:

Section 2: I have decided to withdraw my appeal and request for a fair hearing because:

- IDHS has agreed to reopen my assistance benefits, make a new decision, and send a new notice
- I now understand the action taken by IDHS and agree with their decision
- IDHS has determined I am disabled and will determine my eligibility from the original date of application _____ with a back date to _____
- IDHS has agreed to NOT reduce or cancel my benefits
- Other (Specify) _____

I understand that by withdrawing my appeal, I will not be able to have a fair hearing on this appeal. I also understand that, except for any promises written down in Section (2) above, this form is the complete agreement and I will not be able to appeal this same issue again.

DO NOT SIGN THIS FORM UNLESS IT IS FILLED OUT COMPLETELY AND YOU UNDERSTAND IT. YOU CAN REQUEST A COPY OF THIS FORM AFTER YOU HAVE COMPLETED IT AND IT HAS BEEN SIGNED BY THE FCRC REPRESENTATIVE.

Your Signature (or Signature of Authorized Representative)

Date

FCRC Representative Signature

Date

For IDHS Office Use Only: To be completed by the FCRC

Case Name:	Case Number:
Date Request was Received:	Appeal Number:





Application for Hardship Waiver

This application is used to process your request for a hardship waiver due to a penalty period or denial due to excess home value. A penalty period was created when you transferred resources or income for less than their value or you were determined ineligible due to the value of your home. You must provide proof that an actual hardship exists as a result of the state's decision.

Your Name _____

DHS Case Number _____

Long Term Care Facility _____

Long Term Care Facility Address _____

- I am applying for a waiver due to a penalty period (complete Sections 1 and 3).
- I am applying for a waiver because I was denied due to my home value (complete Sections 2 and 3).

Section 1 for Penalty Periods: **We must review the transfer and the reason for the transfer.**

I transferred (value of property) _____

to (person or other entity) _____

my (relationship to me) _____

The reason I made this transfer was:

We must review what you have done to recover the transfer including taking all reasonable legal action. Use additional sheets for multiple transfers.

I have contacted the person/entity I made the transfer to and I have recovered _____ to pay for my care.

What steps have you taken to recover more than the amount you entered above?

Provide specific proof of the action you have taken.
Attach copies of documentation, if available.

I am unable to recover any more because:

Section 2 for Home Value: **We must review what you have done to access the value of your home to pay for medical care.**

- My spouse (name) _____
or my minor or disabled child (name) _____
lives in the home.
- I contacted a realtor (name) _____
whose phone number (with area code) is _____
on (date) _____ to list my home for sale.
- Other Provide the reason you believe we should not consider the value of your home:

Section 3 for all Waivers: **We must review the reason a hardship exists.**
Without a hardship waiver, I will be deprived of (check those that apply):

- Food because _____
- Shelter because _____
- Clothing because _____
- Necessary Medical Care because _____
- Other Necessities of Life such as _____
because _____

We must review your proof that an actual hardship exists.

Provide supporting proof that you will actually be deprived of food, shelter, clothing, medical treatment or other necessities of life.

We must review your current resources.

My current income is _____ per month from _____

I currently have resources totaling _____

My spouse has resources totaling _____ and _____

income per month from _____

Do you own or are you purchasing a home? Yes No

We may need to contact you if we need more information, or if we need to discuss the information you gave us. What is the best phone number to contact you?

Phone Number _____

Is there someone else that you will allow us to talk to about your hardship waiver application?

Name _____

Address _____

Phone Number _____

Sign below only if you declare under penalty of perjury that this information is true and correct to the best of your knowledge. Providing false information on this application may result in a denial.

Signature

September 22, 2017
Date

Authorized Representative's Signature (if any)

Send this Application for Hardship Waiver to:
Office of Counsel to the HFS Inspector General
401 S. Clinton St., 6th Floor
Chicago, IL 60607

or:
Fax 312-793-1475



Statement of Hardship - Waiver of Penalty Period

Complete this form to request a waiver of a penalty period because it will cause you a hardship. This penalty period was created because you transferred resources or income before 11/1/11 for less than fair market value.

Read the statements below carefully. By completing and signing this form, you confirm the truth of the statements and information you provide below under penalty of perjury. You can be held legally responsible for giving false information.

Your Name _____

DHS Case Number _____

Long Term Care Facility _____

Long Term Care Facility Address _____

I confirm that in making the transfer that caused this penalty I was aware of the transfer policy (89 Ill. Adm. Code 120.387) that was in effect before 1/1/12, and made my decision about the transfers based on that policy.

If the State of Illinois does not pay for my care, I will be deprived of:

(check all that apply)

- Food
- Life-Sustaining Medical Care
- Clothing
- Shelter

I understand that by signing this **Statement of Hardship - Waiver of Penalty Period**, 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 this request. I understand that I must cooperate in these efforts to verify information. I understand that if I have given false information or intentionally failed to disclose information, I may be subject to criminal or civil prosecution or both. I certify under the penalty of perjury that the information I have provided on this form is the truth to the best of my knowledge.

Client's Signature

Date

Address (If different than facility shown above.)

Authorized Representative's Signature

Date

Address

Phone Number

Return completed and signed form to: Office of Counsel to the HFS Inspector General, 401 S Clinton, 6th Floor, Chicago IL 60607 or Fax (312) 793-1475

