IMPORTANT MEDICAID INFORMATION

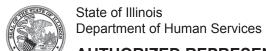
Responsible Party/ Family Member/Power of Attorney:

Medicaid applications are now submitted online. Our Medicaid Coordinator at the facility is available to assist you with this process. Below is a list of some of the information you will need to complete the application:

- HFS-3654 Form (Additional Financial Information for Long-Term-Care Applicants)
 MUST be completed for LTC Benefits
- 2) Consent Form (IL 444-2998)
- 3) State ID or Driver's License (copy front and back)
- 4) Birth Certificate (copy)
- 5) Social Security Card (copy front and back)
- 6) Medicare Card (copy front and back)
- 7) Health Insurance Card; supplement or Option C (copy of front and back)
- 8) Marriage License; Divorce Decree; Death Certificate- whichever applies
- 9) POWER OF ATTORNEYS for HEALTHCARE and PROPERTY
- 10) Proof of Assets (copy)
 - a. Social Security letter showing amounts receiving along with a copy of check or bank statement if EFT. Include Spouse's if necessary.
 - b. Pension- gross \$ amount (copy of check) and the Pension award letter showing all possible deductions.
 - ALL Bank Accounts- checking/savings/CDs
 Copy detailed bank statements. Printouts are not acceptable.
 (Minimum 1 year- preferably 3 years)
 - d. Copy of any checks and deposits written for over \$1000.00
 - e. Annuities (name/address/\$ amount)
 - f. Other income not listed:(Child support, alimony, rental income, etc... along with proof)
 - g. Life Insurance \$ amount- inc. (policy #, name/address of company/cash & face values)
 - h. Titles of ownership (vehicle/boat/RV/etc.)
 - i. Owned property- address/assessed value/mortgage/taxes
 - j. 3-5 years of tax returns, if filed including all attachments of 1099's etc.
 - k. NOTE: If you have a spouse in the community, you must provide proof of both incomes and total assets

11) Proof of Expenses:

- a. Copy of Health Insurance Premium \$ amount (any and all insurance premiums)
 The insurance premium notice is the best source document
- b. Prepaid funeral/burial plans (proof of ownership/value and date of purchase)



AUTHORIZED REPRESENTATIVE FORM FOR APPEALS

Use this form if you want someone to act on your behalf with the Department of Human Services for purposes of appealing: the inaction of the Department; or a decision made by the Department.

INSTRUCTIONS FOR COMPLETING THIS FORM:

- Appoint an Authorized Representative for Appeals: Complete Section A (the Appellant/Client Information section) and complete, sign, and date Section B (the Appellant/Client Permission section). Have your Representative complete, sign and date Section C (the Representative section).
 - o You can only name one person or organization as your Authorized Representative.
 - o If Section A is signed by the Appellant/Client's power of attorney or legal guardian per a court order, you must send that legal document with this form.
 - An Authorized Representative for Appeals may be any person or organization you choose, regardless of whether you pay them. To apply for free legal help:
 - In Cook County (including the City of Chicago) Legal Assistance Foundation of Metropolitan Chicago: (312) 341-1070
 - In other counties in Northern or Central Illinois with area codes (309), (815) or (847) Prairie State Legal Services: (800) 531-7057
 - In other counties in Central or Southern Illinois where the area code is (217) or (618) Land of Lincoln Legal Assistance Foundation: (877) 342-7891.
- Right to End Representation: You may stop this person or organization from acting as your Authorized
 Representative for Appeals at any time. If you decide you no longer want this person or organization to act on
 your behalf, complete Section A (the Appellant/Client Information section) and complete, sign, and date
 Section D (the End My Authorized Representative for Appeals section). This change will take effect once the
 Bureau of Hearings receives the signed request from you.
- Keep a copy of this form for your records.

HOW TO SUBMIT THIS FORM - Use one of the 2 easy ways below:

- You can assign an Authorized Representative for Appeals online, using the ABE Appeals Portal. Go to: https://abe.illinois.gov/abe/access/appeals and follow the prompts when filing an appeal or updating your account, and then upload this completed form into ABE; or
- 2. Fill out, sign, and send this form by email, fax, mail, or deliver in person to:
 - a. Email: DHS.BAH@illinois.gov
 - b. Mail: DHS Bureau of Hearings
 69 W. Washington, 4th Floor
 Chicago, IL 60602
 - c. Fax: 312 793-3387
 - d. In Person at the mailing address above; or at your local FCRC.
 - Requests to End My Authorized Representative for Appeals made on this form may be returned as indicated above
 - If you have questions about this form, you may contact the Bureau of Hearings via the methods listed above or by calling: 1-800-435-0774.

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AUTHORIZED REPRESENTATIVE FORM FOR APPEALS

SECTION A

APPELLANT/CLIENT INFORMATION: Complete this section if you are the Appellant/Client (If, signed by the Client's power of attorney or legal guardian per a court order, then you **must** submit that legal document with this form or it will not be accepted).

Appellant/Clien	t Name:	Date of Birth	
Social Security	Number: Individual	I.D. Number (if known):	
Name of Author	rized Representative for Appeals, named in Section C, below	w:	
Relationship of	Representative for Appeals to Appellant/Client:		
I want to (che	ck only one box):		
Appoint	a new Authorized Representative for Appeals, pursuant to	89 III. Adm. Code 14.21;	
☐ Change	e the powers my Authorized Representative for Appeals has	; or	
	Authorized Representative's authorization for Appeals (skip y Authorized Representative for Appeals) on Page 3).) Sections B and C and go to S	Section D
SECTION B			
APPELLANT/C	CLIENT PERMISSION: Complete, sign, and date this section	n if you are the Appellant/Clien	t.
Item	Things I want my Authorized Repres Appeals to do for me	sentative for	Check the boxes that apply
Appeals	 Act on my behalf for Appeals. Representation will before the appeal is complete 	continue in the event that I die	
Survive Death	In the event that I die before a Final Administrative De do not authorize this representative to continue with the		(check if you do not want representation to survive death)
behalf for the ite inaction of an a responsible for may be incorred longer want to a	w, I give permission to the Authorized Representative for A ems I have checked in Section B of this form, pursuant to 8 authorized representative shall be deemed to be the action the information my Authorized Representative for Appeals ct. Finally, I understand that I must complete a request to enact on my behalf.	9 III. Adm. Code 14.21. I unde on or inaction of myself. I als gives the Department, included and any Authorized Representate	rstand that the action of ounderstand that I aming any information that
Appellant/Client Signature: Date:			

AUTHORIZED REPRESENTATIVE FORM FOR APPEALS

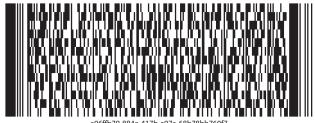
SECTION C

REPRESENTATIVE SECTION: Complete, sign, and date this section if you are the Representative.

· · · · · · · · · · · · · · · · · · ·	
Check only one box:	
☐ I am an individual representing the Appellant/Client. Complete 1, 2, 3, 4 and 5a.	
☐ I am with an organization representing the Appellant/Client. Complete 1, 2, 3, 4 and 5b.	
1. Representative Name:	
2. Representative Address:	
3. Representative Telephone Number:	
4. Representative Email Address:	
5a.	
I agree to keep the confidentiality of any information regarding the Appellant/Client provided to Authorized Representative for Appeals. I understand that I am expected to be knowledgeable or circumstances.	
Signature of Representative: Date:	
5b.	
Name of Individual completing this section and signing below:	
Name of Organization:	
I agree that I have authority to represent the Organization listed above. I also agree, on behalf of the organization will maintain the confidentiality of any information regarding the Appellant or client. I providers, staff members, and volunteers of the Organization will adhere to all applicable State and conflicts of interest, confidentiality of information, and prohibitions against reassignment of provider cl	The Organization and all Federal laws concerning
Signature on behalf of Organization Representative: Date:	
SECTION D	
END MY AUTHORIZED REPRESENTATIVE FOR APPEALS SECTION	
 Instructions to the Appellant/Client: You should complete this section only if you no longer want your Authorized or Organization R your behalf for appeals. Complete, sign, and date below and submit this form according to the instructions on page 1. 	Representative to act on
You must also complete Section A on page 2.	
I no longer want the person or organization named below to act as my Authorized Representative for A	ppeals.
Signature: Date:	



	~~4011000~
Date:	
Case N	



Use this form if you want someone to act on your behalf with the Department of Healthcare and Family Services or the Department of Human Services for Cash, SNAP and Medical benefits

INSTRUCTIONS FOR COMPLETING THIS FORM:

- Appoint an Approved Representative: Complete Section A (the Applicant/Client Information section) and complete, sign, and date Section B (the Applicant/Client Permission section) on Page 2. Have your Representative complete, sign, and date Section C (the Representative section) on Page 3.
 - o If you have a power of attorney or a court order establishing a legal guardianship, you should send that legal document with this form.
 - An applicant living in a drug or alcohol facility must have an approved representative to apply for and receive SNAP benefits.
 - o You should not have to pay anyone to help you apply for benefits.
- Health Information: Federal law says that we cannot share your health information without your permission except in certain situations. If you complete, sign, and return this form, you are giving us permission to share your health information with the person or organization you name as your Approved Representative. More information about our privacy practices is available at http://www2.illinois.gov/hfs/SiteCollectionDocuments/0921063806.pdf and http:// www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL444-4775.pdf
- Right to Cancel: You may stop this person or organization from acting as your Approved Representative at any time. If you decide you no longer want this person or organization to act on your behalf, complete Section A (the Applicant/Client Information section) and complete, sign, and date Section D (the Cancel My Approved Representative section). This change will take effect after we receive the signed request from you.
- Keep a copy of this form for your records. A blank copy of this form is also available at http://www.dhs.state.il.us/ onenetlibrary/12/documents/Forms/IL444-2998.pdf or http://www.hfs.illinois.gov/hipaa/forms.html.
- **HOW TO DESIGNATE AN APPROVED REPRESENTATIVE** Use one of the 3 easy ways below
 - 1. You can assign an Approved Representative online. Go to https://abe.illinois.gov and approve a Representative when completing the application or add one through Manage My Case - Report My Changes - Change in Contact Information, add text, submit change and upload this form; or
 - 2. Fill out, sign, and send this form by mail or fax to:
 - a. Mail to State of Illinois, P.O. Box 19138, Springfield, IL 62794-9138 or
 - b. Fax to 1-844-736-3563.
 - 3. You can return this form in person to your local Family Community Resource Center.
- Requests to Cancel My Approved Representative on this form may be returned as indicated above.
- If you have questions about this form, email them to: DHS.ABE.Questions@Illinois.gov, or call 1-800-843-6154.

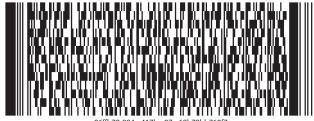






APPROVED REPRESENTATIVE FORM

Date:		
Case Number: (if known)		



Use this form if you want someone to act on your behalf with the Department of Healthcare and Family Services or the Department of Human Services for Cash, SNAP and

Date:			
Case Number: (if known)			
OFOTION A			

SECTION A

APPLICANT/CLIENT INFORMATION: Complete this section if you are the

client or the applicant.	Medical benefits
Applicant/Client's Name:	Date of Birth:
Address:	
Telephone Number:	
Social Security Number (not required):	Recipient I.D. or Case Number:
Name of Approved Representative:	
Relationship of Representative to Applicant/Client:	
I want to (check only one box):	
Appoint a new Approved Representative	
Cancel my Approved Representative (skip See Representative) on Page 3).	ections B and C and go to Section D (Cancel My Approved

SECTION B

APPLICANT/CLIENT PERMISSION: Complete, sign, and date this section if you are the client or the applicant.

Item	Things I want my Approved Representative to do for me
All Matters	 Act on my behalf in all matters, including all items listed below. (Note: This Approved Representative Form does not authorize representation for Appeals. To authorize a representative for appeals, please submit a separate, written authorization when filing the appeal).
Application for Benefits	 Complete, sign, and submit an application for benefits. Receive and submit information about the application.
Continuing Eligibility	 Complete, sign, and submit redeterminations. Receive and submit information about the redetermination Report changes in my circumstances that may affect my eligibility.
Health Information	 Receive copies of all notices about my benefits. Request information (both oral and in writing) relating to my healthcare. I give permission to the Departments to share my health information (including information related to substance abuse, mental health, genetic testing information, and HIV/AIDS) with the Approved Representative.
Health Plan Enrollment and Disenrollment	 Request and receive education and information regarding managed care programs and health plans. Act on my behalf to enroll with, switch to or dis-enroll from a managed care health plan and/or primary care provider (PCP), as allowed by the program.

By signing below, I give permission to the Approved Representative to act for me for the items above. I understand that I am responsible for the information my Approved Representative gives the Departments, including any information that may be incorrect. I also understand that I must complete a request to cancel any Approved Representative that I no longer want to act on my behalf.

Client's Signature:



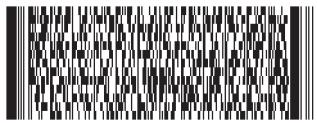




APPROVED REPRESENTATIVE FORM



(if known)

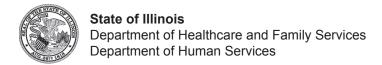


Use this form if you want someone to act on your behalf

Notice to Approved Representative: It is a Class C misdemeanor for any person or organization to fee for certain services. See 305 ILCS 5/8A-18 and 20 ILCS 2225/5. Check only one box: I am an individual representing the client or applicant. Complete 1, 2, 3 and 4a. I am with an organization representing the client or applicant. Complete 1, 2, 3 and 4f. Representative Name: Representative Address: 3. Representative Telephone Number: 4a. I agree to adhere to the regulations in 42 CFR Part 431, Subpart F and at 45 CFR 155.260(f) (r information), 42 CFR 447.10 (relating to the prohibition against reassignment of provider claims an organization acting on the facility's behalf), as well as other relevant State and Federal laws interest and confidentiality of information Representative's Signature: Date: 4b. Name of Individual completing this section and signing below: Name of Organization: I agree that I have authority to represent the Organization listed above. I also agree, on behalf of the organization will adhere to the regulations in 42 CFR Part 431, Subpart F, 45 CFR 155.260(f) (relating formation), 42 CFR 447.10 (relating to the prohibition against reassignment of provider claims as organization acting on the facility's behalf), as well as other relevant State and Federal laws concert confidentiality of information	elating to confidentiality of
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	ng to confidentiality of appropriate for a facility or an
Signature on behalf of Organization Representative:Date:	
SECTION D CANCEL MY APPROVED REPRESENTATIVE SECTION	
 Instructions to the Applicant/Client: You should complete this section only if you no longer want your Approved or Organization your behalf. Complete, sign, and date below and submit this form according to the instructions on page You must also complete Section A on page 2. 	·
I no longer want the person or organization named below to act as my Approved Representative.	
My Name:	
Name of Approved or Organization Representative:	
Signature:Date:	







ADDITIONAL FINANCIAL INFORMATION FOR LONG TERM CARE APPLICANTS

Questions on this form pertain to resources that you and your spouse, including someone else on behalf of you or your spouse, have transferred in the past 60 months. Transferring a resource means:

- Selling a resource
- Giving a resource away
- Giving part of a resource away
- Changing the ownership of a resource to someone else
- Reducing ownership of a resource, such as adding another owner

If you are:

Mark the box that applies

- A new applicant applying for medical benefits and you need help with Nursing Home or Supportive Living Program services or Department on Aging Home and Community Based Services. Attach completed form to your paper application or upload with your electronic application when you file through abe.illinois.gov. A person who has received medical benefits from the State of Illinois for less than 6 months immediately prior to moving to a Nursing Home or Supportive Living Program facility or requesting Department on Aging Home and Community Based Services. Send completed form by the due date to the appropriate DHS office. A person who has received medical benefits from the State of Illinois for 6 months or longer immediately prior to moving to a Nursing Home or Supportive Living Program facility or requesting Department on Aging Home and Community Based Services and you answer YES to One or More of the questions 1-13 on this form: complete this form; and send completed form by the due date to the appropriate DHS office. If you are: A person who has received medical benefits from the State of Illinois for 6 months or longer immediately prior to moving to a Nursing Home or Supportive Living Program facility or requesting Department on Aging Home and Community
 - You are not required to complete; or
 - return this form by the due date

Any false statements or concealment of material fact may be cause for prosecution or other appropriate legal action. Failure to cooperate or provide documentation or information may result in the denial of assistance.

Based Services and your answer to Every question 1-13 on this form is NO:

Page 1 of 8 HFS 3654 (R-12-17)

Notice will be sent to all persons approved to receive assistance with nursing home and supportive living program services and Department on Aging Home and Community Based Services.

Name of Person Requesting Assistance

Last Name	First Name	Mic	ddle Initial
SS#	DOB		
Name of nursing home or	applicable)		
Date of Admission			
 Provide document resources you che uploaded to abe. Documentation y 	pages if more room is needed to comp ntation with this form to support informa nanged, sold, or gave away. Verification illinois.gov rou do not provide with this form will be this form for information about how and	ition you have told is should be sent wrequested later.	us about the ith the form or
1. In the past 60 months property? Yes □	s, did you or your spouse; sell, give awa	ay or change owne	rship in any way to
Property includes; hom	ne, land or buildings, farmland, mineral	rights, life estate, n	nobile home
If yes, date of transact	ion and amount received?		
Examples of acceptab	n to verify the transaction, including the alle documentation are; settlement states ansaction, statement from reputable real	ment, deed, tax ass	sessment that correlate
2. In the past 60 months any of the following?	s , did you or your spouse; close, give a Yes ☐ No ☐	way or change owr	nership in any way to
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			

Provide documentation to verify the transaction/s

Other

HFS 3654 (R-12-17) Page 2 of 8

ა.	pertaining to a vehicle/s? Yes No
	If yes, what type of vehicle?
	Date of transaction and amount received?
	Provide documentation to verify the transaction, including the value at the time of the transfer. <i>Examples</i> of acceptable documentation are: bill of sale, copy of signed title, signed statement from the buyer, copy of check from buyer.
4.	In the past 60 months, did you or your spouse sell, give away or change ownership in any way pertaining to a business? Yes No
	Business includes but is not limited to: home based business, farm, partnership, sole ownership, corporation, limited liability, sole proprietorship.
	If yes, name of business?
	Date of transaction and amount received?
	Provide documentation to verify the transaction, including the value at the time of the transfer. Examples of acceptable documentation are: name of business, the value of you or your spouses' ownership interest in the business, date of the transaction, profit and loss statements relative to time of transfer, tax returns.
5.	In the past 60 months, did you or your spouse: sell, give away or change ownership in any way to business equipment? Yes ☐ No ☐
	Business equipment includes but is not limited to: farm equipment, livestock, grain, wind turbines, computers, office equipment, any equipment used to run the business
	If yes, date of transaction and amount received?
	Provide documentation to verify the transaction, including the value at the time of the transfer. <i>Examples</i> of acceptable documentation should include type of equipment, value of equipment and date of transaction.
6.	In the past 60 months, did you or your spouse receive rental income or income from a farm lease/ cash rent? Yes No
	If yes, date and amount of most recent income received
	Provide a copy of the rental/lease agreement and verification of the income received.
7.	In the past 60 months, did you or your spouse take out a loan or a reverse mortgage? Yes No
	If yes, date and amount of most recent income received
	Loan includes but is not limited to personal loans to friends or family.
8.	In the past 60 months, did you or your spouse enter into an agreement with anyone such as a: mortgage agreement, promissory note or contract for deed? Yes No
	Include anyone who owes you or your spouse money with an agreement to repay.
	If yes, date loan was made Amount of loan \$
	Provide a copy of all promissory notes, mortgage agreements or contracts for deed.

HFS 3654 (R-12-17) Page 3 of 8

9.	In t	he past 60 months, have you or your spouse purchased an annuity? Yes ☐ No ☐
		es, date of purchase vide a copy of all annuity contracts
10.	A.	In the past 60 months, did you or your spouse inherit anything including but not limited to: money, property, stocks, bonds, etc Yes ☐ No ☐
	If ye	es, date and amount received
	Nar	ne of deceased person
		ationship to deceased person
		e of death
	Pro Ex a	vide documentation of the inheritance amples of acceptable documentation include: all distributions of an estate settlement, life urance death benefit payout.
	B.	In the past 60 months, did you or your spouse decline receipt of an inheritance? For example, did you or your spouse receive an inheritance and waive your right to receive it so the inheritance would go to your children? Yes \(\subseteq \text{No} \subseteq \)
	If ye	es, provide a brief explanation including the amount you declined.
11.	If y Pro	Do you or your spouse have a trust? Yes No ses, date established vide a copy of the trust agreement and include a list of all the resources held in the trust. In the past 60 months, did you or your spouse add resources to that trust? Yes No Section No
	If y	es, date and type of resource/s added
12.	Ye If ye	In the past 60 months, did you or your spouse establish a trust for someone else? s
		you or your spouse related to this person? Yes No
	If ye	es, what is your relationship to this person?
	ls th	is person disabled as defined by the Social Security Administration? Yes 🗌 No 🗌
	If ye	es, provide copy of letter from Social Security Administration.
	В.	In the past 60 months, did you or your spouse add your resources to the trust including at the time established? Yes ☐ No ☐
	If ye	es, date, type and amount of resources/s added?

HFS 3654 (R-12-17) Page 4 of 8

any of the following? Yes a. How to use your income and b. How to apply for medical ass c. Plan for dividing your resourced Plan for placing your resource.	resources to pay for a nursing home or suppor istance ces between family members or other heirs es in a trust.				
Provide the following information about the person or group					
Name	Name				
Address	Address				
Email Address Phone	Email Address Phone				
 You are not required to complete or return this form if you have: received medical benefits from the State of Illinois for 6 months or longer immediately prior to moving to a Nursing Home or Supportive Living Program facility or requesting Department on Aging Home and Community Based Services and you answered NO to Every question 1-13. You are required to complete and return this form if you are: applying for medical benefits and you need help with Nursing Home or Supportive Living Program services or Department on Aging Home and Community Based Services; received medical benefits from the State of Illinois for less than 6 months immediately prior to moving to a Nursing Home or Supportive Living Program facility or requesting Department on Aging Home and Community Based Services; or received medical benefits from the State of Illinois for 6 months or longer immediately prior to moving to a Nursing Home or Supportive Living Program facility or requesting Department on Aging Home and Community Based Services and you answered YES to at least one of the questions 1-13. Notice will be sent to all persons approved to receive assistance with nursing home, supportive living program services and Department on Aging Home and Community Based Services. 14. Do you or your spouse have an interest in a Time Share? Yes \(\sum \) No \(\sum \) 					
If yes, provide documentation about the time share.					

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15.	Yes No No					
	If yes, name of insurance company and policy number					
		es the benefit payments from the insu				
		se If someone else, provide n				
	Provide a co benefit rate, number, nar	ppy of your policy agreement that giv	es details abou umstances. Doc ny.	tthe payments including; daily cumentation should also include policy		
16.	Have you filed a federal income tax return in the past 60 months? Yes ☐ No ☐					
17.	In which years?					
	Provide information about your current or most recent spouse.					
Name Phone						
18.	18. Provide the addresses of the last two places you lived in the past 60 months: Address #1					
	Address #2					
19.	•	esignated someone to be your: Attorney (POA) for Financial Affai	rs (not to be co	nfused with POA for Health)?		
	Yes □ No □					
	If yes, provide a copy of your <u>Financial</u> POA papers • Guardian Yes No					
	If yes, provide a copy of guardianship papers • Authorized/Approved Representative (Not including POA, guardian or person/group named in #13					
	Yes No	o 🗌				
	 Has some 	de a copy of the authorized/approved cone (friend, family member) been he ated POA, guardian or authorized rep	elping you with y	our financial affairs but they are not		
If you answered yes to any of the above, provide the following information:						
	Name		Name			
	Address		Address			
	Email Address		Email Address			
	Phone		Phone			

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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 may result in the denial of assistance.

SIGN YOUR NAME OR MAKE YOUR MARK:	
Applicant	 Date
Spouse	 Date

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CONTACT INFORMATION

Nursing Home or Supportive Living Program

Medical Field Operations North

If you are requesting assistance for Nursing Home Services, Supported Living Program and you live in **Cook** County send completed form to:

Medical Field Operations North 1112 S. Wabash Chicago, IL 60605-2351 Phone: 312-793-8000

Fax: 312-793-4566
DHS.MFOInfo@illinois.gov

Medical Field Operations Central

If you are requesting assistance for Nursing Home Services, Supported Living Program and you live in one of the following counties: Boone, Bureau, Carroll, Champaign, DeKalb, DuPage, Ford, Fulton, Grundy, Henderson, Henry, Iroquois, Jo Davies, Kane, Kankakee, Kendall, Knox, Lake, LaSalle, Lee, Livingston, Marshall, Mason, McHenry, McDonough, McLean, Mercer, Ogle, Peoria, Putnam, Rock Island, Stark, Stephenson, Tazewell, Vermilion, Warren, Whiteside, Will, Winnebago or Woodford send completed form to:

Medical Field Operations Central 1642 West 59th Street, 1st FI Chicago, IL 60636 Phone: 773-863-6339

Fax: 773-863-6307

DHS.MFOCentral@illinois.gov

Medical Field Operations Downstate

If you are requesting assistance for Nursing Home Services, Supported Living Program and you live in one of the following counties: Adams, Alexander, Bond, Brown, Calhoun, Cass, Christian, Clark, Clary, Clinton, Coles, Crawford, Cumberland, De Witt, Douglas, Edgar, Edwards, Effingham, Fayette, Franklin, Gallatin, Greene, Hancock, Hamilton, Hardin, Jackson, Jasper, Jefferson, Jersey, Johnson, Lawrence, Logan, Macon, Macoupin, Madison, Marion, Massac, Menard, Montgomery, Monroe, Morgan, Moultrie, Perry, Piatt, Pike, Pope, Pulaski, Randolph, Richland, Saline, Sangamon, Schuyler, Scott, Shelby, St Clair, Union, Wabash, Washington, Wayne, White, or Williamson send completed form to:

Medical Field Operations Downstate 707 E Wood Street Decatur, IL 62523 Phone and Fax: 217-362-6515 DHS.MaconLTC@illinois.gov

Department on Aging Home and Community Based Services

If you are requesting assistance for Department on Aging, Home and Community Based Services send completed form to the Family Community Resource Center (FCRC) in the county where you live or give the completed form to your Community Care Partner case manager.

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