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:

1) 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.
    c. 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)

State of Illinois
Department of Human Services

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).
  - You can only name one person or organization as your Authorized Representative.
  - 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:

1. 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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State of Illinois
Department of Human Services

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/Client Name: _____ Date of Birth _____

Social Security Number: _____ Individual I.D. Number (if known): _____

Name of Authorized Representative for Appeals, named in Section C, below: _____

Relationship of Representative for Appeals to Appellant/Client: _____

I want to (check only one box):

☐ Appoint a new Authorized Representative for Appeals, pursuant to 89 Ill. Adm. Code 14.21;

☐ Change the powers my Authorized Representative for Appeals has; or

☐ End my Authorized Representative's authorization for Appeals (skip Sections B and C and go to Section D (End My Authorized Representative for Appeals) on Page 3).

SECTION B

APPELLANT/CLIENT PERMISSION: Complete, sign, and date this section if you are the Appellant/Client.

Item	Things I want my Authorized Representative for Appeals to do for me	Check the boxes that apply
Appeals	• Act on my behalf for Appeals. Representation will continue in the event that I die before the appeal is complete	☐
Survive Death	In the event that I die before a Final Administrative Decision is implemented, I **do not** authorize this representative to continue with the appeal after my death.	☐ (check if you **do not** want representation to survive death)

By signing below, I give permission to the Authorized Representative for Appeals, named in Section C of this form, to act on my behalf for the items I have checked in Section B of this form, pursuant to 89 Ill. Adm. Code 14.21. I understand that the action or inaction of an authorized representative shall be deemed to be the action or inaction of myself. I also understand that I am responsible for the information my Authorized Representative for Appeals gives the Department, including any information that may be incorrect. Finally, I understand that I must complete a request to end any Authorized Representative for Appeals that I no longer want to act on my behalf.

Appellant/Client Signature: _____ Date: _____

State of Illinois
Department of Human Services

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 me, in my capacity as Authorized Representative for Appeals. I understand that I am expected to be knowledgeable of the Appellant's/Client's 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, that such organization will maintain the confidentiality of any information regarding the Appellant or client. The Organization and all providers, staff members, and volunteers of the Organization will adhere to all applicable State and Federal laws concerning conflicts of interest, confidentiality of information, and prohibitions against reassignment of provider claims.

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 Representative to act on your behalf for appeals.
- Complete, sign, and date below and submit this form according to the instructions on page 1.

• **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 Appeals.

Signature: _____ Date: _____

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

APPROVED REPRESENTATIVE FORM

Date: _____

Case Number:
(if known) _____

a96ffb79-884e-417b-a97a-68b78bb760f7

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.
  - 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.
  - 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.

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

APPROVED REPRESENTATIVE FORM

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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

Date: _____

Case Number:
(if known) _____

SECTION A

APPLICANT/CLIENT INFORMATION: Complete this section if you are the client or the applicant.

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 Sections B and C and go to Section D (Cancel My Approved Representative) on Page 3).

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: _____ Date: _____

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

APPROVED REPRESENTATIVE FORM

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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

Date: _____

Case Number:
(if known) _____

SECTION C

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

Notice to Approved Representative: It is a Class C misdemeanor for any person or organization to charge an applicant or client a 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 4b.

1. Representative Name: _____

2. 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) (relating to confidentiality of information), 42 CFR 447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as other relevant State and Federal laws concerning conflicts of 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, that such organization will adhere to the regulations in 42 CFR Part 431, Subpart F, 45 CFR 155.260(f) (relating to confidentiality of information), 42 CFR 447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information

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 Representative to act on your behalf.
- Complete, sign, and date below and submit this form according to the instructions on page 1.
- **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: _____

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

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

- **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.

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 _____ Middle Initial _____

SS# _____ DOB _____

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

Date of Admission _____

Instructions:

- Attach additional pages if more room is needed to completely answer any question(s)
- Provide documentation with this form to support information you have told us about the resources you changed, sold, or gave away. 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.
- See last page of this form for information about how and where to send the completed form (if applicable)

1. **In the past 60 months**, did you or your spouse; sell, give away or change ownership in any way to property? Yes ☐ No ☐

   Property includes; home, land or buildings, farmland, mineral rights, life estate, mobile home

   If yes, 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; settlement statement, deed, tax assessment that correlates with the year of the transaction, statement from reputable realtor, appraisal, market analysis.

2. **In the past 60 months**, did you or your spouse; close, give away or change ownership in any way to any of the following? 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			

Provide documentation to verify the transaction/s

3. **In the past 60 months**, did you or your spouse sell, give away or change ownership in any way 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. ***Examples*** 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. ***Examples*** 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.

9. **In the past 60 months**, have you or your spouse purchased an annuity? Yes ☐ No ☐

If yes, date of purchase _____

Provide 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 yes, date and amount received _____

Name of deceased person _____

Relationship to deceased person _____

Date of death _____

Provide documentation of the inheritance

Examples of acceptable documentation include: all distributions of an estate settlement, life insurance 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 ☐ No ☐

If yes, provide a brief explanation including the amount you declined.

11. **A.** Do you or your spouse have a trust? Yes ☐ No ☐

If yes, date established _____

Provide a copy of the trust agreement and include a list of all the resources held in the trust.

B. **In the past 60 months**, did you or your spouse add resources to that trust? Yes ☐ No ☐

If yes, date and type of resource/s added _____

12. **A.** **In the past 60 months**, did you or your spouse establish a trust for someone else?

Yes ☐ No ☐

If yes, date established and name of trust? _____

Provide a copy of the trust.

Are you or your spouse related to this person? Yes ☐ No ☐

If yes, what is your relationship to this person? _____

Is this person disabled as defined by the Social Security Administration? Yes ☐ No ☐

If yes, provide copy of letter from Social Security Administration.

B. **In the past 60 months**, did you or your spouse add your resources to the trust including at the time established? Yes ☐ No ☐

If yes, date, type and amount of resources/s added? _____

13. Have you met with a financial planner, estate planner or other professional to discuss or get help with any of the following? Yes ☐ No ☐

a. How to use your income and resources to pay for a nursing home or supportive living program facility
b. How to apply for medical assistance
c. Plan for dividing your resources between family members or other heirs
d Plan for placing your resources in a trust.

Provide the following information about the person or group

Name		Name	
Address		Address	
Email Address		Email Address	
Phone		Phone	

Stop Here

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 ☐ No ☐

If yes, provide documentation about the time share.

15. 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 insurance company and policy number _____
Who receives the benefit payments from the insurance company? Nursing home ☐ You ☐
Someone else ☐ If someone else, provide name of person _____
Provide a copy of your policy agreement that **gives details about the payments** including; daily benefit rate, length of coverage, any special circumstances. Documentation should also include policy number, name and address of insurance company.
You do not need to provide a copy of the entire policy.

16. Have you filed a federal income tax return in the past 60 months? Yes ☐ No ☐
In which years? _____ _____ _____ _____ _____
Provide a copy of your tax returns including attachments and 1099's filed in the past 60 months.

17. What is your current marital status?
Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐
Provide information about your current or most recent spouse.
Name _____ Phone _____
Address _____

18. Provide the addresses of the last two places you lived in the past 60 months:
Address #1 _____
Address #2 _____

19. Have you designated someone to be your:
- **Power of Attorney (POA) for Financial Affairs** *(not to be confused with POA for Health)*?

Yes ☐ No ☐
If yes, provide a copy of your Financial 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 ☐
If yes, provide a copy of the authorized/approved representative papers.
- Has someone (friend, family member) been helping you with your financial affairs but they are not a designated POA, guardian or authorized representative? Yes ☐ No ☐

If you answered yes to any of the above, provide the following information:

Name		Name	
Address		Address	
Email Address		Email Address	
Phone		Phone	

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

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 Fl
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.