



## Health Benefits for Workers with Disabilities Application

Note: This is **NOT** an application for cash assistance, food stamps or enrollment in the Medicaid spenddown program. If you want to apply for these programs or for your dependents, contact your local Department of Human Services office. If you want to apply for your dependent children under age 18 call toll-free 1-866-4-OUR-KIDS or for persons using TTY: 1-877-204-1012. This application is available in Spanish.

### 1. INSTRUCTIONS:

<p>Read the application carefully and follow all instructions.</p> <ul style="list-style-type: none"> <li>▶ Answer questions completely and accurately. Attach additional sheets of paper if needed.</li> <li>▶ If you wish, you may have someone help you complete this application.</li> <li>▶ <b>Sign the application.</b></li> <li>▶ Mail the application to Health Benefits for Workers with Disabilities, P.O. Box 19145, Springfield, IL 62794-9145.</li> <li>▶ An interview is not required for this program.</li> </ul>	<p><b>AGENCY USE ONLY</b></p> <p>Case Number _____</p> <p>Date Received _____</p>
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### 2. PERSONAL INFORMATION:

Name (Last, First, Middle Initial)	Do you live in a nursing facility? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you live in a supported living facility? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address (Where you currently live)	If you answered yes above, write the name of the facility: _____ _____
City _____ State _____	
Zip _____ County _____	Work Phone _____ Home Phone _____
If we need to contact you, when and where is the best time? _____	

Birth Date	Social Security Number	Sex	Are you married?	Are you living with your spouse?
/ /		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you employed or self-employed?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, begin date _____ If no, what date will employment start? _____

Are you a U.S. Citizen?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, write alien registration number. _____

For help in completing this form, call 1-800-226-0768 (TTY: 1-866-675-8440)

Language Preference (Optional)	Race or Ethnic Group (This information is optional.)		
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	<input type="checkbox"/> White <input type="checkbox"/> American Indian Or Alaskan Native	<input type="checkbox"/> Black <input type="checkbox"/> Asian or Pacific Islander	<input type="checkbox"/> Hispanic <input type="checkbox"/> Other: _____

<b>How many people live with you?</b>	<b>Only include yourself, your spouse, and your children under age 18.</b>		
<b>Complete the information below for the people who live with you. Do not include yourself.</b>			
Name	Social Security Number (Optional)	Birth Date	Relationship to you
		/ /	
		/ /	
		/ /	
		/ /	

**3. HEALTH INSURANCE:**

You must report all health insurance you have now. Include Medicare and all other health, long term care, prescription drug and indemnity policies.

Do you have Medicare?	Effective date of coverage	Medicare Claim Number
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, send a copy of the Medicare card with the application.	Part A <hr/> Part B	

<b>Are you covered by a group health plan, including a plan through your most recent employer?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Employer (current or former)	<input type="checkbox"/> Pension	<input type="checkbox"/> Union Local # _____
<input type="checkbox"/> School	<input type="checkbox"/> CHAMPVA <input type="checkbox"/> TRICARE	<input type="checkbox"/> Other _____
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<b>Are you covered by an individual or private policy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Health/hospitalization <input type="checkbox"/> Prescription Drug	<input type="checkbox"/> Medicare supplement <input type="checkbox"/> Indemnity or income protection	<input type="checkbox"/> Long term care <input type="checkbox"/> Other _____
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<b>Is free health insurance available to you or your family through your job or union?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		

**4. ASSETS:**

<b>Do you own or are you buying your home?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>If you or your spouse own any other property complete the following for each piece of property.</b>			
Owner	Address	Current Value	Amount Owed
		\$	\$
		\$	\$
		\$	\$
		\$	\$

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If you or your spouse own a car, truck, motorcycle, boat, trailer, or other vehicle complete the following.					
Owner(s)	Year	Make/Type of Vehicle	Model	Current Value	Amount Owed
				\$	\$
				\$	\$

Do you or your spouse own any of the following assets? Do not include real estate.	You	Spouse
Cash on Hand <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Checking account <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Savings account <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Government bonds <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Trust funds <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Funeral plans/burial arrangements <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Burial plots <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Stocks and bonds <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Other <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$

Complete the following for any asset marked yes above.			
Type of asset	Account/Policy Number	Value	Name of Bank, Company, Etc.

If you or your spouse have life insurance, complete the following.				
Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

**5. INCOME AND EARNINGS:**

List all types of earnings and income that you or your spouse receive. List the income amount before deductions (such as taxes or insurance). Income includes, but is not limited to:					
Wages/Self-employment		Roomer/Boarder		Social Security	
Railroad Retirement Benefits		SSI		Trust or Annuity Payments	
Pensions/Retirement Benefits		Veteran's Benefits		Royalties, Oil/Mineral Rights	
Child Support/Spousal Support		Rental Income		Contributions	
Other _____					
Name of Person Who Receives Income	Type of Income	Employer or Source of Income	Amount	How Often Received?	Claim Number (if applicable)
			\$		
			\$		
			\$		

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If you or your spouse have earned income (wages or self-employment), complete the following.	You	Spouse
Does the person buy or bring lunch to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the person buy uniforms or special tools?	<input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____
How does the person get to and from work?	<input type="checkbox"/> Bus \$_____ Weekly <input type="checkbox"/> Taxi \$_____ Weekly <input type="checkbox"/> Train \$_____ Weekly <input type="checkbox"/> Car _____ Weekly Miles <input type="checkbox"/> Other _____	<input type="checkbox"/> Bus \$_____ Weekly <input type="checkbox"/> Taxi \$_____ Weekly <input type="checkbox"/> Train \$_____ Weekly <input type="checkbox"/> Car _____ Weekly Miles <input type="checkbox"/> Other _____

### 6. SPOUSAL OR CHILD SUPPORT

Do you or your spouse pay ordered spousal or child support? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following.	
Name of Person _____	Monthly Amount _____
Name of Person _____	Monthly Amount _____

Do you or your spouse pay for day care so you can work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following.			
Name of Caregiver		Person Paying Day Care	
Name of Children	Relationship of Care Giver to Child (if any)	Monthly Amount	

### 7. OLD MEDICAL BILLS:

Did you receive any medical care in the past 3 months you want the State to pay for? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what months?
1) _____ 2) _____ 3) _____

### 8. HEALTH INFORMATION: This information is optional. By completing the following question, you will help us to better serve persons with disabilities.

Please check the boxes below which best describe your disability.		
<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Physical Disability	<input type="checkbox"/> Mental/Emotional Disability
<input type="checkbox"/> Visual Disability	<input type="checkbox"/> Hearing Disability	

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**Read and Sign:**

- If I am approved for Health Benefits for Workers with Disabilities, I give my right to collect medical support payments to the State of Illinois.
- If my application is approved, I give the State of Illinois the right to recover under the terms of any private or public health care coverage any amount for which I may be eligible.
- I authorize the State of Illinois to release information concerning medical services I have received through any program paid for by medical assistance for any purpose authorized by law.
- Officials with responsibilities for the health benefits program for which I have applied may verify all information, including employment status, on this form. I understand that I must cooperate in these efforts to verify information. I understand that verification may occur through electronic means.
- I agree to inform the Department within 10 days of any change in my address, household size, income, property, or living arrangements, and within 30 days if I become unemployed.
- I understand that anyone who knowingly misuses the health benefits card issued by the State of Illinois may be committing a crime.
- I understand that if I have given false information or intentionally failed to disclose information for this application, I may be subject to criminal prosecution civil action or both. I certify under the penalty of perjury that the information I have provided on this application form is the truth to the best of my knowledge.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (If unable to sign, make a mark and have a witness sign next to your mark.)

If someone completed this application on behalf of the applicant, they must sign and complete the information below.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Name (print) \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone \_\_\_\_\_

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 for hearing impaired persons) or by writing to: Illinois Department of Healthcare and Family Services, Bureau of Administrative Hearings, 401 South Clinton Street, 6<sup>th</sup> Floor, Chicago, IL 60607.

The Medicaid program is open and accessible without regard to sex, disability, national origin, religion, or protected age group. The State of Illinois is an equal opportunity employer which practices affirmative action. The State of Illinois provides reasonable accommodations according to Section 504 of the Rehabilitation Act of 1973 and the American with Disabilities Act of 1990.

## Important Information to Include with Your Application

To get medical benefits, you must provide proof for some of the information you provide on your application.

- ✓ **Proof of your income.** Proof of earnings includes payment of FICA or IMRF taxes or their equivalent. If you are not currently working, but you will start a job within 30 days of the date of your application, you may apply. Provide proof of each type of income (except for SSA, SSI, or UI) you list on the application.

To decide whether you qualify for benefits, we will deduct the following amounts from your earned income if you provide us proof of:

- ◆ Federal, State, or City Income Taxes
  - ◆ Social Security Tax
  - ◆ Transportation to work at the most reasonable rate. We allow 19 cents per mile if you use your own car.
  - ◆ Lunch allowance not to exceed \$9.00 per month.
  - ◆ Special tools and uniforms required for the type of work performed.
  - ◆ Union Dues.
  - ◆ Group Life Insurance Premiums
  - ◆ Retirement plan withholding
  - ◆ Day care expenses per child, not to exceed \$160 per month for full-time employment or \$128 per month for part-time employment.
  - ◆ Special work expenses that allow you to work, such as but not limited to: special transportation to work, or a telecommunication device for the hearing impaired. To be allowed as a deduction, you must pay for it and not be reimbursed by an agency or other person.
- ✓ **Proof of age.**
  - ✓ Provide a **Social Security Number** or proof of application for a Social Security Number. If you do not have a Social Security Number, you must provide a signed statement from the Social Security Administration that application has been made.
  - ✓ **Proof of health insurance.**

If you have health insurance, mail the following items with the application:

- ◆ a copy of the insurance plan or benefit ID card showing the group number
  - ◆ name and address of the employer, union or school,
  - ◆ name of the insurance company or plan, and
  - ◆ address where the claims are mailed
- ✓ **Immigration documents** for non-citizens

If you are not a citizen, the State of Illinois will contact the United States Immigration and Naturalization

Service (INS) to verify your legal immigration status if you provide an alien registration number on the application. Unless the State can verify your immigration status, you may only be eligible for emergency medical services. You must apply at your local Department of Human Services office for emergency medical services.

If you are not a citizen, you must supply proof of your immigration status, such as copies of any one of the following:

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

Noncitizens who are related to active or honorably discharged members of the U.S. armed services may qualify to receive Health Benefits for Workers with Disabilities by providing proof of such status.

Please include your telephone number, or a number at which you can be reached. This is VERY important. If we need more information about your application, we will try to contact you by telephone

Remember: If your address or other information changes, please notify Health Benefits for Workers with Disabilities by calling toll-free 1-800-226-0768 (TTY: 1-866-675-8440).