



Application for Payment of Medicare Premiums, Deductibles and Coinsurance

NOTE: This is **NOT** an application for full Medicaid, cash assistance, or food stamps. If you want to apply for these programs, contact your local Department of Human Services office. This application is available in Spanish.

1. INSTRUCTIONS:

<p>Read the application carefully and follow all instructions.</p> <ul style="list-style-type: none"> Answer questions completely and accurately. Attach additional sheets of paper if needed. If you wish, you may have someone help you complete this application. Sign the application. Mail the application to your local Department of Human Services (DHS) Office. If you do not know the address of your local DHS office, call 1-800-843-6154. Persons using a teletypewriter (TTY) can call toll free to 1-800-447-6404. An interview is not required for these programs. 	<p style="text-align: center;">AGENCY USE ONLY</p> <p>Case No. _____</p> <p>Date Received _____</p>
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2. PERSONAL INFORMATION:

Name (Last, First, Middle Initial)	Do you live in a nursing facility or assisted living facility? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address (Where you currently live)	If yes, write the name and address of the facility: _____
City State	
Zip County	Phone
Mailing Address (If different from above)	

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

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

Language Preference of Applicant	Race or Ethnic Group
<input type="checkbox"/> English <input type="checkbox"/> Spanish	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic
<input type="checkbox"/> Other _____	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other: _____

3. HEALTH INSURANCE

You must report all health insurance you have now. Include Medicare and all other health, dread disease, 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	
	Part B	
	Part D	

Are you covered by a group health plan, including a plan through your most recent employer?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Employer (current or former) <input type="checkbox"/> School	<input type="checkbox"/> Pension <input type="checkbox"/> CHAMPVA <input type="checkbox"/> TRICARE	<input type="checkbox"/> Union Local # _____ <input type="checkbox"/> Other _____
Are you covered by an individual or private policy?		<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 _____
Is free health insurance available to you or your family through your job or union?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If you checked yes in any box above, mail the following items with the application: <ul style="list-style-type: none"> o a copy of the insurance plan or benefit ID card showing the group number, o name and address of the employer, union or school, o name of the insurance company or plan, and o address where the claims are mailed. 		

4. ASSETS:

If you or your spouse own any property in which you <i>do not live</i> complete the following for each piece of property and current value. Do not list the house in which you live.		
Address	Total Value	Equity Value

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	Value	Equity Value

Do you or your spouse own any of the following assets? Do not include real estate.					
Checking account	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Funeral plans/ burial arrangements	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Savings account	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Burial plots	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Government bonds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stocks and bonds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Trust funds	<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:					
Social Security		SSI		Wages/ Self-Employment	
Railroad Retirement Benefits		Veterans' Benefits		Trust or Annuity Payments	
Pensions/ Retirement Benefits		Rental Income		Royalties, Oil/ Mineral Rights	
Name of Person Who Receives Income	Type of Income	Employer or Source of Income	Amount	How Often Received?	Claim Number (if applicable)

If you or your spouse have earned income (wages or self-employment), complete the following:		
Does the person buy or bring lunch to work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the person buy uniforms or special tools?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the person pay for child care so they can work? If yes, how much?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How does the person get to and from work?		

Read and Sign:

- If I am approved for payment of Medicare deductibles coinsurance and/or Medicare Part B premiums, 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 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 of Human Services (DHS) within 10 days of any change in my address, household size, income, property, or living arrangements.
- 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: 1-800-447-6404 for hearing impaired persons) or by writing to: Illinois Department of Healthcare and Family Services, Bureau of Administrative Hearings, 401 South Clinton Street, 6th Floor, Chicago, IL 60607.

The Medicaid program is open and accessible without regard to sex, race, 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.