State of Illinois
Department of Healthcare and Family Services

Health Benefits for Workers with Disabilities Mail-In Application

This is **NOT** an application for cash assistance, food stamps or Medical spenddown. You can apply for these programs at your local Department of Human Services (DHS) Family Community Resource Center (FCRC). To find the DHS office near you visit the DHS Office Locator on their Web site or call 1-800-843-6154 (TTY: 1-800-447-6404). The call is free. You may also apply for FamilyCare and All Kids online or by calling 1-866-ALL-KIDS (1-866-255-5437) (TTY: 1-877-204-1012). The call is free.

Voter's Registration Information

If you are interested in registering to vote, please visit the Illinois State Board of Elections Web site or call the Department of Human Services Helpline at 1-800-843-6154 or (TTY: 1-800-447-6404). If you would like assistance or need translation services, please contact your DHS FCRC.

What Medical Services Are Covered

Most needed medical services are covered. We cannot make payment for services that are free or paid by anyone else, like health insurance. The following services are covered:

- Hospital care
- Nursing facility care
- Doctor visits
- Prescription drugs
- Physical, occupation and speech therapy
- Laboratory test and X-rays
- Medical equipment, supplies and appliances
- Medical transportation
- Hospice care
- Kidney dialysis
- Family planning
- Eye care
- Podiatry care
- Limited dental care
- Chiropractic care
- Hearing care
- Mental health services

You can go to any medical provider who accepts the Illinois State Medical Card.

Instructions

- Answer every question. Write 'none' if a question does not apply to your situation.
- You can have someone help you fill out the application.
- Attach additional sheets of paper if needed to completely answer a question.
- **Be sure to sign the application.**
- You may need to send us proof so that we can approve your case.
- Keep this page for your records.

1. Tell us about the applicant.

The applicant must be someone who has a disability and is working. The applicant is usually the person filling out this form.

Applicant's name: ____________________ ____________________ ________
Last name First name Middle initial

Birth date: ____________________ **Sex:** ☐ Male ☐ Female

Social Security Number: ____________________

Address: ____________________

City: ____________ **State:** ______ **Zip:** ______ **County:** ____________

Home Phone: ____________ **Work or Cell Phone:** ____________

What language do you use the most? (optional)

☐ English ☐ Spanish ☐ Other ____________________

You can help us by giving us your race and ethnic group, but you do not need to tell us.

Are you of Hispanic or Latino origin? ☐ Yes ☐ No

Race:

☐ White ☐ Asian ☐ Native Hawaiian or other Pacific Islander
☐ Black or African American ☐ Native American Indian or Alaska Native ☐ Unknown (Mark all that apply)

Are you employed or self-employed? ☐ Yes ☐ No

If yes, when did you start? ____________________

If no, when will you start working? ____________________

Are you married? ☐ Yes ☐ No **Do you live with your spouse?** ☐ Yes ☐ No

Your Spouse (You can help us by answering the following questions, but you do not have to tell us.)

If you are married, please provide the following information (even if your spouse is not living with you):

Name of Spouse: ____________________

Spouse's Social Security Number: ____________________

Name of Spouse's Employer (if employed): ____________________

Do you live in a nursing facility or a supported living facility? ☐ Yes ☐ No

If yes, what is the name of the facility? ____________________

Are you a U.S. citizen? ☐ Yes ☐ No

If you answered yes, and you receive Medicare, you do not have to provide verification of birth or identity.

If yes and you do not receive Medicare, 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 item from the list in each column below:

Place of Birth:

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

Identity:

- Driver's License;
- State issued ID card;
- School ID;
- U.S. military ID;
- U.S. military dependent card; or
- Other government ID (city, county or U.S. State issued)

Read page 10 for more information on how to get your birth certificate.

If no, write your alien registration number: ____________________

Send a copy of one of the items listed below as proof of the Alien Registration Number you listed.

- Alien Registration Receipt Card, Permanent Resident Card or Green Card
- Passport with the following stamps or attachments: Arrival-Departure Record (I-94) including the stamp showing status, Resident Alien Form (I-551) or Temporary Resident Card (I-688)
- A court-ordered notice for asylees
- Other proof of lawful immigration status

Receiving most public health benefits should not affect a person's immigration status. The U.S. Citizenship and Immigration Service may consider someone to be a public charge if they live in long-term care, like a nursing home or mental health facility that the government pays for.

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2. Tell us about your health insurance and any unpaid medical bills.

Do you have health insurance? ☐ Yes ☐ No

If yes, include a copy of your insurance card (front and back).

Is it through your employer or a former employer? ☐ Yes ☐ No

Is it through another group you belong to, such as a union? ☐ Yes ☐ No

Is it a private policy you bought on your own? ☐ Yes ☐ No

Do you have a high cost medical condition? ☐ Yes ☐ No

If yes, what is the condition? ____________________

Can you get insurance through your job, union or through a relative's policy? ☐ Yes ☐ No

If yes, you may be able to get help with your premiums.

Do you have Medicare? ☐ Yes ☐ No

Have you received medical care in the past 3 months that you want us to pay for? ☐ Yes ☐ No

If yes, tell us which months:

____________________ ____________________ ____________________

3. Tell us about the people that live with you. Include your spouse and your children or step-children (under age 19) that live with you.

Children under 19 may be eligible for All Kids healthcare coverage. Call 1-866-All-Kids (1-866-255-5437) (TTY: 1-877-204-1012) or visit the All Kids Web site for more information. The call is free.

How many people live with you? __________

Name: ____________________ SSN: ____________________

Birth date: ____________________ Relationship to applicant: ____________________

Name: ____________________ SSN: ____________________

Birth date: ____________________ Relationship to applicant: ____________________

Name: ____________________ SSN: ____________________

Birth date: ____________________ Relationship to applicant: ____________________

Name: ____________________ SSN: ____________________

Birth date: ____________________ Relationship to applicant: ____________________

4. Tell us about the assets that you and/or your spouse own. If you check yes, write down what the asset is worth and the name of the owner. If yes, include title or registration.

Do you or your spouse own a car, truck, motorcycle, boat, or other type of vehicle? ☐ Yes ☐ No

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

Do you or your spouse own any property such as a home, land or building? ☐ Yes ☐ No
If yes, include a copy of your deed or tax bill for each piece of property you own or are buying.

Owner	Address	Type	Value	Amount Owed
1) ______	1) ______	1) ______	$ ______	$ ______
2) ______	2) ______	2) ______	$ ______	$ ______

Do you or your spouse own life insurance? ☐ Yes ☐ No If yes, include proof of current cash value.

Owner	Insurance Company	Policy Number	Face Value	Current Cash Value
1) ______	1) ______	1) ______	$ ______	$ ______
2) ______	2) ______	2) ______	$ ______	$ ______

Write down all assets that you or your spouse have. If yes, include proof of current value.			Amount	Name of Person	Bank, Company, etc.
Cash on Hand (no proof needed)	☐ Yes	☐ No	$ ______	______	______
Checking Account(s)	☐ Yes	☐ No	$ ______	______	______
Savings Account(s)	☐ Yes	☐ No	$ ______	______	______
Stocks, Bonds, Trust Funds	☐ Yes	☐ No	$ ______	______	______
Mutual Funds, Money Market(s), Certificate(s) of Deposit	☐ Yes	☐ No	$ ______	______	______
Funeral Plans/Burial Arrangements	☐ Yes	☐ No	$ ______	______	______
Burial Plots	☐ Yes	☐ No	$ ______	______	______
Medical/Health Savings Account (some accounts may be exempt)	☐ Yes	☐ No	$ ______	______	______
Retirement Accounts (only counted if the account can be accessed without penalty before age 59 1/2)	☐ Yes	☐ No	$ ______	______	______
Other (describe): ______			$ ______	______	______

5. Tell us if you or your spouse is currently employed or self-employed. If self-employed, enter "self" for employer.

Send in copies of pay stubs (including tips and proof of FICA) received in the last 30 days from each job. If anyone is self-employed, provide 30 days of detailed business records that include income and expenses and proof of FICA (IRS 1040 or 1040ES).

Name: ______________________ Employer: ______________________

Number of hours worked: ________ Amount paid before taxes (including tips): $__________ How often paid:__________

Name: ______________________ Employer: ______________________

Number of hours worked: ________ Amount paid before taxes (including tips): $ __________ How often paid:__________

6. Tell us about anyone named on this form who GETS money from any source other than employment (such as Social Security, spousal support, rental property, unemployment benefits, pensions, trusts). Complete the following.

Send proof of payments received in the last 30 days for each source of income you list. We will get proof of Social Security and Illinois unemployment benefits for you.

Name: ______________________ Source: ______________________

Payment amount: $ ______________________ How often paid: ______________________

If this is rental property income, does the person receiving the income manage the property? ☐ Yes ☐ No

Name: ______________________ Source: ______________________

Payment amount: $ ______________________ How often paid: ______________________

If this is rental property income, does the person receiving the income manage the property? ☐ Yes ☐ No

Name: ______________________ Source: ______________________

Payment amount: $ ______________________ How often paid: ______________________

If this is rental property income, does the person receiving the income manage the property? ☐ Yes ☐ No

7. Tell us if you or your spouse PAY child support or spousal support. Tell us how much was paid in the last month.

Send proof of payments made to each person in the last 30 days and a copy of the court order.

Name: ______________________ Amount: $ __________ How often paid: __________

Name: ______________________ Amount: $ __________ How often paid: __________

8. Tell us about anyone named on this form that pays for child care so they can work.

Send proof of the child care you paid within the last 30 days for each child.

Name of children in child care: ______________________ Name of care givers: ______________________

Person paying for child care: ______________________ Payment amount: $ ______________________

Relationship to child (if any): ______________________ How often paid: ______________________

9. Tell us about your employment expenses.

Include a copy of your receipt for special tools or uniforms.

Do you buy or bring your lunch to work? ☐ Yes ☐ No

Does your spouse? ☐ Yes ☐ No

Do you have to buy special uniforms or tools for work? ☐ Yes ☐ No

Does your spouse? ☐ Yes ☐ No

How do you get to and from work?	How does your spouse get to and from work?
☐ Bus Amount: $ __________ How often paid: __________	☐ Bus Amount: $ __________ How often paid: __________
☐ Taxi Amount: $ __________ How often paid: __________	☐ Taxi Amount: $ __________ How often paid: __________
☐ Train Amount: $ __________ How often paid: __________	☐ Train Amount: $ __________ How often paid: __________
☐ Car Weekly miles: __________	☐ Car Weekly miles: __________
☐ Other (describe) : __________ Amount: $ __________ How often paid: __________	☐ Other (describe) : __________ Amount: $ __________ How often paid: __________

10. Tell us about your disability. Check the boxes that best describe your disability. You can help us by answering this question, but you do not have to tell us.

☐ Developmental Disability ☐ Physical Disability ☐ Mental or Emotional Disability

☐ Visual Disability ☐ Hearing Disability

Read and Sign

1. We will keep what you tell us private as required by law.
2. You have to make a payment each month for this insurance. This payment is called a premium. The amount of your premium depends on your family income.
3. You have to pay part of the bill when you visit the doctor, go in the hospital, or get a prescription filled. These payments are called co-payments.
4. You agree the state may seek reimbursement for services the state covered for you if any other party should have paid for those services.
5. 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.
6. You must tell us 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;
    - You go into a nursing home or move out of Illinois; or
    - If you get health insurance or Medicare.
7. We will cancel your health insurance if you go to jail or prison.
8. Anyone who misuses our 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.

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: ____________

Next Steps

- If any information changes after you send the application, call 1-800-226-0768 (TTY: 1-866-675-8440). This call is free.
- We will review your application as quickly as possible.
- If we find something is missing, we will send you a letter telling you what else to send.
- Please allow 45 days for us to make a decision.
- We will send you a notice to tell you if you can get HBWD. If you do not qualify, we will also send a notice and tell you why.

If you are not satisfied with the actions taken on your application, you have the right to a fair hearing. You can ask for a fair hearing by writing us, or by writing to HFS Fair Hearings, 401 South Clinton Street, Sixth Floor, Chicago, Illinois 60607 or by calling 1-800-435-0774 (TTY: 1-877-734-7429). Use these numbers only to file an appeal.

Final Checklist

- Did you answer all the questions? Attach additional pages if you need more space.
- Did you sign and date the application?
- Do you have copies of all the proofs we said you would need?
- Keep this page for your records.

Mail your application along with copies to:
Health Benefits for Workers with Disabilities
P.O. Box 19145
Springfield, IL 62794-9145

U.S. Citizenship Documents

Because of a new federal law, we must ask people who are United States citizens to send us documents that prove they are citizens. This new law affects all children and adults who apply for medical benefits if they are U.S. citizens.

You can get birth certificates from the state or county where the person was born. You may have to pay for the official copies of birth certificates. Usually, you need to know the person's name, date of birth and parents' names to order their birth certificate.

Persons who were born in Illinois can get their birth certificate from the county where they were born. Here are a few county phone numbers and websites:

County	Phone	Website
Champaign	1-217-384-3720	Champaign County Clerk -- Vital Records
Cook	1-312-603-7799	Cook County Clerk -- Vital Records
Peoria	1-309-672-6059	Peoria County Clerk -- Vital Records (Select "Get Vital Records")
St. Clair	1-618-277-6600	St. Clair County Clerk -- Vital Records (Select "5")

You can visit the Illinois Department of Public Health's Web site to get a complete list of who to contact for your birth certificate. The Illinois Department of Public Health can help you find a county office if you call 1-217-782-6553. If you use a TTY, call 1-800-547-0466. This call is free.

You can order your birth certificate over the Internet from the Illinois Vital Record Web site, if you use a credit card.

The National Center for Health Statistics can help you find out where to get birth certificates for people who were born in a state other than Illinois. Call 1-866-441-6247. The call is free. You may visit the National Center for Health Statistics Web site for information.

If you cannot get these documents, call 1-800-226-0768 to tell us why. If you use a TTY, call 1-866-675-8440. The call is free. There may be other documents that you can use to show that you are a U.S. citizen. Mail copies of your documents to Health Benefits for Workers with Disabilities, P.O. Box 19145, Springfield, Illinois 62794-9145 or fax them to 1-217-558-0031.

Internet Quick Reference Guide

This list was developed to provide a reference guide for users who print the application and prefer to work from a paper copy.

DHS Office Locator	http://www.dhs.state.il.us/officeLocator
All Kids	http://www.allkids.com
Illinois State Board of Elections	http://www.elections.il.gov
Champaign County Clerk - Vital Records	http://www.champaigncountyclerk.com/vitals/
Cook County Clerk - Vital Records	http://www.cookcountyclerk.com
Peoria County Clerk - Vital Records	http://www.co.peoria.il.us (Select "Get Vital Records")
St. Clair County Clerk - Vital Records	http://www.countyclerk.co.st-clair.il.us/
Illinois Vital Records County Listing	http://www.idph.state.il.us/vitalrecords/countylisting.htm
Illinois Vital Records	http://www.idph.state.il.us/vitalrecords/
National Center for Health Statistics	http://www.cdc.gov/nchs