Table of Contents

State/Territory Name: Illinois

State Plan Amendments (SPA) #: IL-14-0008

This file contains the following documents in the order listed:

The complete title XXI state plan for Illinois consists of the most recent state plan posted on Medicaid.gov under CHIP and State Plan Amendments. The link is provided below. The following approved templates are in addition to, or replace sections of the state's posted current state plan. The attached approval letter(s) explain how these templates fit into that state plan.

Link to state title XXI state plans and amendments: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-State-Program-Information.html

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

SEP 0 8 2015

Felicia F. Norwood
Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763

Dear Ms. Norwood:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved Illinois' Children's Health Insurance Program (CHIP) state plan amendment (SPA), IL-14-0008 submitted on March 27, 2014. This SPA incorporates the Modified Adjusted Gross Income (MAGI)-based eligibility process requirements in accordance with the Affordable Care Act and implementing regulations. The effective date of this SPA is October 1, 2013.

The approval of SPA IL-14-0008 includes full approval of the state's paper application. The state is using an interim alternative single streamlined online application. By December 31, 2015, the state will implement a revised alternative single streamlined online application that addresses CMS concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the following state plan pages and attachments to be incorporated within a separate section at the end of Illinois' approved state plan:

- Template CS24 – Separate Child Health Insurance Program General Eligibility-Eligibility Processing
- Attachment 1 – Statement of use with respect to the alternative single streamlined online application
- Attachment 2 – Alternative single streamlined paper application

This approval and the enclosures supercede the following sections of the current CHIP state plan:

- Section 4.3: Single Streamlined Application Screen and Enroll Process
- Section 4.4: Renewals, Screening by Other Insurance Affordability Programs

The CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan Amendment. Your title XXI project officer is Ms. Kathleen Cuneo. She is available to answer questions concerning this amendment and other CHIP-related issues.

Ms. Cuneo's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Blvd.
Baltimore, MD 21244-1850
Telephone: (410) 786-5913
Facsimile: (410) 786-5882
E-mail: Kathleen.Cuneo@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Cuneo and Ms. Ruth Hughes, Associate Regional Administrator, in our Chicago Regional Office. Ms. Hughes' address is:

Ms. Ruth Hughes
Office of the Regional Administrator
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

If you have additional questions, please contact Mr. Manning Pellanda, Director, Division of State Coverage Programs at 410-786-5143.

We look forward to continuing to work with you and your staff.

Sincerely,

[redacted]

Anne Marie Costello
Acting Director

Enclosure

cc:
Ms. Ruth Hughes, ARA, CMS Chicago Region

Control Panel

General Information

File Management

Tribal Input

Summary

Children's Health Insurance Program Eligibility: Summary Page

State/Territory name: Illinois

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

IL-14-0008

Type of SPA:

- [ ] MAGI Eligibility & Methods
- [ ] XXI Medicaid Expansion
- [ ] Establish 2101(f) Group
- [x] Eligibility Processing
- [ ] Non-Financial Eligibility

Proposed Effective Date

01/01/2014 (mm/dd/yyyy)

Federal Statute/Regulation Citation

2102(b)(3); 2107(e)(1)(O); 42 CFR 457, subpart C

Federal Budget Impact

- [ ] This SPA has a budget impact.

Total budget impact:

State Funds: $

Federal Funds: $

Subject of Amendment

Please provide a brief summary of SPA changes.

Character Count:51 out of 2000

General Eligibility: Eligibility Processing (CS24)

Signature of State Agency Official

Submitted By: Jamie Ursch

Last Revision Date: Mar 27, 2014

Submit Date: Mar 27, 2014

BACK CONTINUE

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
General Eligibility - Eligibility Processing **CS24**

2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

☑ The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.

☒ An alternative single, streamlined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

☑ The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.

The agency accepts applications in the following other electronic means.

☐ Other electronic means:

Screen and Enroll Process

☑ The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.

Procedures include:

■ Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and

■ Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and

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CHIP Eligibility

☒ Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.

The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA. No

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:

☒ Once every 12 months.

☒ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.

☒ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Screening by Other Insurance Affordability Programs

☑ The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.

☐ The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.

☐ The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130917

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: IL-14-0008	**STATE:** Illinois

Through December 31, 2015, the state is using an interim alternative single streamlined online application. After December 31, 2015, the state will use a revised alternative single streamlined online application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

State of Illinois
Department of Healthcare and Family Services

SEP 0 8 2015

Application for Health Coverage & Help Paying Costs

Use this application to apply for health coverage.

- Health coverage means Medicaid, All Kids, or insurance you buy from the Health Insurance Marketplace.
- You can get comprehensive benefits to help you stay well.
- You may qualify for low-cost coverage under Medicaid or All Kids or you may qualify to get a tax credit to help pay your premiums for health insurance from the Health Insurance Marketplace.

Do not use this application if you want to apply for SNAP or cash assistance at the same time. By using this application, you are stating that you only want to apply for health coverage and you do not want to apply for SNAP or cash assistance.

Apply faster online.

You can apply faster online at ABE.Illinois.gov.

Who should use this application?

- Use this application to apply for health coverage for children, parents or other caretaker relatives raising dependent children, pregnant women and other adults older than 19, but younger than age 65.
- If someone is helping you fill out this application, you may need to complete Appendix C.
- Immigrants can apply. You can apply for your children even if you do not qualify for coverage. Applying will not affect your immigration status or your chances of becoming a permanent resident or citizen.

Seniors, persons on Medicare and people who receive SSI or SSDI payments from Social Security should apply online at ABE.illinois.gov or use a different paper application, Form 2378H. You can get it at: http://www2.illinois.gov/hfs/SiteCollectionDocuments/hfs2378h.pdf or call the number below.

What you may need to apply.

- Social Security numbers or document numbers for any legal immigrants who need health coverage.
- Employer and income information for everyone in your family. You can get this from paystubs, W-2 forms, or wage and tax statements.
- Policy numbers for any current health insurance.

Information about any job-related health insurance you can get.

Why do we ask this information?

We ask for the information to decide what health coverage you qualify for and to decide if you can get any help to pay for it.

The law requires that we have to keep all the information you give us private.

What happens next?

Fill out your application, sign it and send it to the address on page 14.

If you cannot answer all the questions, sign your application and send it anyway. We will contact you if we need more information. We will send you a notice when we decide if the people you apply for qualify for Medicaid or All Kids. If anyone does not qualify for Medicaid or All Kids, we will send the information from the application to the Health Insurance Marketplace to see if they can get help to buy insurance.

Get help with this application.

- Online: Log onto GetCoveredIllinois.gov/get-help/
- Phone: Call the ABE Customer Call Center at 1-800-843-6154.
- In person: to find a local office near you log-on to: https://www.dhs.state.il.us/page.aspx?module=12&officetype=&county

Step 1: Tell us about yourself. (We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name & Suffix

_____

2. Home address (Leave blank if you don't have one.) 3. Apartment or suite number

_____ _____

4. City 5. State 6. Zip 7. County

_____ _____ _____ _____

8. Mailing address (if different from home address) 9. Apartment or suite number

_____ _____

10. City 11. State 12. Zip 13. County

_____ _____ _____ _____

14. Phone number 15. What is the best number to reach you during the day?

(_____) - _____ - _____ (_____) - _____ - _____

16. Do you want to get information from us by e-mail? ☐ Yes ☐ No

E-mail address: _____

17. Preferred spoken or written language (if not English) ☐ Spanish ☐ Other _____

Step 2: Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't have to file taxes to get health coverage.)

DO Include:

- Yourself
- Your spouse
- Your children under 19 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 19 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 19)
- Other adult relatives who file their own tax return

The amount of assistance and type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, and then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status of a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information to check if you're eligible for health coverage.

PERSON 1 (Start with yourself)

Complete PERSON 1 for yourself. See page 3 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

_____

2. Relationship to you?

SELF

3. Date of birth (mm/dd/yyyy)

_____/_____/_____

4. Sex ☐ Male ☐ Female

5. Social Security Number (SSN): _____ - _____ - _____

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ YES **If yes**, please answer questions a - c. ☐ NO **If no,** SKIP to question c

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, name of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant or have you been pregnant in the last 3 months? ☐ Yes ☐ No

If yes, how many babies are expected: _____

8. **Do you need health coverage?**

(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ YES **If yes,** answer all the questions below. ☐ NO **If no,** SKIP to the income questions on page 5.

9. **Do you live in a medical facility or nursing home or do you need support services to help you stay in your home to prevent going into a nursing home or other facility?**

☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. **If you aren't a U.S. citizen or U.S. National,** do you have eligible immigration status?

☐ Yes Fill in your document type and ID number below.

a. Immigration document type: _____

b. Document ID number: _____

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

e. What is the date of entry into the United States? _____

12. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

14. Were you in foster care at age 18 or older? ☐ Yes ☐ No

15. Are you a full-time student? ☐ Yes ☐ No

16. **If Hispanic/Latino, ethnicity (OPTIONAL - check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

17. **Race (OPTIONAL - check all that apply.)**

☐ White ☐ Black or African American ☐ Asian

☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native

☐ Other _____

Current Job & Income Information

Employed
If you're currently employed, tell us about your income. Start with question 18.

Not employed
Skip to question 28.

Self-employed
Skip to question 27.

Current Job 1:

18. Employer name and address:

_____

19. Employer phone number (_____) - _____ - _____

20. Wages/tips before taxes: ☐ Hourly ☐ Weekly ☐ Every 2 weeks

$ _____ ☐ Twice a month ☐ Monthly ☐ Yearly

21. Average hours worked each week: _____

Current Job 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address:

_____

23. Employer phone number (_____) - _____ - _____

24. Wages/tips before taxes: ☐ Hourly ☐ Weekly ☐ Every 2 weeks

$ _____ ☐ Twice a month ☐ Monthly ☐ Yearly

25. Average hours worked each week: _____

26. **In the past year, did you:**

☐ Change Jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

27. **If self-employed, answer the following questions:**

a. Type of work: _____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it. **NOTE:** You don't need to tell us about child support, veteran's payment, or supplemental security income (SSI).

☐ None

☐ Unemployment	$ _____	How often?	_____
☐ Net farming/fishing	$ _____	How often?	_____
☐ Pensions	$ _____	How often?	_____
☐ Net rental/royalty	$ _____	How often?	_____
☐ Social Security	$ _____	How often?	_____
☐ Retirement accounts	$ _____	How often?	_____
☐ Alimony recieved	$ _____	How often?	_____
☐ Other	$ _____	How often?	_____

If other, type: _____

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b.)

☐ Alimony paid: **$** _____ How often? _____

☐ Student loan interest: **$** _____ How often? _____

☐ Other deductions: **$** _____ How often? _____

If other, type: _____

30. **YEARLY INCOME:** Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year: $** _____

Your total income **next year** (If you think it will be different): **$** _____

THANKS! This is all we need to know about you.

PERSON 2

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 3 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you. **If you have more than two people to include, make a copy of Person 2 (pages 7 through 10) and complete.**

1. First name, Middle name, Last name, & Suffix

2: Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

_____/_____/_____

5. Social Security Number (SSN): _____

We need this if you want health coverage and have an SSN. Providing an SSN can be helpful if PERSON 2 doesn't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ YES **If yes,** please answer questions a - c. ☐ NO **If no,** SKIP to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant or have they been pregnant in the last 3 months?

☐ Yes ☐ No

If yes, how many babies are expected: _____

9. **Does PERSON 2 need health coverage?**

(Even if PERSON 2 has insurance, there might be a program with better coverage or lower costs.)

☐ YES **If yes,** answer all the questions below. ☐ NO **If no,** SKIP to the income questions on page 9, Step 2, PERSON 2.

10. **Does PERSON 2 live in a medical facility or nursing home or does this person need support services to prevent them going into a nursing home or other facility?**

☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 2 isn't a U.S. citizen or U.S. National,** do they have eligible immigration status?

☐ Yes Fill in their document type and ID number below.

a. Immigration document type: _____

b. Document ID number: _____

c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No

d. Is PERSON 2 or their spouse or parent a veteran or an active-duty member of the U.S. military?

☐ Yes ☐ No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is 20 or younger:

16. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. **If yes,** end date: b. Reason the insurance ended:

17. Is PERSON 2 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL - check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

19. **Race (OPTIONAL - check all that apply.)**

☐ White ☐ Black or African American ☐ Asian

☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native

☐ Other _____

Current Job & Income Information for PERSON 2

Employed
If PERSON 2 is currently employed, tell us about their income. Start with question 20.

Not employed
Skip to question 30.

Self-employed
Skip to question 29.

Current Job 1:

20. Employer name and address:

_____

21. Employer phone number (_____) - _____ - _____

22. Wages/tips before taxes: ☐ Hourly ☐ Weekly ☐ Every 2 weeks

$ _____ ☐ Twice a month ☐ Monthly ☐ Yearly

23. Average hours worked each week: _____

Current Job 2: (If PERSON 2 has more jobs and needs more space, attach another sheet of paper.)

24. Employer name and address:

_____

25. Employer phone number (_____) - _____ - _____

26. Wages/tips before taxes: ☐ Hourly ☐ Weekly ☐ Every 2 weeks

$ _____ ☐ Twice a month ☐ Monthly ☐ Yearly

27. Average hours worked each WEEK: _____

28. **In the past year, did PERSON 2:**

☐ Change Jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work: _____

b. How much net income (profits once business expenses are paid) will PERSON 2 get from this self-employment this month?

$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it. **NOTE:** There is no need to tell us about child support, veteran's payment, or supplemental security income (SSI).

☐ None

☐ Unemployment	$ _____	How often?	_____
☐ Net farming/fishing	$ _____	How often?	_____
☐ Pensions	$ _____	How often?	_____
☐ Net rental/royalty	$ _____	How often?	_____
☐ Social Security	$ _____	How often?	_____
☐ Retirement accounts	$ _____	How often?	_____
☐ Alimony recieved	$ _____	How often?	_____
☐ Other	$ _____	How often?	_____

If other, type: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 2 gets it. If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** Don't include a cost that is already considered in the answer to net self-employment (question 29b).

☐ Alimony paid: **$** _____ How often? _____

☐ Student loan interest: **$** _____ How often? _____

☐ Other deductions: **$** _____ How often? _____

If other, type: _____

32. **YEARLY INCOME:** Complete only if PERSON 2's income changes from month to month. If you don't expect changes to PERSON 2's monthly income, skip to the next section and complete.

PERSON 2's total income **this year: $** _____

PERSON 2's total income **next year** (If you think it will be different)**: $** _____

THANKS! This is all we need to know about PERSON 2.

Step 3: American Indian or Alaska Native (AI / AN) family member(s)

1. **Are you or is anyone in your family American Indian or an Alaska Native?**

☐ **NO.** **If No**, skip to Step 4.

☐ **YES.** **If Yes**, go to Appendix B.

Step 4: Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ **NO.** ☐ **YES.** **If yes**, check the type of coverage and write the person(s) name(s) next to the coverage they have.

☐ Medicaid _____

☐ CHIP _____

☐ Medicare _____

☐ TRICARE (Don't check if you have direct care or Line of Duty)

_____

☐ VA health care programs _____

☐ Peace Corps _____

☐ Employer insurance _____

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other _____

Name of health insurance: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?**
Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES.** **If yes,** you'll need to complete and include Appendix A.

Is this a state employee benefit plan? ☐ Yes ☐ No

☐ **NO.** **If no,** continue to Step 5.

Step 5: Other Questions

33. Is anyone on this application currently in jail or prison? ☐ Yes ☐ No

If yes, who? _____

Where are they held? _____

If they have a release date, show it here: _____

34. Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No

Step 6: Read carefully and sign this application. These are your Rights and Responsibilities as an applicant for medical benefits.

1. We will keep what you tell us private as required by law.

2. Be sure to answer the questions correctly. We may check all information on your application. You must help us if we ask you to prove that your information is correct.

3. We will use the information you provided as well as information from other sources such as Social Security benefits, unemployment insurance, unearned income and wages from employment to decide if you qualify.

4. You agree the state may seek reimbursement for services the state covered for your family if those services should have been paid for by any other health coverage your family may have.

5. If we pay medical bills for you, you give your right to collect medical support payments to the State of Illinois. You must help us if we ask you to establish parentage or obtain medical support payments for members of your family. You may not have to do this if you have a good reason not to. Your children can get health insurance even if you do not help us when we ask you to help.

6. You must apply for other financial benefits for which you may qualify such as Social Security Benefits or Unemployment Insurance.

7. We will not share any information about immigration of any person who does not have an Alien Registration Number. We will verify the immigration status of any person if you gave us their Alien Registration Number. To do that, we will check the number with the U.S. Citizenship and Immigration Service (USCIS). We may send other information to USCIS, such as copies of proof you sent of an Alien Registration Number and the person's Social Security Number, if they have one.

8. If you are seeking benefits as a person with a disability, you authorize staff at the Illinois Department of Healthcare and Family Services (HFS) and the Illinois Department of Human Services (DHS) to obtain information from your records or copy your records from the Social Security Administration (SSA) with respect to any claims for disability benefits and all related appeals. You certify that you understand that the materials requested may be protected under state and federal privacy laws. You authorize release of any material protected under state and federal privacy laws to the staff of HFS and DHS.

9. Some families or individuals have to make a payment each month for this health insurance. This payment is called a premium. The amount of the premium depends on the family's income.

10. Some families or individuals have to pay part of the bill when they visit the doctor, go into the hospital or get a prescription filled. These payments are called co-payments. The amount of the co-payment depends on the family's income.

11. You must report changes within 10 days if any of the following happens:
- Your income changes.
- The number of people in your family who live with you changes.
- Your address or phone number changes.
- Someone who gets health benefits moves out of Illinois, dies, or goes to jail or prison.
- Someone becomes covered by other insurance.

12. You understand that anyone who knowingly misuses the medical card issued by or on behalf of the State of Illinois may be committing a crime.

13. You understand that if you have given false information or intentionally failed to disclose information, you may be subject to civil prosecution, criminal prosecution or both.

14. You may withdraw your application or cancel your benefits at any time.

15. The State of Illinois does not discriminate on the basis of race, color, national origin, sex, age, or disability, religion or political belief. The State of Illinois provides reasonable accommodations according to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

16. 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 calling 1-800-435-0774 (TTY: 1-877-734-7429), by writing to the Department of Human Services, Bureau of Hearings. at 401 South Clinton Street, 6th Floor, Chicago, IL 60607, or by e-mailing your request to DHS.BAHNewAppeal@illinois.gov. The call is free. Use this phone number, e-mail and address only for appeal-related inquiries. All other inquiries should be directed to 1-800-843-6154 (TTY 1-800-447-6404.)

17. You understand that if you or anyone you have applied for is not eligible for Medicaid or All Kids, the state will send the information from the application to the Health Insurance Marketplace. The Health Insurance Marketplace needs detailed information about health coverage that your employer may offer even if you do not take it. The information requested on Appendix A may be required if the state sends your application to the Health Insurance Marketplace.

18. If you qualify to buy health insurance from the Marketplace, to make it easier to determine your eligibility for help paying for it in the future years, you agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send you a notice, let you make any changes, and you can opt out at any time. Indicate below if you agree and for how many years. Check only 1 box.

☐ 5 years - This is the maximum number of years allowed, or check

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ Do not use information from tax returns to renew my coverage.

Sign this application. The person who filled out Step 1 should sign this application. If you are an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

Step 7: Mail completed application.

Mail your signed application to:

Illinois Department of Healthcare and Family Services
P.O. Box 19122
Springfield, IL 62794-9122

If you want to register to vote, you can complete a voter registration form at www.elections.il.gov.

Appendixes:

Appendix A - Health Coverage from Jobs
Appendix B - American Indian or Alaskan Native Family Member (AI / AN)
Appendix C - Assistance with Completing this Application

APPENDIX A Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)

2. Employee Social Security number

_____ _____ - _____ - _____

EMPLOYER Information

3. Employer

4. Employer Identification Number (EIN)

_____ _____ - _____ - _____

5. Employer address

6. Employer phone number

_____ (_____) - _____ - _____

7. City

8. State

9. Zip

_____ _____ _____

10. Who can we contact about employee health coverage at this job?

_____

11. Phone number (if different from above)

(_____) - _____ - _____

12. E-mail address

_____

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage?

_____ / _____ / _____
Date (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

_____ _____ _____
Name Name Name

☐ **No** (Stop here and go to Step 5 in the application.)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much will the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

_____

Date of change (mm/dd/yyyy)

---

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed health benefit costs covered by the plan is no less than 60 percent of such costs. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security Number in boxes 1 and 2 and ask the employer to fill out the rest of the form.

EMPLOYEE Information

The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last)

_____

2. Employee Social Security number

_____ - _____ - _____

EMPLOYER Information

Ask the **employer** for this information.

3. Employer

_____

4. Employer Identification Number (EIN)

_____ - _____ - _____

5. Employer address (the Marketplace will send notices to this address)

_____

6. Employer phone number

(_____) - _____ - _____

7. City

_____

8. State

_____

9. Zip

_____

10. Who can we contact about employee health coverage at this job?

_____

11. Phone number (if different from above)

(_____) - _____ - _____

12. E-mail address

_____

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?

_____ / _____ / _____
Date (mm/dd/yyyy)

☐ **No** (Stop and return this form to the employee)

Tell us about the **health plan** offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)
☐ No

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return the form to the employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much will the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return the form to employee.

---

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

_____/_____/_____
Date of change (mm/dd/yyyy)

---

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed health benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986.)

APPENDIX B American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your **American Indian** or **Alaska Native Family Member(s)**

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. NAME	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name ☐ No	☐ Yes **If yes**, tribe name ☐ No
3. Has the person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:	$ _____ How often?	$ _____ How often?

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties.
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations.
- Money from selling things that have cultural significance.

APPENDIX C Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Phone number

(_____) - _____ - _____

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Signature

11. Date (mm/dd/yyyy) _____/_____/_____

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name & Suffix

3. Organization name

9. ID number (if applicable)