State of Illinois
Department of Human Services

Request for Cash Assistance - Medical Assistance - Supplemental Nutrition Assistance Program (SNAP)

Last Name: _____

First Name: _____ MI: ____

Maiden Name: _____

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Present Address: _____ Apartment Number: _____

City: _____ State: _____ Zip Code: _____ County: _____

Birth Date: _____ Social Security Number: _____ Are you homeless? ☐ Yes ☐ No

Mailing Address (if different from above): _____

City: _____ State: _____ Zip Code: _____ County: _____

Telephone number(s) Home: _____ Work: _____ Other: _____

Daytime phone: _____ Best time to call you: _____

Signing here will start your application. You must sign Page 18 before we approve you for any benefits.

Signature: _____ Date: _____

Approved Representative

When you sign to have an approved representative it means you give permission for this person (1) to sign your application for you, (2) to receive official information about this application, and (3) to act for you on all matters with this agency.

Do you want to name an approved representative? ☐ Yes ☐ No If yes, complete the following:

Name of approved representative: _____ Address: _____

Phone Number: _____ Organization Name: _____ ID # if applicable: _____

Signature of applicant: _____

Instructions to person(s) applying for Cash, Medical, and/or SNAP benefits

Cash - $ **Medical - ✚** **SNAP - 🍴**

1. Please **print** all of your answers on the application form so that we can read and understand your answers.
2. You have the right to immediately file the application as long as the top of this page (Page 1) is completed with your name, address and signature. The filing of this signed page (Page 1) starts the application processing timetable. Providing your date of birth and Social Security Number on this signed page will help us with the application registration process.
3. Read pages 14 & 15 to know your rights and responsibilities for SNAP benefits.
   Read pages 16, 17 and 18 to know your rights and responsibilities for Cash and Medical benefits.
4. **Before you can get any benefits, you must sign page 18.**
5. If applying for SNAP benefits, a decision on your eligibility will be made within 30 days. If determined eligible, SNAP benefits will be issued from the date the application is filed.
6. You may be entitled to receive SNAP benefits right away if:
   * your gross nonexempt income and liquid assets are less than your monthly rent or mortgage payment and the appropriate utility standard: or,
   * you have assets of $100 or less **and**
     - your gross monthly income for the month of application is less than $150; or
     - at least one person applying is a migrant who is "out of funds."
7. This application must be filed with the Illinois Department of Human Services (IDHS). You may complete this form at home and return it to your local Family Community Resource Center (FCRC) in person or by mail. You have the right to choose the office where you apply. Use the IDHS Office Locator to find an FCRC at www.dhs.state.il.us/page.aspx?module=12 or call the IDHS Helpline at 1-800-843-6154. **You may also mail this form to the Central Scan Unit (CSU), P.O. Box 19138, Springfield, IL 62763**. **You can also apply for benefits at ABE.illinois.gov or by calling the IDHS Helpline at 1-800-843-6154.** Another member of the household or an adult who knows you may complete and return the form to us also. If someone else completes this form for the household, they are to answer the questions for the person(s) they are applying for, not himself or herself.
8. If you want to register to vote, fill out the enclosed Illinois Voter Registration Application (SBE R-19) and give it to your IDHS Family Community Resource Center (FCRC) or your local election official. For help filling it out or for translation services, contact your IDHS Family Community Resource Center (FCRC). You may also call the Helpline at 1-800-843-6154, or 1-866-324-5553 TTY/Nextalk, 711 TTY Relay. For information online, see www.dhs.state.il.us or www.elections.il.gov/. Filling out the Voter Registration Application as part of this application is optional. Registering to vote is your choice and will not affect the amount of benefits you get from this agency.

State of Illinois
Department of Human Services

Request for Cash Assistance - Medical Assistance - Supplemental Nutrition Assistance Program (SNAP)

Citizenship/Immigration Status

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If you or any other persons are not applying because you do not wish to provide information about your immigration status, you do not have to give us that information. The failure to provide immigration information will not affect processing the application for the remaining persons. However, any person who is applying for benefits for himself or herself has to provide information on their immigration status.

Are all persons U.S. Citizens? ☐ Yes ☐ No

Complete the following for any non-citizens who are applying for benefits. If you need more room, attach another sheet of paper.

Name	Age	Arrival Date in the United States	Registration document/number
1.			
2.			
3.			
4.			

If there are persons who are not applying for SNAP and/or cash benefits because they do not wish to provide proof of their immigration status, please list them below. **We will only ask questions about their income & assets.**

Name (Last) (First) (MI)	Name (Last) (First) (MI)
1.	3.
2.	4.

General Household Questions

1. Are you or is anyone who lives with you blind? ☐ Yes ☐ No Disabled? ☐ Yes ☐ No
2. Does anyone in the household receive Social Security Disability or Railroad Retirement benefits? ☐ Yes ☐ No
   If yes, who: _____ What is their SSN or RRB claim number? _____
3. Does anyone have a physical, mental or emotional health condition that limits common activities (like bathing, dressing, daily chores, etc)? ☐ Yes ☐ No
   If yes, who: _____
4. Does anyone applying live in a nursing home facility, supportive living facility, or other facility or institution? ☐ Yes ☐ No
   If yes, who: _____ Name of facility: _____
5. Does anyone in your household want help paying for medical bills from the last 3 months? ☐ Yes ☐ No
6. Has anyone in your household been in foster care at age 18 or older? ☐ Yes ☐ No
   If yes, name of person: _____
7. Is anyone in your household age 18 or older a full time student? (college, or trade school) ☐ Yes ☐ No
   If yes, name of person: _____

Language Preference

Does the adult member of your household who will discuss your case with IDHS speak English fluently? ☐ Yes ☐ No

If no, please list your preferred spoken language: _____

Does the adult member of your household who will usually receive mail or written information from IDHS read English fluently? ☐ Yes ☐ No

If no, please list your preferred written language: _____

State of Illinois
Department of Human Services

Request for Cash Assistance - Medical Assistance - Supplemental Nutrition Assistance Program (SNAP)

Household Composition

How many people live with you (include yourself)? _____

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Complete the following for everyone in the household. Include people who live with you who are not requesting assistance. You must give us the Social Security Number for each person for whom you are requesting benefits. You **do not** have to give us the number for any person for whom you are not requesting benefits, but if you do, it may speed up the application process.

Person 1	Mark the box for the program this person is applying for: ☐ SNAP ☐ Medical ☐ Cash				
First	M.I.	Last	Suffix	Former Name, if any	Relationship to you SELF
Social Security #	Gender ☐ M ☐ F	Birth Date	Marital Status	Pregnant? If yes, due date	How many babies expected?

If this person is applying for Medical assistance answer question 1.

1. Do you plan to file a Federal Tax Return next year? ☐ Yes ☐ No If yes, answer 2-4 below
2. Will you file jointly with a spouse? ☐ Yes ☐ No If yes, list name(s): _____
3. Do you have any dependents? ☐ Yes ☐ No If yes, list name(s): _____
4. Will you be claimed as a dependent on someone else's tax return? ☐ Yes ☐ No

If yes, list the name of the tax filer: _____ How are you related to the tax filer? _____

The following two questions are optional. Answering these questions will not affect your eligibility or benefit amount. This information is to assure that program benefits are distributed without regard to race, color or national origin.

1. Is this person Hispanic or Latino? ☐ Yes ☐ No
2. What is your race? (Select one or more)

☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Person 2	Mark the box for the program this person is applying for: ☐ SNAP ☐ Medical ☐ Cash				
First	M.I.	Last	Suffix	Former Name, if any	Relationship to you
Social Security #	Gender ☐ M ☐ F	Birth Date	Marital Status	Pregnant? If yes, due date	How many babies expected?

If this person is applying for Medical assistance answer question 1.

1. Does this person plan to file a Federal Tax Return next year? ☐ Yes ☐ No If yes, answer 2-4 below
2. Will this person file jointly with a spouse? ☐ Yes ☐ No If yes, list name(s): _____
3. Does this person have any dependents? ☐ Yes ☐ No If yes, list name(s): _____
4. Is this person claimed as a dependent on someone else's tax return? ☐ Yes ☐ No

If yes, list the name of the tax filer: _____ How is this person related to the tax filer? _____

The following two questions are optional. Answering these questions will not affect your eligibility or benefit amount. This information is to assure that program benefits are distributed without regard to race, color or national origin.

1. Is this person Hispanic or Latino? ☐ Yes ☐ No
2. What is his/her race? (Select one or more)

☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Household Composition (Continued)

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Person 3	Mark the box for the program this person is applying for: ☐ SNAP ☐ Medical ☐ Cash				
First	M.I.	Last	Suffix	Former Name, if any	Relationship to you

Social Security #	Gender ☐ M ☐ F	Birth Date	Marital Status	Pregnant? If yes, due date	How many babies expected?

If this person is applying for Medical assistance answer question 1.

1. Does this person plan to file a Federal Tax Return next year? ☐ Yes ☐ No If yes, answer 2-4 below
2. Will this person file jointly with a spouse? ☐ Yes ☐ No If yes, list name(s): _____
3. Does this person have any dependents? ☐ Yes ☐ No If yes, list name(s): _____
4. Is this person claimed as a dependent on someone else's tax return? ☐ Yes ☐ No

If yes, list the name of the tax filer: _____ How is this person related to the tax filer? _____

The following two questions are optional. Answering these questions will not affect your eligibility or benefit amount. This information is to assure that program benefits are distributed without regard to race, color or national origin.

1. Is this person Hispanic or Latino? ☐ Yes ☐ No
2. What is his/her race? (Select one or more)

☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Person 4	Mark the box for the program this person is applying for: ☐ SNAP ☐ Medical ☐ Cash				
First	M.I.	Last	Suffix	Former Name, if any	Relationship to you

Social Security #	Gender ☐ M ☐ F	Birth Date	Marital Status	Pregnant? If yes, due date	How many babies expected?

If this person is applying for Medical assistance answer question 1.

1. Does this person plan to file a Federal Tax Return next year? ☐ Yes ☐ No If yes, answer 2-4 below
2. Will this person file jointly with a spouse? ☐ Yes ☐ No If yes, list name(s): _____
3. Does this person have any dependents? ☐ Yes ☐ No If yes, list name(s): _____
4. Is this person claimed as a dependent on someone else's tax return? ☐ Yes ☐ No

If yes, list the name of the tax filer: _____ How is this person related to the tax filer? _____

The following two questions are optional. Answering these questions will not affect your eligibility or benefit amount. This information is to assure that program benefits are distributed without regard to race, color or national origin.

1. Is this person Hispanic or Latino? ☐ Yes ☐ No
2. What is his/her race? (Select one or more)

☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

State of Illinois
Department of Human Services

Request for Cash Assistance - Medical Assistance - Supplemental Nutrition Assistance Program (SNAP)

Household Composition (Continued)

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Person 5	Mark the box for the program this person is applying for: ☐ SNAP ☐ Medical ☐ Cash				
First	M.I.	Last	Suffix	Former Name, if any	Relationship to you

Social Security #	Gender ☐ M ☐ F	Birth Date	Marital Status	Pregnant? If yes, due date	How many babies expected?

If this person is applying for Medical assistance answer question 1.

1. Does this person plan to file a Federal Tax Return next year? ☐ Yes ☐ No If yes, answer 2-4 below
2. Will this person file jointly with a spouse? ☐ Yes ☐ No If yes, list name(s): _____
3. Does this person have any dependents? ☐ Yes ☐ No If yes, list name(s): _____
4. Is this person claimed as a dependent on someone else's tax return? ☐ Yes ☐ No

If yes, list the name of the tax filer: _____ How is this person related to the tax filer? _____

The following two questions are optional. Answering these questions will not affect your eligibility or benefit amount. This information is to assure that program benefits are distributed without regard to race, color or national origin.

1. Is this person Hispanic or Latino? ☐ Yes ☐ No
2. What is his/her race? (Select one or more)

☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Person 6	Mark the box for the program this person is applying for: ☐ SNAP ☐ Medical ☐ Cash				
First	M.I.	Last	Suffix	Former Name, if any	Relationship to you

Social Security #	Gender ☐ M ☐ F	Birth Date	Marital Status	Pregnant? If yes, due date	How many babies expected?

If this person is applying for Medical assistance answer question 1.

1. Does this person plan to file a Federal Tax Return next year? ☐ Yes ☐ No If yes, answer 2-4 below
2. Will this person file jointly with a spouse? ☐ Yes ☐ No If yes, list name(s): _____
3. Does this person have any dependents? ☐ Yes ☐ No If yes, list name(s): _____
4. Is this person claimed as a dependent on someone else's tax return? ☐ Yes ☐ No

If yes, list the name of the tax filer: _____ How is this person related to the tax filer? _____

The following two questions are optional. Answering these questions will not affect your eligibility or benefit amount. This information is to assure that program benefits are distributed without regard to race, color or national origin.

1. Is this person Hispanic or Latino? ☐ Yes ☐ No
2. What is his/her race? (Select one or more)

☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

If needed, please list extra household members on an additional piece of paper.

If you are applying for SNAP benefits complete this page.

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How much money do you or anyone who lives with you have in cash, checking, and/or savings? $_____

What is the monthly **gross income** (income of all sources before any deductions) for you and everyone who lives with you? $_____

How much money have you or anyone who lives with you received or expect to receive from any source in the month of application?

$ _____ When? _____ Who: _____ Source: _____

Shelter Costs

1. How much are you charged each month for your rent or mortgage? $_____
   (For mortgage include property taxes and insurance.)
   Do you share this expense with anyone? ☐ Yes ☐ No

2. Did you receive a payment of $21 or more this month or in any of the last 12 months from the Low Income Home Energy Assistance Program (LIHEAP), (in Chicago paid through CEDA)? ☐ Yes ☐ No

3. If No, are you billed separately from rent or mortgage for:
   NOTE: Air conditioning is a window air or central air conditioning unit.
   - **A.** Heat or air conditioning? ☐ Yes ☐ No
   - **B.** Excess cost for heat or air conditioning? ☐ Yes ☐ No
   - **C.** Does anyone outside of your SNAP household pay or help pay for your housing costs? ☐ Yes ☐ No
   - **D.** Does anyone outside of your SNAP household pay your utility expenses? ☐ Yes ☐ No

   If yes, please list the bills and the amounts paid: _____

Please complete the following information if you answered No, to question 2 or 3 and are not billed for heat or air conditioning separately

Expenses	Amount	How Often Due	Amount You Pay	Paid By Others
Electricity				
Water and/or Sewerage				
Garbage				
Cooking Fuel				
Basic Phone Service (including cell phone)				
Septic Tank Installation Maintenance				
Well Installation /Maintenance				
A Fee for Starting Utility Service				
A Flat Amount for Utilities				
Explain:				

Migrant or Seasonal Farmworker Questions

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Is this a SNAP household of migrant or seasonal farm workers? ☐ Yes ☐ No

Did the household have income prior to the date of application? ☐ Yes ☐ No

If yes, did the income recently stop? ☐ Yes ☐ No If yes, date the income stopped? _____

Are liquid assets of household $100 or less **AND** does the household have a destitute migrant or seasonal farmworker?

☐ Yes ☐ No

Are you or is anyone who lives with you expecting to receive more than $25 in income from a new source within the next 10 days? ☐ Yes ☐ No

Benefit Information

Has the primary applicant received SNAP benefits in any state in the month of application? ☐ Yes ☐ No

Is the applicant a resident of a domestic violence shelter? ☐ Yes ☐ No

Medical Deduction for Persons Disabled or Age 60 or Older

If a SNAP household member is disabled or age 60 or older your SNAP household may be entitled to a Standard Medical Deduction. To get the Standard Medical Deduction, you have to prove you pay out of pocket monthly medical expenses of $36 or more.

*If you do not live in a group home the Standard Medical Deduction is $200.

*If you live in a group home the Standard Medical Deduction is $485.

Can you prove that you pay $36 or more monthly in medical expenses? ☐ Yes ☐ No

If yes and you give us proof, we will allow the Standard Medical Deduction that applies to your household. If your monthly medical expenses that you pay are more than $200/$485 and you give us proof, we will allow your actual medical expenses.

Application Interview - Cash and SNAP

Please complete the following:

We will interview you within 14 days, or right away if you qualify for an expedited SNAP interview.

☐ I am able to come to an office interview.

☐ I must be interviewed by phone because: _____

☐ I am applying for SNAP

- ☐ And someone in my household is employed.
- ☐ Problems with health, transportation, caring for a child or disabled adult, ongoing severe weather or educational activities conflict with work hours.

☐ I am applying for cash assistance

- ☐ Hours of work or educational activities conflict with office hours.
- ☐ Problems with health, transportation, caring for a child or disabled adult, ongoing severe weather or educational activities conflict with work hours.

I can be reached by phone Monday - Friday between 8:30 and 5:00 at: _____

State of Illinois
Department of Human Services

Request for Cash Assistance - Medical Assistance - Supplemental Nutrition Assistance Program (SNAP)

Income - Benefits - Expenses

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Is anyone in your household currently employed? ☐Yes ☐No

If yes, complete the following:

Name of Person: _____ Employer: _____

Employer Address: _____ Employer Phone: _____

Number of hours worked weekly: _____ Amount Paid (including tips) before taxes $ _____

How often paid: ☐Weekly ☐Every two weeks ☐Twice a month ☐Monthly

Name of Person: _____ Employer:

Employer Address: _____ Employer Phone: _____

Number of hours worked weekly: _____ Amount Paid (including tips) before taxes $ _____

How often paid: ☐Weekly ☐Every two weeks ☐Twice a month ☐Monthly

Is anyone in your household self-employed? ☐Yes ☐No If yes, name of person: _____

What kind of work do they do? _____

How much will they make this month, once they pay business expenses? $ _____

Complete only if your income changes from month to month. If you don't expect changes, skip this section.
What is the total income for each person for this year? If you anticipate a change, what will it be next year?

Person: _____ Total income this year: $ _____ Total income next year: $ _____

Person: _____ Total income this year: $ _____ Total income next year: $ _____

Person: _____ Total income this year: $ _____ Total income next year: $ _____

Does anyone named on this form RECEIVE money from any source other than employment (such as Social Security, educational benefits, child support, spousal support, rental property, unemployment benefits, pensions, retirement, trusts)? ☐Yes ☐No

If yes, complete the following:

Name of Person: _____ Source: _____ Monthly Amount $ _____

Name of Person: _____ Source: _____ Monthly Amount $ _____

Name of Person: _____ Source: _____ Monthly Amount $ _____

(Include additional pages, if needed.)

If this income is from rental property, is this person receiving the income also the property manager? ☐Yes ☐No

In the past year, has anyone in your household changed jobs, stopped working or started working fewer hours? ☐Yes ☐No

If yes, name of Person: _____

Does anyone in your household pay any of the following expenses?

Alimony paid: $ _____ How often? ☐Weekly ☐Every two weeks ☐Twice a month ☐Monthly

Student loan interest: $ _____ How often? ☐Weekly ☐Every two weeks ☐Twice a month ☐Monthly

Day-care: $ _____ How often? ☐Weekly ☐Every two weeks ☐Twice a month ☐Monthly

Child Support paid : $ _____ How often? ☐Weekly ☐Every two weeks ☐Twice a month ☐Monthly

Other deductions (Do not include any expenses you have already reported)

Type of expense: _____ $ _____ How often? ☐Weekly ☐Every two weeks ☐Twice a month ☐Monthly

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

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Are you or anyone in your family American Indian or Alaska Native (AI/AN)? ☐Yes ☐No

Are you or anyone in your household a member of a federally-recognized tribe? ☐Yes ☐No

If yes, tribe name: _____

If No, skip to next section.

Indian Health Services

List any family members who received services from the Indian Health Service, a tribal health program, or urban Indian health program. If nobody received these services, is anyone qualified to receive them?

List the names of anyone who received services: _____

List the names of anyone who qualifies for services: _____

Tribal Related Income

Does the income you listed on Page 7 include money from any of the following:
Payments from a tribe that come from natural resources, usage rights, leases or royalties? ☐Yes ☐No

If yes, amount: $ _____

Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations)? ☐Yes ☐No

If yes, amount: $ _____

Money from selling things that have cultural significance? ☐Yes ☐No

If yes, amount: $ _____

SNAP and Cash Applicants:

Have you or any other person applying for Cash been convicted of a felony involving drugs on or after 08/22/96? ☐Yes ☐No

If yes, Name of Person: _____

If the drug-related felony conviction was NOT Class X or Class I, did the felony take place more than 2 years ago, or has the person completed a drug treatment program, or is the person in a drug treatment program now? ☐Yes ☐No

Has any person been convicted in state or federal court of misrepresenting an address to receive assistance in two or more states at the same time? ☐Yes ☐No

If yes, who _____

Is any person in violation of their parole or probation? ☐Yes ☐No

If yes, who _____

Is anyone fleeing from felony prosecution, an outstanding felony warrant or jail? ☐Yes ☐No

If yes, who _____

Your Family's Health Coverage

Complete this page if you are applying for cash or medical benefits.

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Is anyone enrolled in health coverage now from any of the following? If **YES**, check the type of coverage and write their names next to the coverage they have.

- ☐ Medicaid _____
- ☐ CHIP _____
- ☐ Medicare _____
- ☐ Tricare (Don't check if you have Direct Care or a Line of Duty) _____
- ☐ Veteran's Health Insurance Program _____
- ☐ Peace Corps Health Insurance _____
- ☐ Employer Insurance _____

  Name of Insurance _____

  Policy Number _____

  Is this a retiree health plan? ☐Yes ☐No

  Is this COBRA coverage? ☐Yes ☐No
- ☐ Other _____

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

  Is anyone listed on this application offered health coverage from a job? ☐Yes ☐No

  Check **YES** even if the coverage is from someone else's job, such as a parent's or spouse's.

  If **YES**, complete Page 11.

Tell us about the job that offers coverage:

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____

Employer Identification Number (EIN): _____

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

Phone Number: _____ E-Mail address: _____

Can you get coverage now or sometime in the next 3 months? ☐Yes ☐No

If yes, when?: _____

List the name of anyone who can get coverage from this job:

_____

Your Family's Health Coverage

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Complete this page if you are applying for cash or medical benefits and anyone listed on this application is offered health coverage from a job.

Does the employer offer a health plan that pays at least 60% of the total costs of benefits? (The minimum value standard for health plans) ☐Yes ☐No

For the lowest-cost minimum value plan offered to the employee ONLY (don't include family plans):

Does the employer offer wellness programs? ☐Yes ☐No

If yes, what premium would the employee pay if he or she got the maximum discount for a tobacco cessation program? $_____

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

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

What changes will the employer make for the new plan year, if you know?

☐ Employer won't offer health coverage.

☐ Employer will start offering health coverage to employees.

☐ Employer will change the premium for the lowest-cost plan minimum value plan available to the employee only.

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

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

You must answer for all household members age 19 or younger:
Did anyone lose health insurance from a job within the past three months? ☐Yes ☐No

If yes, answer the questions below:

a. Name of household member: _____

b. When did the insurance end? _____

c. Reason insurance ended: _____

General Medical Questions

Does anyone applying receive services through Department on Aging's Community Care Program or has anyone applied for these services? ◯Yes or ◯No

If yes, enter the person's name: _____

Is anyone applying a Veteran or the spouse, child, widow(er) or parent of a Veteran? ◯Yes or ◯No

If yes, enter the person's name and relationship to the Veteran: _____

RESOURCE INFORMATION

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Complete only for persons who are blind, have a disability or are age 65 or older. If married and living with spouse, also enter any resources the spouse owns. If yes to any of the following, enter the details below. Attach proof. Attach additional sheet(s) if needed.

Does anyone own any property (ies) such as a home, vacation home, time share, building or land? ☐Yes ☐No

Owner	Address	Type	Value	Amount Owed
			$	$
			$	$

Does anyone own a car, truck, motorcycle, boat, trailer or other vehicle? ☐Yes ☐No

Owner	Type	Make/Model/Year	Value	Amount Owed
			$	$
			$	$

Does anyone own any life insurance? ☐Yes ☐No

Owner	Insurance Company	Policy Number	Face Value	Cash Value
			$	$
			$	$

Does anyone have an insurance policy that pays when he or she is in a nursing home? ☐Yes ☐No

If yes, list the following:

Policy Number: _____

Name of Company: _____

Does anyone own any of the following resources? Check all that apply:

☐ Business ☐ Savings ☐ Checking Account ☐ Stocks, Bonds ☐ Government Bonds
☐ Life Estate ☐ Funeral/Burial Plans ☐ Money Market Account ☐ Deferred Comp ☐ Mutual Funds
☐ Annuity ☐ Nursing Home Account ☐ Trust Funds ☐ Inheritance ☐ Promissory Note/Loan
☐ Burial Plots ☐ IRA/401 K ☐ Certificates of Deposit ☐ Reverse Mortgage ☐ Mineral/Oil Rights
☐ Other List, If other: _____

Owner(s)	Type of Resource	Account/Policy No.	Value	Name of Bank, Company, etc.
			$	
			$	

Do you have resources that are held jointly with another person? ☐Yes ☐No

(Jointly held resources are those held in two or more names; for example, in your name and in the name of another person(s). This includes resources that may be held by you and your spouse, son or daughter, brother or sister, grandchild, friend, companion, etc.)

Resource:	Value:	Name and relationship of Other Person(s) Holding the Resource:
Property in Illinois:	$	
Property in another state:	$	
Checking/Savings account:	$	
Certificate of Deposit:	$	
Stocks/Mutual Funds:	$	
Other:	$	

Employment and Employment Related Expenses


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Complete only for employed persons who are blind, have a disability or are age 65 or older. Also enter the employment expenses for an employed spouse or parent of a child under age 18 if they live together.

Employed person's name: (1) _____

Amount received before deductions (gross amount): $ _____

How often paid: ☐Weekly ☐Every two weeks ☐Bi-Monthly ☐Monthly

Federal, State and City taxes withheld: $ _____ Social Security tax withheld: $ _____

Does this person buy or bring lunch to work? ☐Buy Lunch ☐Bring Lunch

Does this person buy uniforms or special tools? ☐Yes ☐No

If yes, enter the items bought, how often, and cost. Attach proof. _____

How does this person get to and from work? ☐Own car ☐Bus ☐Other Please list. if other: _____

If this person uses his/her own car, how many miles to and from work? _____

If this person person takes the bus, what is the fare to and from work? $ _____

If other transportation is used, enter type and cost. Attach proof. _____

Must this person pay union dues, group life insurance premiums, group health insurance premiums, or retirement plan withholding as a condition of employment? ☐Yes ☐No Monthly amount: $ _____

Employed person's name: (2) _____

Amount received before deductions (gross amount): $ _____

How often paid: ☐Weekly ☐Every two weeks ☐Bi-Monthly ☐Monthly

Federal, State and City taxes withheld: $ _____ Social Security tax withheld: $ _____

Does this person buy or bring lunch to work? ☐Buy Lunch ☐Bring Lunch

Does this person buy uniforms or special tools? ☐Yes ☐No

If yes, enter the items bought, how often, and cost. Attach proof. _____

How does this person get to and from work? ☐Own car ☐Bus ☐Other Please list. if other: _____

If this person uses his/her own car, how many miles to and from work? _____

If this person person takes the bus, what is the fare to and from work? $ _____

If other transportation is used, enter type and cost. Attach proof. _____

Must this person pay union dues, group life insurance premiums, group health insurance premiums, or retirement plan withholding as a condition of employment? ☐Yes ☐No Monthly amount: $ _____

SNAP - CLIENT RIGHTS AND RESPONSIBILITIES

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Read carefully before signing this application on page 18. Ask your caseworker to explain anything you do not understand.

Because the SNAP program requires a Social Security Number (SSN) for every member of your household who is applying for SNAP benefits, we are explaining how your SSN is used by IDHS.

What does IDHS do with your Social Security Number?

The SSN will be used in the administration of the SNAP program to check the identity of household members, prevent duplicate participation, and to facilitate making mass changes. If you or any member of your household wants to apply for SNAP benefits, but does not have a SSN, we can help you apply for one. The SSN (or any other information in this application) may be used in computer matching and program reviews or audits and to make sure the household is eligible for SNAP benefits, other Federal assistance programs, and Federally assisted state programs, such as school lunch, TANF, and Medicaid. This may result in criminal or civil action or administrative claims against persons fraudulently participating in the SNAP program. We do not require a Social Security Number for any member of your household who is not eligible for the SNAP program or who does not wish to apply.

Why does IDHS collect your Social Security Number?

IDHS secures and uses information about all clients through the income and eligibility verification system. This includes such information as receipt of social security benefits, unemployment insurance, unearned income and wages from employment. When information does not match, we may contact a third party, such as employers, claims representatives, or financial institutions to verify the information. This information may affect your eligibility for assistance and the amount of assistance provided.

Right to appeal.

A fair hearing may be requested either orally, in writing, by using the ABE Appeals Portal, facsimile (fax), mail or in person at the Bureau of Hearings or at any FCRC if there is a disagreement with any action taken on this case. The SNAP unit's case may be presented at the hearing by any person chosen by the SNAP unit.

Non-Discrimination.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State of Illinois Department of Human Services) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html , and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Additional Illinois Nondiscrimination Information

You may also write the Illinois Department of Human Services (IDHS) at Illinois Department of Human Services, Bureau of Civil Affairs, 401 South Clinton St., 6th Floor, Chicago, Illinois, 60607 or call the IDHS Helpline Number at 1-800-843-6154 or 866-324-5553 TTY/Nextalk or 711 TTY Relay.

IDHS, HHS, and USDA are equal opportunity providers and employers.

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

SNAP - CLIENT RIGHTS AND RESPONSIBILITIES continued

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Declaration Regarding Citizenship/Alien Status
I declare, under penalty of perjury, that the statements I have made regarding the citizenship or alien status of each person requesting assistance are true and correct. I understand that the alien status of each person requesting assistance who is not a citizen of the United States will be verified with the United States Citizenship and Immigration Services (USCIS). This will require the disclosure to USCIS of certain identifying information which I have provided. The information received from USCIS may affect eligibility for assistance and the benefit level.

I understand that documents may have to be provided to prove what I have said. I agree to do this. If documents are not available, I agree to give the name of the person or organization the IDHS Family Community Resource Center (FCRC) may contact to obtain the necessary proof. **The information on this form is subject to verification by Federal, State, and Local Officials. If any information is found to be inaccurate, I may be denied SNAP benefits, and/or be subject to criminal prosecution for knowingly providing false information.**

I understand that a change that happens after the eligibility interview and before the notice of decision must be reported within 10 calendar days unless otherwise notified. If I have any doubt about whether to report a change, I will ask my Human Services caseworker.

I understand that if I am approved for SNAP benefits and I receive more benefits than I am entitled to, whether an error on my part or an agency error, the amount of overpaid benefits may be subtracted from my monthly benefit amount.

AT THE APPLICATION	
You Must Report	**You must report and verify:**
Child care expenses	Medical expenses
Rent or mortgage payment, property taxes and insurance and utility expenses.	Child support paid to a non-SNAP Unit member

Failure to report or verify above expenses will be seen as a statement by your SNAP Unit that you do not want to receive a deduction for the unreported expenses.

Child support payments are subject to verification by computer matching with the records of the Division of Child Support Enforcement.

Penalty Warning - **What are the SNAP Program Penalties?**

If you.....	**Then you will lose SNAP benefits**
* Hide or give wrong information on purpose to get SNAP benefits * Trade, steal or sell SNAP benefits, or resell food bought with SNAP benefits * Use SNAP benefits to buy non-food items like alcohol or tobacco. * Use someone else's SNAP benefits for yourself or someone else. * Throw away beverages purchased with SNAP benefits just to get money back from a container deposit.	*** 12 months first time** *** 24 months the second time** *** Permanently the third time**
Trade SNAP benefits for controlled substance, such as drugs.	*** 24 months first time** *** Permanently the second time**
Trade SNAP benefits for firearms, ammunition or explosives.	*** Permanently**
Buy, sell, steal or trade SNAP benefits of more than $500.00	*** Permanently**
* Give false information about who you are and where you live so you can get extra SNAP benefits.	*** 10 years**

You can also be fined up to $250,000 and put in prison up to 20 years or both. In addition, you may be barred from SNAP for an additional 18 months if court ordered. You can also be charged under other Federal Laws. Persons who are fleeing felons or probation/parole violators are ineligible for SNAP benefits.

Cash/Medical Assistance - CLIENT RIGHTS AND RESPONSIBILITIES

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Read carefully before signing this application on page 18. Ask your caseworker to explain anything that you do not understand.

To receive benefits, a person must have a valid Social Security Number (SSN) or proof that he or she has applied for one, unless exempt. If you or any member of your household wants to apply for assistance, but do not have a SSN, we can help you to apply for one. State law requires us to explain how your SSN is used by the State of Illinois.

- ✓ **Your Social Security Number (**SSN) will be used in the administration of the cash and/or medical program to check the identity of household members, prevent duplicate participation, and to facilitate making mass changes to the cash and/or medical program.
  - The SSN (or any other information in this application) may be used in computer matching and program reviews or audits and to make sure the household is eligible for assistance, other federal assistance programs, and federally assisted state programs, such as school lunch, TANF, and Medicaid.
  - IDHS secures and uses information about all clients through the income and eligibility verification system. This includes such information as receipt of social security benefits, unemployment insurance, unearned income and wages from employment.
  - Any information obtained will be used in determining eligibility for assistance and the amount of assistance provided for all programs.
  - When discrepancies are found, verification of this information may be obtained through contacts with a third party, such as employers, claims representatives, or financial institutions. This information may affect your eligibility for assistance and the amount of assistance provided.
  - IDHS will only use your SSN for the purpose for which it was collected.
  - IDHS will not: sell, lease, loan, trade, or rent your SSN to a third party for any purpose; publicly post or publicly display your SSN; print your SSN on any card required for you to access our services; require you to transmit your SSN over the Internet, unless the connection is secure or your SSN is encrypted; or print your SSN on any materials that are mailed to you, unless State or Federal law requires that number be on documents mailed to you, or unless we are confirming the accuracy of your SSN.
- ✓ When an application for cash or medical assistance is filed, a determination of eligibility under all of the programs administered by IDHS will be made unless I do not want to be considered for a particular program(s). If I do not want to be considered for a particular program, IDHS will not consider my eligibility for that program(s).
- ✓ The information provided on this form will be subject to verification by Federal, State, and Local officials. If any information is found to be inaccurate, I may be denied cash benefits and/or medical assistance. I understand that anyone who knowingly misuses the medical card issued by the State of Illinois may be committing a crime.
- ✓ All information related to the establishment of paternity and child support enforcement has been provided to the best of my knowledge.
- ✓ 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 or a member of my family may be eligible.
- ✓ I also authorize staff of the IDHS to obtain information from my records or copy my records from the Social Security Administration (SSA). I authorize release of my records from SSA to the staff of IDHS with respect to any claims for disability benefits and all related appeals. I certify that I understand that the materials requested may be protected under the Privacy Act. I authorize release of any material protected under the Privacy Act to the staff of IDHS.


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Cash/Medical Assistance - CLIENT RIGHTS AND RESPONSIBILITIES continued

- ✓ I understand that the State of Illinois will release information concerning medical services that I have received for any reason authorized by law.
- ✓ I understand that if the children I am applying for are approved for "**All Kids Share or All Kids Premium"**, then I am responsible for paying the premiums and copayment amounts.
- ✓ If I am approved for TANF Cash and/or medical benefits for myself and my children, and the State of Illinois pays medical bills for me, I give my right to collect medical support payments to the State of Illinois. I understand I must help to obtain medical support payments for members of my family unless I have a good reason not to. My children can get health insurance even if I do not help when the Department asks me to.
- ✓ As a condition of eligibility, if I am approved for TANF Cash and/or medical assistance for myself and my children, I understand that I may be required to cooperate with child support enforcement.
    - Cooperation includes establishment of paternity and/or support enforcement and modification of child support orders.
    - I assign and give all my rights, title and interest of child support and medical support to Healthcare and Family Services (HFS) as long as I receive TANF Cash/or medical assistance.
    - I understand and agree that any child support payments paid through the clerk of the circuit court and through the State Disbursement Unit (SDU) may be forwarded to the HFS as long as I receive TANF Cash.
    - I understand that if I apply for TANF Cash and/or medical assistance for my children only, I am not required to cooperate with child support enforcement, but I may request services.
- ✓ I declare under penalty of perjury, that the statements I have made regarding the citizenship or immigration status of each person requesting assistance are true and correct.
- ✓ I understand the Department will not share any information about immigration or any persons who do not have an Alien Registration Number.
- ✓ The Department will verify the immigration status of any person for whom I give an Alien Registration Number. To do that, the Department will check the number with the U.S. Citizenship and Immigration Service (USCIS). The Department may send other information to USCIS, such as copies of proof that I give of an Alien Registration Number and the person's Social Security Number, if they have one.
- ✓ If I am approved for **Aid to the Aged, Blind, or Disabled (AABD**) for cash and/or medical assistance, I understand that IDHS may have the right to place a lien on my home or other real property I own. The amount of the lien is the amount of assistance IDHS has provided to me.
- ✓ I agree to inform the agency within 10 days of any change in my household's size, income, property, living arrangements, school attendance, or address.
- ✓ I understand that if approved for cash benefits, and I receive more benefits than I am entitled to, whether it be an error on my part or an agency error, the amount of overpaid benefits are subject to recoupment/recovery.
- ✓ I understand that a person convicted of a Class X or Class I felony or a comparable federal law, for acts that occurred on or after 08/22/96 involving possession, use, or distribution of a controlled substance is ineligible to receive Cash assistance. I understand that a person convicted of drug-related felony, other than a Class X or Class I, under Illinois or any comparable federal law an act that occurred on or after 08/22/96, is ineligible for Cash assistance for 2 years following the date of the conviction, unless they are in drug treatment or aftercare, or successfully participated in and completed drug treatment and/or aftercare subsequent to their conviction.

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Cash/Medical Assistance - CLIENT RIGHTS AND RESPONSIBILITIES continued

✓ **Right to Appeal** I understand that if I am not satisfied with the action taken on my application that I have the right to a fair hearing. I understand that I can ask for a fair hearing by getting in touch with the office where I applied or by writing to: Illinois Department of Human Services, Bureau of Assistance Hearings, 401 South Clinton Street, 6th Floor, Chicago, Illinois 60607, or by calling 1-800-435-0774.

✓ I understand that if I am mentally and physically unable to apply and I want someone else to apply for cash and/or medical benefits for me, I must attach a written statement that gives the person permission. The statement must include the person's name, address, and phone number. The statement must say that I am still responsible for the information provided by the person

✓ I understand that if I or anyone I 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 my employer may offer even if I do not take it. The information requested on Pages 10 and 11 may be required if the state sends my application to the Health Insurance Marketplace.

✓ I understand that by signing this application form, I consent to any investigation made by the Department to verify or confirm the information I have given or any other investigation made by them in connection with my request for public assistance. I understand that I must cooperate in these efforts to verify information.

Applicant Signature

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

I declare under penalties of perjury that I have examined this form and all accompanying statements or documents pertaining to the income and resources of myself (the applicant) or any member of my family (the applicant's family) included in this application for aid, or pertaining to any other matter having bearing upon my (the applicant's) eligibility for aid, and to the best of my knowledge and belief the information supplied is true, correct, and complete.

Applicant: _____ Date _____

Spouse: _____ Date _____

Signature: Applicant Makes a Mark (X)

☐ If you have made your mark (X) instead of signing your name, one witness must sign here:

Signature of Witness: _____ Date _____

Signature: Applicant Blind

☐ Applications based on blindness must be attested to by two witnesses.

Signature of Witness: _____ Date _____

Signature of Witness: _____ Date _____

APPROVED REPRESENTATIVE SIGNATURE

If the application is initiated by someone else for the applicant, they must sign below. If an approved representative completes and signs this application, written authorization from the applicant is required.

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

Signature of Approved Representative: _____ Relationship: _____

Home Address: _____ Apt. Number: _____

Phone Number: _____

You can mail or bring this form to an Illinois Department of Human Services, Family Community Resource Center (FCRC). Use the IDHS Office Locator to find an FCRC at www.dhs.state.il.us/page.aspx?module=12 or call the IDHS Helpline at 1-800-843-6154. You can also apply for benefits at ABE.Illinois.gov or by calling the Helpline at 1-800-843-6154.

ILLINOIS VOTER REGISTRATION APPLICATION

FOR ILLINOIS RESIDENTS ONLY

(September 2017)

TO VOTE YOU MUST:

- Be a United States citizen
- Be at least 18 years old (some 17 year olds may vote in the General Primary Consolidate Primary or Caucus.)
- Live in your election precinct at least 30 days
- Not be convicted and incarcerated.
- Not claim the right to vote anywhere else

TO VOTE IN THE NEXT ELECTION:

- **Mail or deliver this application to your County Clerk or Boardof Election Commissioners** no later than 28 days before the next election. (click here for County Clerk/Election Boardlistings) **or go to http://www.elections.il.gov**

IMPORTANT INFORMATION:

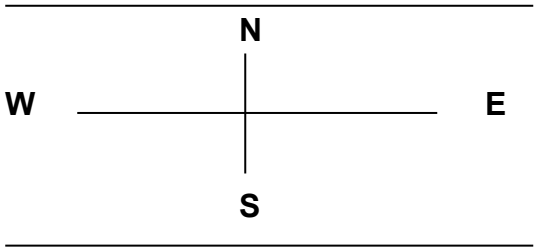
- If you do not have a driver's license, State Identification Card or social security number, and this form is submitted by mail, and you have never registered to vote in the jurisdiction you are now registering in, then you must send, with this application, either (i)a copy of a current and valid photo identification, or (ii) a copy of a current utility bill, bank statement, government check, paycheck,or other government document that shows the name and address of the voter. If you do not provide the information required above,then you will be required to provide election officials with either (i)or (ii) described above the first time you vote in person or prior to voting by mail.
- If you change your name you must re-register.
- If you register at a public service agency, any information regarding the agency that assisted you will remain confidential as will any decision not to register.
- If you do not receive a Notice within 2 weeks of mailing or delivering this application, call your County Clerk or Board of Election Commissioners.

TO COMPLETE THIS FORM:

Box 1-If you do not have a middle name, leave blank.
Box 3-If mailing address is same as Box 2, write "same".
Box 4-By providing an email address you agree to receiveelection related notices via email.
Box 5-If you have never registered before, leave blank. If you do not remember your former address; provide as muchinformation as possible.
Box 6-If you have not changed your name, leave blank.
Box 10-If you have an Illinois Driver's License or Secretary of State ID, check the first box and fill in the number. If you do not have a Driver's License or SOS ID, check the second box and fill in the last four digits of your Social Security Number. If you do not have a SSN, check the third box and send a copy of the appropriate document (as described in the "Important Information" section) along with this form.
Box 11-Read, date and personally sign your name or make your mark in the box.

IF YOU HAVE NO STREET ADDRESS,

below describe your home: list the name of subdivision; cross streets; roads; landmarks; mileage and/or neighbors' names.



If you have questions about completing this form, please call the State Board of Elections at (217) 782-4141 or (312) 814-6440 (or webmaster@elections.il.gov).

TYPE OR PRINT CLEARLY IN BLACK OR BLUE INK

Are you a citizen of the United States of America? (check one) Yes ☐ No ☐
Will you be 18 years of age on or before the next election day OR are you currently 17 and will be 18 by the day of the next General or Consolidated Election? (check one) Yes ☐ No ☐
If you checked "no" in response to either of these questions, then do not complete this form.

Office Use

You can use this form to: (Check One) ☐ apply to register to vote in Illinois ☐ change your address ☐ change your name

1. Last Name | First Name | Middle Name or Initial | Suffix (Circle One) Jr. Sr. II III IV
2. Address where you live (House No., Street Name, Apt. No.) | City/Village/Town | Zip Code | County | Township
3. Mailing address (P.O. Box) | City/Village/Town | Zip Code
4. Email (optional)
5. Former Registration address: (include City and State and Zip Code) | Former County
6. Former Name: (if changed)
7. Date of Birth: MM/DD/YY
8. Sex (circle one) M F
9. Home telephone number, including area code (optional) ( ) -
10. ID Number - check the applicable box and provide the appropriate number
    - ☐ IL Driver's License or, if none, Sec. of State ID, ot
    - ☐ Last 4 digits of Social Security Number
    - ☐ I have none of the above identification numbers

11. Voter Affidavit - Read all statements and sign within the box to the right.
I swear or affirm that:

- I am a citizen of the United States;
- I will be at least 18 years old on or before the next election **(or the next General or Consolidated Election)**;
- I will have lived in the State of Illinois and in my election precinct at least 30 days as of the date of the next election;
- The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, then I may be fined, imprisoned, or if I am not a U.S. citizen, deported from or refused entry into the United States.

This is my signature or mark in the space below.

Today's date: _____ / _____ / _____

12. If you cannot sign your name, ask the person who helped you fill in this form to print their name, address and telephone number.

Name of person assisting. | Full Address | Telephone No.

YOUR ADDRESS

Back of SBE No. R-19

PUT
FIRST
CLASS
STAMP
HERE

MAIL TO:

CHANGE OF ADDRESS

PCT	WARD	CODE	ADDRESS	CITY	ZIP	COUNTY	DATE	CLERK

SUSPENSION, CANCELLATION AND REINSTATEMENT

DATE	EXPLAIN	CLERK	DATE	EXPLAIN	CLERK

To Election Judges

For Primary, mark
D for Democrat
R for Republican
for all other
elections mark V

Voting Record	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
Primary																			
General																			
NonPartisan																			
Special																			