

SECTION D: Does your total income allow you to file this application? See instructions.

25 Write household size (add the number of persons on Lines 2 and 9, and on Schedule B, Line 9). **25**

SECTION E: Tell us about the Illinois property tax or rent you paid in 2008.

26 Property tax you paid or was payable in 2008 (total of both installments)..... **26**

27 Mobile home tax you paid in 2008 (yearly total). **27**

28 Rent you paid in 2008 (yearly total). Does your rent include food? **yes** **no** **28**

a To whom did you pay rent in 2008?

Name _____ Phone (_____) _____ - _____

Address _____ City _____ State _____ ZIP _____

b How many months did you rent here in 2008? **b** _____  *Attach page if other rentals.*

Note **Do not** include amounts paid by a "Section 8" program.
If you now live in public housing, but last year lived in private housing, see the instructions for Line 28.

29 Nursing, retirement, or shelter care home charges you paid in 2008 (yearly total)..... **29**


a To whom did you pay nursing, retirement, or shelter care home charges in 2008?

Name _____ Phone (_____) _____ - _____

Address _____ City _____ State _____ ZIP _____

b How many months did you live here in 2008? **b** _____  *Attach page if other charges.*

Note **Do not** include amounts paid by Human Services.

 **Sections F, G and H should only be filled out if you are requesting Illinois Cares Rx benefits or the monthly rebate. (If "no," go to Section I.)**

SECTION F: For your Illinois Cares Rx benefits or monthly rebate. See instructions.

30 Are you a U.S. citizen or qualified noncitizen?
Note You may still get some drug coverage, a grant, and a license plate discount even if no box is checked above.

31 Are you currently eligible for Medicare Part A and/or Part B for your hospital or doctor expenses? **yes** **no**
(If "no," go to Line 32.)

a If "yes," print the name and claim number as it appears on your red, white and blue Medicare card or Railroad Retirement card.

First name Last name Claim number

- b** If you are already enrolled in a Medicare Part D plan, what is the name of your plan?
- | | | |
|----------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> 1 AARP Medicare Rx Preferred | <input type="checkbox"/> 6 Group Health Plan (GHP) | <input type="checkbox"/> 11 SecureHorizons by United Healthcare |
| <input type="checkbox"/> 2 Essence | <input type="checkbox"/> 7 Health Alliance Medical Plans | <input type="checkbox"/> 12 SilverScript |
| <input type="checkbox"/> 3 Erickson | <input type="checkbox"/> 8 HealthSpring | <input type="checkbox"/> 13 UnitedHealth Rx Basic |
| <input type="checkbox"/> 4 Evercare | <input type="checkbox"/> 9 Humana | <input type="checkbox"/> 14 WellCare Classic |
| <input type="checkbox"/> 5 First Health Part D — Premier | <input type="checkbox"/> 10 PersonalCare | <input type="checkbox"/> 15 Other: _____ |

c Do you have HIV/AIDS? **yes** **no** See instructions for added "wrap around" benefits.

(Section F continued.)

32 You can choose to receive a \$25 monthly rebate **instead of** help paying for prescriptions.

a Do you have private, creditable health insurance, Veterans Administration (VA) benefits, or a non-coordinating Medicare Part D plan that pays for prescription drugs? **yes** **no** (If “no,” go to Section G.)

b Do you want a \$25 monthly rebate **instead of** help paying for prescriptions? **yes** **no**

Note Do not mark “yes” if you are receiving prescriptions through a coordinating Medicare Part D plan listed in Line 31b. If you are enrolled in one of these plans, Illinois Cares Rx will help pay for your prescriptions.

SECTION G: For your spouse’s Illinois Cares Rx benefits or monthly rebate. See instructions.

33 Is your spouse a U.S. citizen or qualified noncitizen?

Note Your spouse may still get some drug coverage even if no box is checked above.

34 Is your spouse currently eligible for Medicare Part A and/or Part B for his or her hospital or doctor expenses? **yes** **no** (If “no,” go to Line 35.)

a If “yes,” print the name and claim number as it appears on your spouse’s red, white and blue Medicare card or Railroad Retirement card.

First name	Claim number

b If your spouse is already enrolled in a Medicare Part D plan, what is the name of your spouse’s plan?

- | | | |
|-------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> 1 AARP Medicare Rx Preferred | <input type="checkbox"/> 6 Group Health Plan (GHP) | <input type="checkbox"/> 11 SecureHorizons
by United Healthcare |
| <input type="checkbox"/> 2 Essence | <input type="checkbox"/> 7 Health Alliance
Medical Plans | <input type="checkbox"/> 12 SilverScript |
| <input type="checkbox"/> 3 Erickson | <input type="checkbox"/> 8 HealthSpring | <input type="checkbox"/> 13 UnitedHealth Rx Basic |
| <input type="checkbox"/> 4 Evercare | <input type="checkbox"/> 9 Humana | <input type="checkbox"/> 14 WellCare Classic |
| <input type="checkbox"/> 5 First Health Part D
— Premier | <input type="checkbox"/> 10 PersonalCare | <input type="checkbox"/> 15 Other: _____ |

c Does your spouse have HIV/AIDS? **yes** **no** See instructions for added "wrap around" benefits.

35 Your spouse can choose to receive a \$25 monthly rebate **instead of** help paying for prescriptions.

a Does your spouse have private, creditable health insurance, Veterans Administration (VA) benefits, or a non-coordinating Medicare Part D plan that pays for prescription drugs? **yes** **no** (If “no,” go to Section H.)

b Does your spouse want a \$25 monthly rebate **instead of** help paying for prescriptions? **yes** **no**

Note Do not mark “yes” if your spouse is receiving prescriptions through a coordinating Medicare Part D plan listed in Line 34b. If your spouse is enrolled in one of these plans, Illinois Cares Rx will help pay for his or her prescriptions.

SECTION H: For your or your spouse's Illinois Cares Rx benefits or monthly rebate.

If you or your spouse want help paying for drugs or a monthly rebate, failure to complete this section will delay the processing of your application.

36 Do you, your spouse (if married and living together), or both of you own any of the following items:

- Bank accounts (checking, savings and certificates of deposit);
- Stocks, bonds, savings bonds, mutual funds, individual retirement accounts and similar investments;
- Real estate (other than your home); **or**
- Any other cash at home or elsewhere?

yes no

If "yes,"

a Single: Is the total value of the items listed above worth more than \$12,510? yes no

b Married and living together: Is the total value of the items listed above worth more than \$25,010? yes no

Note If you answered "no" on Line 36, Line 36a or 36b, you **must** complete Schedule C.

SECTION I: For the People with Disabilities Ride Free Transit Card. See instructions.

Complete this section only if you or your spouse want to apply for the People with Disabilities Ride Free Transit Card.

37 Yes, I want to apply for the Transit Card.

38 Yes, my spouse wants to apply for the Transit Card.

SECTION J: Sign below.

Under penalties of perjury, I state that I have examined this form and, to the best of my knowledge, it is true, correct, and complete. I give the state of Illinois permission to get records from anyone concerning information on this form. As permitted by law, and subject to revocation, I authorize disclosure of the following information to, by, and between the Illinois Department on Aging and the Illinois Department of Healthcare and Family Services for the Circuit Breaker/Illinois Cares Rx Programs: (1) citizenship, identification, and HIV/AIDS status information maintained by the Illinois Department of Public Health; (2) tax return information maintained by the Illinois Department of Revenue; (3) citizenship and identification information maintained by the Illinois Secretary of State; and (4) identification information for ride programs offered by mass transit authorities, for the limited purposes of confirming my eligibility for applicable benefits and related outreach enrollment efforts through the end of the appropriate audit period. If resource availability permits, I also authorize the state of Illinois to apply on my behalf for any federal drug benefits I may be eligible to receive under the Medicare program. I assign to the state of Illinois my right to any benefits, including reimbursement, under any private plan of assistance, public assistance program, insurance plan, or from any liable third party, for prescription drugs that I receive through the Illinois Cares Rx program. I also agree that if I receive any such payments or other payments or benefits under the programs on this form in error, or that I was not entitled to, I will repay them to the state of Illinois. I authorize release of medical and pharmaceutical records for audit and verification purposes, and exchange of health care information between any drug utilization review service authorized by the state of Illinois and any of my physicians and pharmacists to the extent necessary for the operation of a drug utilization review service.

39 _____ **41** _____
Claimant's signature Date Preparer's name (Please print or type.) Phone number

40 _____
Spouse's signature (If living together) Date

<i>Official use only</i>					
SHAP			County/Sub-Area Code		

If applying for ALL Form IL-1363 benefits, including Illinois Cares Rx, mail to:
CIRCUIT BREAKER/ILLINOIS CARES RX
ILLINOIS DEPARTMENT ON AGING
P.O. BOX 19022
SPRINGFIELD, IL 62794-9022

If ONLY applying for a grant, license plate discount and/or the free ride, mail to:
CIRCUIT BREAKER
ILLINOIS DEPARTMENT ON AGING
P.O. BOX 19003
SPRINGFIELD, IL 62794-9003

**Postmark
deadline for filing
is Dec. 31, 2009.**

If you need assistance, 1) visit www.cbrx.il.gov on the Internet, 2) find a local agency serving seniors by calling the Senior HelpLine at **1-800-252-8966**, or 3) call us at **1-800-624-2459** or **1-888-206-1327 (TTY)**.

2008 Schedule C Pharmaceutical Benefits

Attach to the claimant's Form IL-1363.

If you marked "no" on Line 36, 36a or 36b of Form IL-1363, you **must** complete Schedule C if you or your spouse are eligible for Medicare and want help paying for prescription drugs or the \$25 monthly rebate available through Illinois Cares Rx.

Step 1: Tell us about yourself (claimant) and your spouse. Please print.

1a Claimant's Social Security number

b Claimant's Birth date ____/____/____
Month Day Year

2a Claimant's Name _____
First MI Last

e Marital status (only one box)

- 1 Single, widow(er), or divorced
- 2 Married and living together
- 3 Married, but not living together

b Address _____ Apt. _____

c City _____ State _____ ZIP _____

d Phone (_____) _____ - _____

3a Spouse's Social Security number

b Spouse's Birth date ____/____/____
Month Day Year

4 Spouse's Name _____
First MI Last

Step 2: Complete the following information about you and your spouse (if married and living together).

5 Did you work in 2008 or 2009?

You: yes no

Spouse (If living together): yes no

6 List your expected wages before taxes in 2009. If none, place a zero in the space.

You:

Spouse (If living together):

7 If self-employed, list your expected net earnings or losses in 2009. If none, place a zero in the space.

You:

Spouse (If living together):

8 Have any of the amounts you listed on Lines 6 or 7 decreased in the last two years? yes no

9 If you recently stopped working or plan to stop working, enter the month and year.

You: ____/____ Spouse (If living together): ____/____

10 How many relatives live with you **and** depend on you or your spouse for at least one-half of their financial support? If none, place a zero in the space. **Do not** count yourself or your spouse.

11 a Does anyone provide or help you or your spouse pay for your food, mortgage, rent, heat/gas, electricity, water or property taxes? **Do not** count: food stamps, house repairs, help from a housing agency (Section 8), an energy assistance program, Meals on Wheels, or help with medical treatment and drugs. yes no

b If "yes," how much help do you get each month? If the amount changes from month to month or you do not receive it every month, tell us the average monthly amount for the past year.

Line-by-line instructions for Schedule C

Complete Schedule C if you or your spouse are eligible for Medicare and want help paying for prescription drugs or the \$25 monthly rebate available through Illinois Cares Rx.

If you mark “no” on Line 36, 36a or 36b of Form IL-1363 you must complete Schedule C. If you mark “yes” on Line 36, 36a or 36b, you do not need to complete Schedule C.

Note It is important that you complete your "extra help" application and send it to Social Security for a decision even if you do not think you will be eligible.

Step 1: Tell us about yourself (claimant) and your spouse.

1 through 4

Complete the requested identification information for you and your spouse.

Note Complete Lines 3a, 3b, and 4 only if you checked Marital status 2, “Married and living together,” on Line 2e. Otherwise, if you do not have a spouse, if your spouse is deceased, or if you are not living in the same household with your spouse, go to Step 2.

Step 2: Complete the following information about you and your spouse (if married and living together)

- 5** Mark “yes” if you worked in 2008 or 2009. Otherwise, mark “no.”
- 6** List the amount you expect to earn in wages, before taxes, in 2009. If none, place a zero in the space.
- 7** List the amount of your expected earnings or losses from self-employment in 2009. If none, place a zero in the space.
- 8** Mark “yes” if the amounts listed on Lines 6 or 7 have decreased in the last two years. Otherwise, mark “no.”
- 9** List the month and year that you recently stopped working (or you plan to stop working).

10 List the number of relatives who live with you **and** depend on you or your spouse for at least one-half of their financial support. If none, place a zero in the box.

11a Mark “yes” if anyone provides or helps you or your spouse pay for food, mortgage, rent, heat/gas, electricity, water or property taxes. Otherwise, mark “no” and go to Line 12.

Note **Do not** count: food stamps, house repairs, help from a housing agency (Section 8), an energy assistance program, Meal on Wheels, or help with medical treatments and drugs.

11b If “yes,” list how much help you get each month. If the amount changes from month to month or you do not receive it every month, tell us the average monthly amount for the past year.

12 List the savings and resources owned by you or your spouse.

12a List the total amount of bank accounts (checking, savings and certificates of deposit).

12b List the total amount of stocks, bonds, savings bonds, mutual funds, individual retirement accounts and similar investments.

12c List the total amount of any other cash you or your spouse have at home or elsewhere.

Note For Lines 12a, 12b, and 12c, if you and your spouse **do not** own an item listed, place a zero in the space.

13a Mark “yes” if you own life insurance policies with a total face value greater than \$1,500. (You may need to call your insurance company to help answer this question). Otherwise, mark “no,” and go to Line 14.

13b List the amount you would get by cashing in your life insurance policies. Cash value is different than the face value. (You may need to call your insurance company to help answer this question).

(Continued on next page.)

Line-by-line instructions for Schedule C

- 14** Mark “**yes**” if you plan to use any of the savings or resources on Lines 12a, 12b, 12c, and 13b to pay for funeral and burial expenses for yourself or your spouse. Otherwise, mark “**no**.”
- 15** Mark “**yes**” if you or your spouse own real estate other than your home and the property on which your home is located. Otherwise, mark “**no**.”
- 16** List the monthly income for each of the items. If none, place a zero in the space.
- 16a** List the monthly amount you get from Social Security (include Medicare deductions).
- 16b** List the monthly amount you get from Railroad Retirement (include Medicare deductions).
- 16c** List the monthly amount you get from the Veterans Administration.
- 16d** List the monthly amount you get from any other pensions or annuities.
- Note** For Lines 16a, 16b, 16c, and 16d, use the amount on your annual cost-of-living adjustment letter. This is the amount before any deductions.
- 16e** List the monthly amount you get from any other source, including alimony, net rental income, worker’s compensation, etc. If the amount changes from month to month or you do not receive it every month, tell us the average monthly income for the past year.
Do not count: wages, self-employment, interest, public assistance, medical reimbursement, or foster care payments.

17 Mark “**yes**” if any of the amounts listed on Lines 16a, 16b, 16c, 16d, or 16e have decreased in the last two years. Mark “**no**” if there has been no decrease.

18a Mark “**yes**” if you get Social Security benefits for a disability. Otherwise, mark “**no**.”

18b Mark “**yes**” if you get Social Security benefits because you are blind. Otherwise, mark “**no**.”

18c If “**yes**” for either Line 18a **or** 18b **and** you pay for special transportation, personal attendant services, or adaptive equipment to work, list how much you pay each **month**. If this amount is not the same each month, tell us the average monthly amount for the past year.

Step 3: Sign below.

19 Claimant’s signature

You, the claimant (the person named on Line 2a), must sign this schedule.

20 Spouse’s signature

Your spouse (the person named on Line 4) must sign this schedule.

21 Preparer’s name

If someone other than you or your spouse, such as a son, daughter, or legal representative, prepares this schedule for you, that person should print or type his or her name and telephone number on Line 21.