State of Illinois
Department of Healthcare and Family Services

ADDITIONAL FINANCIAL INFORMATION FOR LONG TERM CARE APPLICANTS

HFS USE ONLY
DHS CASE No.
OIG USE ONLY
OIG CASE No.
DR:
DC:

INSTRUCTIONS

Read carefully and follow all instructions.

< Answer ALL questions completely and accurately. (PLEASE PRINT)
< Sign the document.
< Name of LongTerm Care facility if applicable ______________________
< If submitted by hospital/LTC facility, provide the date of admission ______________ and actual or expected date of discharge ______________

Submitting hospital/LTC facility name

APPLICANT

Last Name ______________ First Name ______________ Middle Initial ______

Street ______________ City ______________ State ______________ Zip Code ______________

County ______________ Phone Number ______________

MAILING ADDRESS (If different from above)

1. Have you filed a State or Federal income tax return in the last 60 months? Yes ☐ No ☐

If YES, which years? ______________________________

If YES, you are required to provide a copy of each of your tax returns, including all attachments, filed the last three years.

2. If you are living in a nursing home, list the two places you lived prior to moving to the nursing home. If you have not yet moved to a nursing home, list the last two places where you lived prior to your current residence.

Address ______________________ Address ______________________

City ______________ State ____ Zip ________ City ______________ State ____ Zip ________

3. How have you paid your nursing care before filing this application for medical assistance?

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4. **Has someone else been helping you handle your money and general financial affairs?** Yes ☐ No ☐

This would include helping you handle things such as checking and savings account; handling your life and health insurance payments; handling financial investments such as IRA(s) and Certificate(s) of Deposit; handling your income such as Social Security checks, pension checks or annuity payments. This could be a family member, a friend, or a financial advisor or attorney, or power of attorney (POA).

If YES, list the name, address, phone number and relationship of each person who assists you with any of these matters:

Name ______________________
Address ______________________
City __________ State _____ Zip ______
Relationship ______________________
Phone: ______________________
Is this person your POA? Yes ☐ No ☐
If YES, for ☐ Property ☐ Health

Name ______________________
Address ______________________
City __________ State _____ Zip ______
Relationship ______________________
Phone: ______________________
Is this person your POA? Yes ☐ No ☐
If YES, for ☐ Property ☐ Health

5. **Within the last 60 months, did you talk with a financial planner, attorney, family member or anyone else about your need to reside in a nursing home and discuss any of the following issues?** Yes ☐ No ☐

- How you can use your income and resources to pay for nursing care.
- How you might become eligible for medical assistance if you are unable to pay for the cost of nursing home care.
- Estate Planning - that is, developing a plan to divide any of your resources between your spouse, members of your family, friends, church or any other organization or placing your resources in a trust for any of these persons.

If YES, who did you talk to? (This may include a financial planner, attorney, banker, family member, friend, community or service organization, other.)

Name ______________________
Address ______________________
City __________ State _____ Zip ______
Relationship ______________________
Phone: ______________________

Name ______________________
Address ______________________
City __________ State _____ Zip ______
Relationship ______________________
Phone: ______________________

6. **What is your marital status?**

☐ Single ☐ Married ☐ Divorced ☐ Widow / Widower ☐ Legally Separated

List the name, address, phone number and Social Security Number (SSN) of your current or most recent spouse:

Name ______________________
Address ______________________
City __________ State _____ Zip ______

Phone ______________________
SSN (Optional) ______________________

If your spouse is deceased, list the following:

Date of Death: __________ Place of Death: City __________ County __________ State ______

If you are divorced, please include a copy of the divorce decree with this form 3654 when subitted.
If this is not available, list the following:

Date of Divorce __________ Place of Divorce: City __________ County __________ State ______

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7. Do you have an insurance policy that pays when you are in a nursing home? Yes ☐ No ☐

If YES, list the following:

Policy Number ____________________

Name of Insurance Company ____________________

Who receives the payments from the insurance company?

☐ Nursing Home ☐ You ☐ Another Person

If another person receives the payments, list the name, address, phone number and relationship of that person:

Name ____________________

Address ____________________

City __________ State __________ Zip __________

Phone: ____________________

Relationship ____________________

8. Did you inherit money, property, stocks, bonds, etc., within the last 60 months? Yes ☐ No ☐

If YES:

What is the amount or value you inherited? ____________________

On what date did you receive the inheritance? ____________________

What is the name, relationship and date of death of the deceased person you received this money from?

Name ____________________ Date of Death: __________

Relationship ____________________

Include any other types of inheritance.

What is the amount or value you inherited? ____________________

When did you receive the inheritance? ____________________

What is the name, relationship and date of death of the deceased person you received this money from?

Name ____________________ Date of Death: __________

Relationship ____________________

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9. **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.)

If YES, do you have any of the following jointly held resources? Yes ☐ No ☐

RESOURCE	VALUE	NAME OF OTHER PERSON(S) HOLDING THE RESOURCE	RELATIONSHIP
Property in Illinois			
Property in Another State			
Checking / Savings account			
Certificate of Deposit			
Stocks / Mutual Funds			
Other			

10. **Have you purchased any type of annuity within the last 60 months?** Yes ☐ No ☐

If YES, please identify:

Name of Bank / Institution __________
Address __________
City ______ State ___ Zip ____
Phone: __________
Purchase Date __________
Value __________

Name of Bank / Institution __________
Address __________
City ______ State ___ Zip ____
Phone: __________
Purchase Date __________
Value __________

11. **Have you, your spouse or anyone on your behalf cashed in (or closed) any resources within the last 60 months?** Yes ☐ No ☐

Resource: (Check all that apply.)

- ☐ Mutual Funds
- ☐ Certificate of Deposit (CD)
- ☐ Stocks
- ☐ Bonds
- ☐ Other (Identify) __________
- ☐ IRA, 401K
- ☐ Deferred Compensation
- ☐ Life Insurance Policies
- ☐ Money Market Accounts
- ☐ Other (Identify) __________

Name of Bank / Institution __________
Address __________
City ______ State ___ Zip ____
Phone: __________
Date Closed __________
Value when closed __________

Name of Bank / Institution __________
Address __________
City ______ State ___ Zip ____
Phone: __________
Date Closed __________
Value when closed __________

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12. Did you give or transfer any of your money or property such as land or buildings, stocks, bonds or Certificates of Deposit to anyone within the last 60 months? Yes ☐ No ☐

Did you sell any of your resources such as cars or property; for example land or buildings, stocks, bonds or Certificates of Deposit to anyone within the last 60 months? Yes ☐ No ☐

Did you give a loan, mortgage or make a promissory note with anyone within the last 60 months? Yes ☐ No ☐

Write the name, relationship and address and phone number of anyone:

- You gave or transferred money or other resources to, the value of what you gave them and the value, if any, of what you received in return for what you gave away or transferred.
- You sold property or other resources to, the value of what you sold and the amount you received from the sale (cash or in - kind services).
- You made a loan, mortgage or established a promissory note with someone.

List the date you sold or transferred the resource ____________________

Name ____________________
Relationship ____________________
Address ____________________
City __________ State _____ Zip _____
Phone: ____________________
Date Sold ____________________
Type of resource ____________________
Amount you received ____________________
Value ____________________

Name ____________________
Relationship ____________________
Address ____________________
City __________ State _____ Zip _____
Phone: ____________________
Date Sold ____________________
Type of resource ____________________
Amount you received ____________________
Value ____________________

List the name of the realtor, attorney or bank who handled the transfer:

Name ____________________
Address ____________________
City __________ State _____ Zip _____
Phone: ____________________

Name ____________________
Address ____________________
City __________ State _____ Zip _____
Phone: ____________________

13. Did you ever own any of the resources listed below within the last 60 months in Illinois or another state or country? If yes, please complete the information below. Attach an additional page if needed.

Resource	Address	City, State and Zip Code	Estimated Value	Date Purchased	Date Sold	Lien Holder	Resource Still owned on Separate document
Business							☐
Farm / Farmland							☐
Time Share							☐
Rental Property							☐
OTHER							
							☐

I, the undersigned, hereby certify and swear, that all information on this form is true, accurate and complete. I understand that the information on this form may be used to determine eligibility for medical assistance and that payments will be made from state and federal funds. Any false statements, or documents, or concealment of material fact may be cause for prosecution or other appropriate legal action.

The undersigned hereby consents and authorizes Illinois Department of Healthcare and Family Services and Department of Human Services to investigate, obtain and verify all information necessary in connection with the request for public assistance. Such information shall include, but not be limited to, documents of financial institutions, trusts, insurance, stocks/mutual funds, real estate, pension, SSI/SSA, and any other type of financial resources. Failure to cooperate or provide documentation or information necessary to determine the applicant's eligibility may result in the denial of assistance.

SIGN YOUR NAME OR MAKE YOUR MARK:

____________________ ____________

Applicant Date

____________________ ____________

Spouse Date

***** IF THIS FORM IS COMPLETED BY SOMEONE ON BEHALF OF THE APPLICANT, THAT PERSON MUST IDENTIFY ** THEIR RELATIONSHIP (LEGAL GUARDIAN, POWER OF ATTORNEY, ETC.) TO THE APPLICANT AND SIGN BELOW.***

I, the undersigned, hereby certify and swear, that all information on this form is true, accurate and complete. I understand that the information on this form may be used to determine eligibility for medical assistance and that payments will be made from State and Federal funds. Any false statements, or documents, or concealment of material fact may be cause for prosecution or other appropriate legal action.

The undersigned hereby consents and authorizes Department of Human Services and Healthcare and Family Services to investigate, obtain and verify all information necessary in connection with the request for public assistance. Such information shall include, but not be limited to, documents of financial institutions, trusts, insurance, stocks/mutual funds, real estate, pension, SSI/SSA, and any other type of financial resources. Failure to cooperate or provide documentation or information necessary to determine the applicant's eligibility may result in the denial of assistance.

Print Name

Relationship (Legal Guardian, Power of Attorney, Etc.)

Signature Date Social Security Number Date of Birth

Home Address Telephone Number

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