



Please read carefully and follow the directions in completing DSCC's Application for Financial Assistance (07.04) attached form. Do not send original documents, send only photocopies as DSCC will not be responsible for returning original documents. All financial information is considered confidential and will not be released unless you sign an appropriate authorization.

- IF YOU ARE PROVIDING A CURRENT FEDERAL INCOME TAX RETURN (Forms 1040, 1040A, 1040EZ or 1040PC) and the supporting schedules and forms with this application, **complete all Sections except Section D.**
- IF YOU ARE PROVIDING WAGE STATEMENTS, **complete Sections A through G.** In Section D provide information about your wages and additional income. You must enclose copies of paychecks from two (2) consecutive pay periods for each wage earner in the family. The pay periods CANNOT be older than 2 months from the date you are completing this application. ***Wage statements can only be used to establish eligibility for one year. Thereafter you will be required to submit federal income tax forms unless your annual income or family size is not accurately reflected on the Federal Income tax forms, or you are not required to file Federal Income taxes.***
- IF YOU ARE NOT REQUIRED TO FILE FEDERAL INCOME TAXES, **complete Sections A through G.** If you do not have wage statements to support your income, you must provide other verification of your income.
- IF YOU MARKED HEALTH INSURANCE, ALL KIDS, MEDICAID, MEDICAID SPEND-DOWN OR ICHIP IN SECTION C "MEDICAL PAYMENT SOURCES" ON YOUR APPLICATION FOR FINANCIAL ASSISTANCE (07.04), you **MUST** complete a Health Insurance Information (05.08-1-2) form **FOR EACH** payment source indicated. If your child is enrolled in All Kids/Medicaid, if possible please enclose a copy of your All Kids/Medicaid card or eligibility letter.
- IF YOU ARE AN ADOPTIVE PARENT OR GUARDIAN WITH ALL KIDS/MEDICAID FOR THE CHILD, you must submit a copy of your subsidized adoption agreement and a copy of your child's ALL KIDS/MEDICAID card or eligibility letter.
- IF YOU ARE CURRENTLY APPLYING TO OR RECEIVING ASSISTANCE FROM THE STATE HEMOPHILIA PROGRAM, you must complete and sign the Application for Financial Assistance (07.04) and the Health Insurance Information form (05.08-1-2). Please indicate in Section C "Medical Payment Sources" on the application that you are receiving assistance from the State Hemophilia Program. Income verification is **NOT** necessary when receiving services through the State Hemophilia Program.
- **NEED HELP WITH THIS FORM?**

For help completing this form or any other DSCC application forms, contact the Regional Office serving your area. If you do not know which office is serving your area, you may contact DSCC at 800-322-3722 (toll free) or (217) 785-4728 (TTY).



A. APPLICANT (Please print)

Child's Legal Name _____ <small>(Last) (First) (Middle)</small>	DSCC ID _____
Child SSN # _____	Relationship to Child: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other _____
Applying Parent/Legal Guardian: Name _____ <small>(Last) (First) (Middle)</small>	Telephone: Home _____ Work _____ Other _____
Social Security Number _____ Street Address _____ City _____ State _____ Zip _____ County _____	Relationship to Child: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other _____
Additional Parent/Legal Guardian: Name _____ <small>(Last) (First) (Middle)</small>	Telephone: Home _____ Work _____ Other _____
<i>Please Complete if Address is <u>Different</u> Than Above:</i> Street Address _____ City _____ State _____ Zip _____ County _____	

B. INCOME DOCUMENTATION

Income Verification MUST be provided:

CHECK ONE:

I am providing my **current Federal Income Tax Return** and supporting tax schedules and forms to document income. Complete Sections C, E, F and G on the application. **DO NOT COMPLETE SECTION D.** (Preferred)

My current Federal Income Tax return does not accurately reflect my income family size. I am providing wage statements to document my income. Complete Sections C, D, E, F and G on the application.

I am not required to file federal income taxes. Complete Sections C, D, E, F and G on the application.

C. MEDICAL PAYMENT SOURCES

Please indicate below all payment sources available to assist with the child's medical care:

<input type="checkbox"/> Health Insurance Number of Policies/Plans _____	<input type="checkbox"/> ICHIP (Illinois Comprehensive Health Insurance Plan)
<input type="checkbox"/> All Kids (Assist, Share, Premium, Rebate)	<input type="checkbox"/> SSI (Supplemental Security Income)
<input type="checkbox"/> All Kids (Managed Care/HMO)	<input type="checkbox"/> State Hemophilia Program
<input type="checkbox"/> Medicaid	<input type="checkbox"/> DCFS (Department of Children and Family Services)
<input type="checkbox"/> Medicaid Spend-down	

Is the above child involved in any legal action regarding his/her medical care? Yes No

(Over – Must Be Signed on Back)

Start Over

