APPLICATION FOR FINANCIAL ASSISTANCE

DIVISION OF SPECIALIZED CARE FOR CHILDREN

A. APPLICANT (Please print)

Child's Legal Name ______________________________
(Last) (First) (Middle)

DSCC ID ______________

Child SSN # ______________________________

Applying Parent/Legal Guardian:

Name ______________________________
(Last) (First) (Middle)

Social Security Number ______________________________

Street Address ______________________________

City ____________ State ______ Zip ________ County ________

Relationship to Child:

☐ Father ☐ Mother
☐ Other ______________

Telephone:

Home ______________
Work ______________
Other ______________

Additional Parent/Legal Guardian:

Name ______________________________
(Last) (First) (Middle)

Social Security Number ______________________________

Please Complete if Address is Different Than Above:

Street Address ______________________________

City ____________ State ______ Zip ________ County ________

Relationship to Child:

☐ Father ☐ Mother
☐ Other ______________

Telephone:

Home ______________
Work ______________
Other ______________

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. OTHER PAYMENT SOURCES

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

☐ Family Health Insurance
☐ KidCare (Assist, Share, Premium, Rebate)
☐ Medicaid
☐ Medicaid Spend-Down
☐ ICHIP (Illinois Comprehensive Health Insurance Plan)
☐ State Hemophilia Program
☐ DCFS (Department of Children and Family Services) *
☐ SSI (Supplemental Security Income) *
☐ Other ______________________________

* A Health Insurance Information Form (05.08-1-2) does not need to be completed for DCFS and SSI, indicated by an asterisk (*).

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

(Over – Must Be Signed on Back)

D. FAMILY WAGES AND ADDITIONAL INCOME *(DO NOT COMPLETE THIS SECTION IF YOU ARE SUBMITTING FEDERAL TAX FORMS)*

Family Wages from Employment *(Round to Nearest Dollar)*

Enter the total wages and dates worked from two (2) consecutive pay periods. The pay period dates cannot be older than two (2) months from the date of this application. Submit copies of the paychecks with this application.

Name of Wage Earner	Paycheck #1	Dates Worked	Paycheck #2	Dates Worked
	$	to	$	to
	$	to	$	to
	$	to	$	to

Additional Family Income *(Round to Nearest Dollar)*

Enter the amounts of additional income expected for the next twelve (12) months.

Examples: Profits from Corporations and Partnerships; Capital Gains; Salary Bonuses, Alimony received; Interest and dividend income; Unemployment Compensation; Rental income: Social Security benefits other than Supplemental Security Income (SSI) benefits, etc.

Source	Annual Amount
	$
	$

E. FAMILY SIZE

Please indicate the persons in the family:

☐ Parent/Guardian Total Family Size ____________

☐ Additional Parent/Guardian

☐ Other Dependents (List Below):

Name (first, middle initial and last name)	Relationship (e.g., Son, Daughter Stepchild, Grandparent)	Birthdate	Social Security Number

F. ADDITIONAL COMMENTS BY FAMILY

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G. CERTIFICATION

I certify the information given on this application is correct to the best of my knowledge. Falsification of this information can result in immediate loss of any financial assistance provided by the Division of Specialized Care for Children (DSCC) and legal action to recover any amounts previously paid by DSCC.

I authorize DSCC to verify any of the information stated in this application.

Signature of Applying Parent/Legal Guardian ______________________ Date ____________