SAMPLE FORM B

State of Illinois
Department of Human Services
Department of Healthcare and Family Services

Date of Notice: May 1, 2023
Case Number: 987654321

Office Name: South Loop
Office Address: 1112 S Wabash
Chicago, IL 60605
Phone: (312)-793-7500
TTY: (866)-217-8037
Fax: (312)-793-7671

<MAILING BARCODE>
Maria Lopez
401 S CLINTON ST.
CHICAGO IL, 60607

You can manage your case online at abe.illinois.gov

Esta notificación está disponible en Español. Usted puede socitarla por Internet en abe.illinois.gov o llame al 1-800-843-6154 (TTY 1-800-447-6404)

Medical Benefits: Time to Renew Notice

Dear Maria Lopez,

It is time to renew your Medical benefits!

You must complete your redetermination to continue your Medical benefits after June 30, 2023

To learn how to renew your Medical benefits, read the first page of the Medical Benefits Renewal Form which is included in this envelope.

Call us at the phone number listed at the top of this form if you cannot send everything on time or if you have questions. We may be able to help you get the proofs you need.

Electronic Review of Eligibility for Medical Benefits

We checked our records for information about your household and put it on your Medical Benefits Renewal Form that is included with this notice. We need more information to decide if you are still eligible.

Please review the information on the Medical Benefits Renewal Form carefully**.** Correct any information that is wrong and add any information that is missing.

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Medical Benefits Renewal Form

You must respond no later than June 1, 2023 to continue getting Medical benefits after June 30, 2023

To find out if you qualify for medical benefits beginning July 1, 2023, tell us about your household. You can do this one of four ways:

1. Complete the electronic version of this form online in ABE Manage My Case at abe.Illinois.gov; or
2. Complete your redetermination over the phone by calling 1-800-843-6154 (TTY: 1-866-324-5553).
3. Fill out, sign, and send us this form and all verifications we ask for. You may send the form by mail or fax.
   - Mail to P.O. Box 19138, Springfield, IL 62704; or
   - Fax the form to 1-844-736-3563; or
4. If you want to complete your redetermination in person, call 1-800-843-6154 (TTY: 1-866-324-5553) to find help near you.

1. Do these people still live with you?

   Maria Lopez 02/17/1981 ☐ **Yes** ☐ **No**

2. Are there other people living with you not listed above? If yes, list them here.

Full Name	**Birth Date**	**Relationship**

For additional persons, please attach a separate sheet.

Turn this page over to read more information on the back.

3. Is the address at the top of this page your correct mailing address? ☐ **Yes** ☐ **No** If No, tell us the correct mailing address:

   _____

   Our records show that you live at 401 S CLINTON ST CHICAGO IL 60607 Is this correct? ☐ **Yes** ☐ **No** If No, tell us the correct address where you live:

   _____

4. Does anyone get paid for working? ☐ **Yes** ☐ **No** **If YES**, enter their name below. **Attach copies of the last 4 pay stubs if paid weekly, last 2 pay stubs if paid every other week or twice a month, and the last pay stub if paid monthly.** If self-employed, attach your income and expense statement for the last 30 days. If someone got tips that are not on their pay stubs, tell us Who? _____ and the total amount of tips received in the last 30 days. Total tips $ _____

According to our records, you told us your household had income from Self-Employment – MARIA LOPEZ INC. Tell us below if you still have this income and the new amount.

List the Name of Everybody Who is Working	Name of Employer If a person works more than one job, list all the employers.	Rate of Pay	Hours Worked Weekly	How often is the person paid? Weekly, every 2 weeks, twice a month, monthly, other?

Attach a sheet of paper if you need more room to list your family's income.

5. During the last 30 days did anyone receive any other income such as Social Security, SSI, Unemployment, Contributions or any other money? ☐ **Yes** ☐ **No** **If YES**, complete the box below.

Name	Type of Income	Amount	How Often
		$	
		$	

Attach a sheet of paper if you need more room to list your family's income.

6. Are you or is anyone who lives with you pregnant?

If yes, name:_____ Due date:_____ Expected number of babies:_____

7. Do you or anyone living with you have health insurance? ☐ **Yes** ☐ **No**

If yes, name of insurance plan:_____ Policy Number _____
Who is covered by this health insurance? _____
Name of insurance plan:_____ Policy Number _____
Who is covered by this health insurance? _____

8. Will you or anyone who lives with you file a federal income tax return *next* year to report income received *this* year? ☐ **Yes** ☐ **No**

If yes, name of person(s) filing tax return: _____ Birth Date _____
If this person will ***file jointly with a spouse,*** write name of spouse: _____
If this person will ***claim dependents*** on the tax return, write name(s) of dependents:

_____ Birth Date _____ _____ Birth Date _____

_____ Birth Date _____ _____ Birth Date _____

9. Will you or anyone who lives with you be claimed as a dependent on anyone's tax return for this year? ☐ **Yes** ☐ **No**

If yes, name of dependent_____ Birth Date _____
Tax filer's name and relationship to dependent:_____

For additional persons, please attach a separate sheet.

10. Do you or anyone living with you pay any expense that can be deducted on your federal income tax return? ☐ **Yes** ☐ **No**

If yes, list the expense: _____ How Much? _____ How Often? _____

Read and sign below:

- I understand that officials in charge of my health benefits may check all information on this form.
- I understand they may check my information electronically. If they ask for my help checking information, I must cooperate.
- I understand that anyone who knowingly lies or provides untrue information, or arranges for someone to knowingly lie or provide untrue information, or intentionally misuses the health benefits card issued by the State of Illinois, may be committing a crime which can be prosecuted or punished under federal law, state law, or both.
- If the Illinois Department of Healthcare and Family Services pays medical bills for me, the State of Illinois may collect my medical support payments instead of me.
- I am signing this form under the penalty of perjury. That means the information I have provided on this renewal form is true to the best of my knowledge, and I may be punished under law if I provide false or untrue information.

_____	_____	_____
Your Signature	Today's Date	Daytime or Cell Phone Number