



State of Illinois

Pat Quinn, Governor

**Illinois Department on
Aging**

John Holton, Director



2011 Circuit Breaker and Illinois Cares Rx IL-1363 and Related Schedules

Online Filing Application

- 235,326 in 2009
- 283,284 in 2010
- 310,465 in 2011

BENEFITS OF ONLINE FILING

- Reduces the number of errors
- Reduces processing time



**Seniors
Ride Free**

People with
**Disabilities
Ride Free**

LICENSE

IL-1363 Application



People with
Disabilities
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Benefits available on Form IL-1363

- ◆ Property Tax Relief Grant
- ◆ Illinois Cares Rx Basic
- ◆ Illinois Cares Rx Plus
- ◆ License Plate Discount
- ◆ People with Disabilities Ride Free
- ◆ Seniors Ride Free



**Seniors
Ride Free**



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Seniors Ride Free

Property Tax Relief Grant

- Property tax relief grants are for applicants who pay property tax on their residence. This includes applicants who pay rent or nursing home charges on a residence that was subject to property tax.
- Individuals living in public housing or in facilities that do not pay property taxes are not eligible for the Circuit Breaker grant, but may be eligible for other benefits.



Illinois Cares Rx Basic

Covers medications for the following illnesses:

- **Alzheimer's disease**
- **Arthritis**
- **Cancer**
- **Diabetes**
- **Glaucoma**
- **Heart and Blood Pressure Problems**
- **Lung Disease and Smoking Related Illnesses**
- **Multiple Sclerosis**
- **Osteoporosis**
- **Parkinson's Disease**
- **HIV/AIDS (if eligible for Medicare)**



Illinois Cares Rx Basic

Once you are determined eligible, Illinois Cares Rx Basic will help pay your drug costs.

In 2012 you will pay:

- \$5 for generic drugs
- \$15 for preferred brand name drugs
- 25% of the cost of each prescription, plus the appropriate co-pays after \$1,750 in drug benefits have been paid on your behalf



Additionally, IL Cares Rx Basic will pay

- The premium for your Medicare Part D coordinating plan
- Any deductible amount associated with a part D coordinating plan.



Illinois Cares Rx Plus

Once you are determined eligible, Illinois Cares Rx Plus will help pay your drug costs.

In 2012 you will pay:

- \$5 for generic drugs
- \$15 for preferred brand name drugs
- \$20 for non-preferred brand name drugs
- 25% of the cost of each prescription, plus the appropriate co-pays after \$2,930 in drug benefits have been paid on your behalf



Illinois Cares Rx Plus will pay for:

- most prescription medications.
- The premium for a Medicare Part D coordinating plan
- The deductible if there is one, for a Medicare Part D coordinating plan.



Illinois Cares RX

- Individuals with Medicare must apply for extra help and be in a coordinating Medicare Part D plan to receive IL Cares Rx help paying for Medicare Part D prescription drugs.



License Plate Discount

- A \$75 discount on the license plate fee for one vehicle annually.

For more information regarding the license plate discount, call toll free 1-800-252-8980 or visit www.cyberdriveillinois.com/services on the Internet and then the “Services for Seniors” link.



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People with Disabilities Ride Free

Seniors Ride Free

Under the People with Disabilities Ride Free program, individuals that have a qualifying disability and meet the income eligibility requirements of the Circuit Breaker program as well as seniors who are over 65 years of age are eligible for free rides on all fixed-route regularly scheduled buses, trains and public transit systems.

Once an individual has been approved, they will receive a postcard from Aging notifying them of their approval and telling them to contact their transit authority.



**Seniors
Ride Free**



People with
**Disabilities
Ride Free**

Free Ride Transit Cards

- Individuals should contact the public transit system of interest for further details on how to access their free ride.
- Illinois fixed-route public transit phone numbers can be found at www.illinois.gov/transit or by calling 1-800-624-2459.



**Seniors
Ride Free**



People with
**Disabilities
Ride Free**

Requirements for eligibility

- **Age**
- **Residency**
- **Income**
- **Deadline**

FORM IL-1363

Age

- 65 years or older before January 1, 2012, or
- Become 65 years of age during 2012 to receive prorated benefits, or
- 16 years of age or older before January 1, 2012, and totally disabled, or
- A widow or widower who was 63 or 64 years old before the death of their spouse. Individuals who qualify for benefits in this category will not be eligible for Illinois Cares Rx until they turn age 65.

FORM IL-1363

Residency

- You must live in Illinois at the time you file your application.
- To be eligible to receive a property tax relief grant you must have lived in an Illinois residence that was subject to property tax or mobile home tax in 2011.

FORM IL-1363

Income

- Less than \$27,610 for a household of one
- Less than \$36,635 for a household of two
- Less than \$45,657 for a household of three or more

Remember- these amounts may increase after the first of the year do to changes in FPL.

Included in the household size may be parties to a civil union. Anywhere that the word spouse is used on the IL-1363 application we are also referring to parties to a civil union.

FORM IL-1363

Deadline

- You must file form IL-1363 Circuit Breaker and Illinois Cares Rx Application postmarked on or before December 31, 2012.

FORM IL-1363

Illinois Cares Rx Basic

If you do not have Medicare and you are 16 years of age or older, but under the age of 65 and totally disabled, or a senior, age 65 or older and you do not meet the requirements for IL Cares Rx Plus and your income is less than:

- \$21,780 for a household size of one; or
- \$29,420 for a household size of two; or
- \$37,060 for a household size of three or more



Illinois Cares Rx Plus

If you have Medicare or you are age 65 or older without Medicare and your income is less than:

- \$21,780 for a household of one
- \$29,420 for a household of two
- \$37,060 for a household of three or more; and
- You are a U.S. citizen or a qualified non-citizen.



Application Status Information

You can get information about the status of an application by logging onto our website at **www.cbrx.il.gov**.

You will need the applicant's social security number and year of birth to access application information.

FORM IL-1363

Form IL-1363



People with
Disabilities
Ride Free

Seniors
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LICENSE

Section A

SECTION A: Tell us about yourself (claimant). Please print.

1 Social Security number

5 Birth date
Month Day Year

2 Name _____
First MI Last

6 Marital status (✓ only one box)

3 Address _____ Apt. _____
City _____ State _____ ZIP _____

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

4 Phone (_____) _____ - _____
Area Code

7 Are you Male Female

Section A (continued)

- Be sure to use the claimant's own Social Security number, not necessarily the one printed on their Medicare card. You must have a social security number to apply for Circuit Breaker and the other benefits. An ITIN is **not** a social security number.
- The address on Line 3 must be the address where the claimant actually lives. We do not accept an in-care of address, PO Box or address of a child or representative payee.
- If this is the first time the claimant is filing we need verification of their date of birth. If they are under 65 years of age we also need verification of their disability.

FORM IL-1363

If the claimant is married or a partner to a civil union and living with their spouse on December 31, 2011 they must mark “married/civil union and living together” and include their total income in Section C.

*** If the spouse died during 2011, the surviving spouse would file as “single” and claim only the living individual’s income.***

FORM IL-1363

Section B

- Personal information about a spouse
- If this is the first time the spouse is filing, we need verification of their date of birth.
- If they are under 65 years of age and requesting IL Cares Rx or the People with Disabilities Ride Free transit card, we need verification of their disability.

SECTION B: Tell us about your spouse. **Note** Spouse includes parties to a civil union.

Complete this section if you checked Marital status 2.

8 Your spouse's Social Security number.8

--	--	--	--	--	--	--	--	--

9 Your spouse's name.9

First		MI	Last	
-------	--	----	------	--

10 Your spouse's birth date.10

Month		Day	Year		

Section C

– Income, losses and deductions for claimant and spouse

SECTION C: Claimant's and spouse's total income for 2011. (See instructions)

You must include your spouse's income (if married and living together).

11	Social Security, SSI benefits. Include Medicare deductions (yearly total)	11	_____
12	Railroad Retirement benefits. Include Medicare deductions (yearly total).....	12	_____
13	Civil Service benefits (yearly total).....	13	_____
14	Annuity benefits (yearly total).....	14	_____
15	Other pensions (yearly total)..... a nontaxable _____ b taxable 15	15	_____
16	Veteran's benefits (yearly total)..... a nontaxable _____ b taxable 16	16	_____
17	Human Services and other cash public assistance benefits (yearly total).....	17	_____
18	Wages, salaries, and tips from work (yearly total) _____ + _____ = 18	18	_____
	Claimant Spouse		
19	Interest and dividends received (yearly total)	19	_____
20	Net farm, business or rental income or (loss). If loss, attach copy of U.S. 1040.....	20	_____
21	Net capital gain or (loss). If loss, attach copy of U.S. 1040 and Schedule D.....	21	_____
22	Other income, (loss) or (deductions). If loss or deductions, attach copy of U.S. 1040..	22	_____
23	Add Lines 11 through 22. This is your total income. -----> 23	23	_____
	Do not include Lines 15a and 16a in your total.		

Section C (continued)

- **Line 11** – Social Security, SSI Benefits – Be sure to include any Medicare deductions. The Medicare Premium for most individuals who would be filing for Circuit Breaker for 2011 was \$115.40 per month or \$1,384.80 per year if the deduction was made all 12 months. Remember to add in any Medicare Part D premiums that were deducted. If Social Security and Railroad Retirement benefits are paid on the same check, write the total amount on Line 11.
- **Line 12** – Railroad Retirement Benefits – Again be sure to add in any Medicare premium deductions. If you reported Railroad Retirement benefits on Line 11, do not write them on Line 12.
- **Line 13** – Civil Service Benefits – Write the total amount in Civil Service benefits you and your spouse received in 2011.
- **Line 14** – Annuity benefits are considered income even though the money being paid may consist of a return of the individual's own funds. This would include both taxable and non-taxable amounts.

FORM IL-1363

Section C (continued)

- **Line 15** – Other Pensions – On Line 15b write the taxable portion of any IRA's, IRA's converted to Roth IRA's and pensions received in 2011. Write the non-taxable amount on Line 15a.
- **Line 16** – Veteran's Benefits – On Line 16b write the federally taxable amount received in Veteran's Benefits. Write the non-taxable amount on Line 16a.
- **Line 17** – Human Service Benefits – Include only cash assistance received from the Department of Human Services or any governmental agency, such as county or local township offices. Do not include food stamps or medical assistance that you may have received.
- **Line 18** – Wages, Salaries and Tips from Work – Be sure to give the appropriate breakdown between the claimant and spouses wages and then total the two amounts on Line 18.

FORM IL-1363

Line 19 – Interest and Dividends – Be sure to include both taxable and non-taxable amounts.

Line 23 – Total your income from Lines 11 through 22 to determine if you qualify for Circuit Breaker benefits. Be sure not to include Lines 15a and 16a. Also, be sure to subtract any losses or deductions that you have reported.

FORM IL-1363

Section C (continued)

- **Line 24a** – Number of Rooms in your Home – If you rent out a portion of your home you must complete this line as well as Line 24b. On 24a write the number of rooms in your home.
- **Line 24b** – Number of Rooms you Rented Out to Someone Else – On Line 24b you should write the number of rooms that you rented to someone else.

24 If you rented out any part of your home to someone else, complete Lines 24a and 24b.

a Number of rooms in your home. a _____

b Number of rooms you rented out to someone else. b _____

***** Remember - if someone states that they rent out part of their home to someone else they should also be claiming the rent they collect as income on their application on Line 20.**

FORM IL-1363

Section D

- Income limits compared to household size
- Line 25 is just to help you determine if you qualify based on your income. The number that you report on Line 25 for household size should include the claimant, spouse and any Qualified Additional Residents.
 - Less than \$27,610 for household size of one
 - Less than \$36,635 for household size of two
 - Less than \$45,657 for household size of three or more

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

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

If you are over the income guidelines for the number of people in your household, you should stop now. You are not eligible to receive any of the Circuit Breaker benefits at this time.

FORM IL-1363

Section E

- Property Tax
- Mobile Home Tax
- Rent
- Nursing, Retirement, Shelter Care

SECTION E: For your Circuit Breaker Grant.

Tell us about the Illinois property tax or rent you paid in 2011. (See instructions)

26 Property tax you paid or was payable in 2011 (total of both installments). 26

27 Mobile home tax you paid in 2011 (yearly total). 27

28 Rent you paid in 2011 (yearly total). Did your rent include food? yes no 28

Note → Do not include amounts paid by a "Section 8" program. Do not include amounts you did not pay. If you now live in public housing, but last year lived in private housing, see the instructions for Line 28. Failure to complete this section will delay the processing of your application.

a To whom did you pay rent in 2011?

Name _____ Phone (_____) _____ - _____

Address _____ City _____ State _____ ZIP _____

b How many months did you rent here in 2011?

b _____  Attach page if other rentals.

29 Nursing, retirement, or shelter care home charges you paid in 2011 (yearly total)..... 29

Note → Do not include amounts paid by Human Services.

a To whom did you pay nursing, retirement, or shelter care home charges in 2011?

Name _____ Phone (_____) _____ - _____

Address _____ City _____ State _____ ZIP _____

b How many months did you rent here in 2011?

b _____  Attach page if other rentals.



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

FORM IL-1363

Section E (continued)

- **Line 26** – Property Tax – If you owned your home, lived in it and accrued property tax on it, write the amount of property tax on this line. This will be your 2010 property taxes that you paid in 2011. Be sure to include both installments that were paid or were payable, but do not include any back taxes, interest, penalties or assessments.
- **Line 27** – Mobile Home Tax – If you owned a mobile home, lived in it and accrued mobile home taxes on it write the amount of mobile home tax that you paid in 2011 on Line 27. Also, be sure to include any real estate tax or lot rent you paid on Line 26 or 28.

FORM IL-1363

Line 28 – Rent – If you rented your home in 2011, write the amount of rent that you paid. Do not include any amount paid by a Section 8 program. Mortgage payments and maintenance fees are not considered rent. Check “yes” or “no” to indicate whether or not your rent included food.

Line 28a – Write the name, address and phone number of each landlord you rented from in 2011. Failure to complete all of the landlord information will delay the processing of your application.

FORM IL-1363

Section E (continued)

- **Line 28b** – Write the number of months you rented from each landlord in 2011

If you had more than one landlord in 2011 attach a sheet with the information requested on Lines 28 through 28b for each landlord.

If you now live in a residence that is not subject to property tax (such as Public Housing), but during all or part of 2011 you lived in a residence that was subject to property tax (such as private housing), you must attach a copy of your lease, notarized statement from your landlord, or cancelled checks to document the rent that you paid to the private landlord or a copy of your property tax bill. Also, attach a letter stating the dates you lived at each residence. We do not accept rent receipts as verification of rent.

FORM IL-1363

Section E (continued)

- **Line 29** – Nursing, Retirement, or Shelter Care Home – If you consider the nursing, retirement, or shelter care home as your principal or permanent residence, write the total amount you paid in charges in 2011. Do not include any amounts paid by the Department of Human Services, any medical assistance programs or your insurance company.
- **Line 29a** – Write the name, address and phone number of the nursing, retirement or shelter care home in which you lived in 2011.
- **Line 29b** – Write the number of months you lived in the nursing, retirement or shelter care home in 2011.

If you lived in more than one nursing, retirement or shelter care home in 2011, attach an additional sheet with the information requested on lines 29, 29a and 29b for each.

Section F

- For Prescription Coverage only. If you do not want prescription coverage, go to Section G. If any part of Section F is completed, we are going to assume that the claimant wants prescription coverage and the processing of the application may be delayed if all of the information is not complete.

SECTION F: For your Illinois Cares Rx benefits. (See instructions)

30 Are you a U.S. citizen or qualified noncitizen?

Note → You may still get some drug coverage even if no box is checked.

31 Illinois Cares Rx Benefits. You can choose help paying for prescriptions.

a Do you have Medicare? yes no

b Do you have HIV/AIDS? yes no (See instructions for additional benefits.)

Section F (continued)

- **Line 30** – If you are a US citizen check the first box. If you are a qualified non-citizen check the second box.
- Qualified non citizens must fall into one of the categories listed on Page 23 of the application booklet.

Section F (continued)

- If you check the qualified non-citizen box you must send us one of the following:
 - Alien Registration Receipt Card (I-151)
 - Permanent Resident Card (I-551)
 - Memorandum of Creation of Record of Lawful Permanent Residence (I-181)
 - Arrival-Departure Record (I-94)
 - Other Department of Homeland Security (U.S. Citizenship and Immigration Services) documents
 - U.S. Military Discharge Papers or Current Orders (DD Form 214, Report of Separation)

These SHOULD be photocopies. Failure to submit required proof may affect your Illinois Cares Rx prescription drug benefit.

FORM IL-1363

Section F (continued)

- **Line 31a** – Indicate whether the individual has Medicare or not.
- **Line 31b** – For drugs on the AIDS Drug Assistance Program (ADAP) formulary, only normal co-payments will be required. There will not be an additional 25% after the claimant reaches \$1750 in benefits in the Illinois Cares Rx Basic plan or \$2930 in the Plus Plan as is required for all other categories of drugs.

FORM IL-1363

Section G

- For spouse’s prescription coverage only
- **Line 32** - If your spouse is a US citizen check the first box. If your spouse is a qualified non-citizen check the second box. Qualified non citizens must fall into one of the categories listed on Page 23 of the application booklet.
- **Line 33a** – Answer whether the spouse has Medicare or not.
- **Line 33b** – Answer whether the spouse has HIV/AIDS or not.

SECTION G: For your spouse’s Illinois Cares Rx benefits. (See instructions)

32 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.

33 Illinois Cares Rx Benefits. Your spouse can choose help paying for prescriptions.

a Does your spouse have Medicare? yes no

b Does your spouse have HIV/AIDS? yes no (See instructions for additional benefits.)

FORM IL-1363

Section H

- Complete if eligible for Medicare Part A and/or B
- Do not include cash or any amount in bank accounts that will be used for normal living expenses during the month.
- The asset information provided in this section will only be used for the “Extra Help” through the Social Security Administration. This asset information does not affect your eligibility for form IL-1363’s benefits.

SECTION H: Additional information required for Illinois Cares RX benefits. (See instructions)

Note → Failure to complete this section will delay the processing of your application.

34 If you are married and living with your spouse, do you have savings, investments or real estate worth more than \$25,260? If you are not married or you do not live with your spouse, is the value more than \$12,640?

Note → Do not count the home you live in, vehicles, personal possessions, burial plots, irrevocable burial contracts or back payments from Social Security or SSI.

yes no

If you marked “no”, you must complete Schedule C. Parties to a civil union must each complete a separate Schedule C.

FORM IL-1363

Section I

- People with Disabilities/Seniors Ride Free Transit Card
- Check the box on Line 35 if the claimant wants to apply for the People with Disabilities or the Seniors Ride Free transit card.
- Check the box on Line 36 if the spouse wants to apply for the People with Disabilities or the Seniors Ride Free transit card.

Remember, we will need proof of the spouse's disability if he or she is requesting the transit card. Acceptable forms of proof of disability can be found on page 23 of the booklet.

SECTION I: For People with Disabilities/Seniors Ride Free Transit Card. (See instructions)

Complete this section if you or your spouse want to apply for or renew the Ride Free Transit Card. You must file an IL-1363 application each year and request a card every year.

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

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

Section J

- Claimant Signature
- Preparer Name
- Spouse Signature
- SHAP Code Field

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 and the Internal Revenue Service; (3) citizenship and identification information maintained by the Illinois Secretary of State and the United States Citizenship and Immigration Services (USCIS); 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.

37 X

Claimant's signature

____/____/____
Date

39

Preparer's name (Please print or type.)

Phone number

38 X

Spouse's signature (if living together)

____/____/____
Date



(Attach proof of authority if someone else signs for you or your spouse.)

Official use only					
			-		
SHAP				County/Sub-Area Code	

FORM IL-1363

Section J (continued)

- **Line 39** – Claimant’s Signature – If the claimant is unable to sign, their legal representative may sign. However, documentation must be attached to the claim proving that the representative is the legal guardian or has power of attorney to sign for the claimant. Health Care Power of Attorney documents are only good to satisfy the HIPPA requirement and are **not** sufficient for signature. Also, if the claimant is only able to make a mark, another person must sign as a witness. If the claimant is under the age of 18, the claimant’s parent or guardian must sign on their behalf and indicate their relationship to the claimant.
- **Line 40** - Spouse’s signature - The same rules apply for the spouse’s signature as those that apply to the claimant.
- **Line 41** - Preparer’s signature -If someone helped you prepare this form they should print their name and phone number.

FORM IL-1363

- **SHAP Code Field** - If you are a SHAP site filling out the application for a client, please be sure to enter your code in this field. If you are unsure of your SHAP code, contact IDOA.
- **Addresses**
 - Use the Blue label (PO Box 19021) if requesting Rx coverage as well as some or all of the other benefits
 - Use the Black label (PO Box 19003) if not requesting Rx coverage, but are wanting some or all of the other benefits of Circuit Breaker

If you need further assistance contact us at:

www.cbrx.il.gov or 1-800- 624-2459

FORM IL-1363

Schedule A



People with
Disabilities
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WHO SHOULD FILE A SCHEDULE A

If you are under the age of 65 on January 1, 2012 and cannot answer “yes” to any of the following 4 questions, but are currently disabled, you must have a Schedule A Physician’s Statement filled out by a licensed physician whose care you have recently been under, if you are wanting prescription coverage.



STEP 1

Answer the following questions to determine if you should complete the Schedule A.

Step 1: Answer the following questions to determine if you should complete this schedule.

- 1 Did you receive Social Security disability benefits in 2011?yes no
- 2 Did you receive disability benefits from Railroad Retirement or Civil Service in 2011?yes no
- 3 Did you receive disability benefits from the Veterans Administration in 2011?yes no
- 4 Did you have a Class 2 disability card from the Illinois Secretary of State's office in 2011?yes no

If you answered "yes" to **any** of the questions 1 through 4, **stop**. **Do not** complete this schedule, instead see the instructions for what you may need to attach to Form IL-1363.



STEP 2

Complete the following information about yourself

Step 2: Complete the following information about yourself. Please print.

Note Complete a separate Schedule A for each person and attach it to the claimant's Form IL-1363.

5 Social Security number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	9 Birth date	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
		Month	Day	Year			
6 Name	_____		10 Phone (_____)	_____ - _____			
	First	MI Last	Area Code				
7 Address	_____		11 Claimant's Social Security number	(from Line 1 on Form IL-1363)			
		Apt.		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
8 City	_____	State	_____	ZIP	_____		



STEP 3

A physician must complete the following information about the person named on Line 6.

Note → The patient must meet the **total disability criteria** established by the Social Security Administration. Social Security Administration guidelines **do not** include alcoholism or drug abuse as a qualification for disability status.

12 Patient's name _____
First MI Last

13 Date patient became disabled ____/____/____
Month Day Year

14 Was the patient able to work for a living after the above date?yes no

15 Has the disability lasted or is it expected to continue for 12 months or more?yes no

16 What is the nature of the disability? _____

17 Physician's name _____

18 Physician's signature and date _____
Month Day Year

19 Physician's Illinois registration number 3 6 - _____
(This number is issued by the Illinois Department of Financial and Professional Regulation.)

20 Physician's phone (_____) _____ - _____
Area Code

Schedule C



People with
Disabilities
Ride Free

Seniors
Ride Free

LICENSE

WHO SHOULD FILE A SCHEDULE C

- If you marked “no” on Line 34 of Form IL-1363, you must complete Schedule C if the spouse or claimant is eligible for Medicare and wants help paying for prescription drugs through IL Cares Rx.

FORM IL-1363

Schedule C: Step 1

– Claimant and spouse personal information

Only a claimant and a spouse may file a Schedule C together. Parties to a civil union must each file a separate Schedule C.

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

1 a Claimant's Social Security number

b Claimant's Birth date
Month Day Year

2 a Claimant's Name _____
First MI Last

e Marital status (only one box)

b Address _____ Apt. _____

1 Single, widow(er), or divorced

c City _____ State _____ ZIP _____

2 Married and living together

d Phone (_____) _____ - _____

3 Married, but not living together

3 a Spouse's Social Security number

b Spouse's Birth date
Month Day Year

4 Spouse's Name _____
First MI Last

FORM IL-1363

Schedule C: Step 2

– Working wages and self employment

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

5 Did you work in 2011 or 2012?

You: yes no **Spouse** (If living together): yes no

6 List your expected wages before taxes in **2012**. 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 **2012**. 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): ____ / ____

C: Step 2 (continued)

– Additional expenses

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.....

C: Step 2 (continued)

– Savings and resources

11 List the total amount of the savings and resources owned by you or your spouse. Also include items that either of you own with another person. If none, place a zero in the space.

a Bank Accounts (checking, savings and certificates of deposit) **a**

b Stocks, bonds, savings bonds, mutual funds, individual retirement accounts
and similar investments **b**

c Any other cash at home or elsewhere **c**

12 Do you plan to use any of the savings or resources on Lines 11a, 11b and 11c, to pay for funeral and burial expenses for yourself or your spouse?

You: yes no

Spouse (If living together): yes no

13 Other than your home and the property on which it is located, do you or your spouse own any real estate?

yes no

c: Step 2 (continued)

– Monthly income

For 14a-14d use the amount from the individual's cost of living adjustment letter. This is the amount before any deductions.

On 14e put income received from other sources such as alimony, net rental income, workman's compensation, etc.

14 List the monthly income for each item below. If none, place a zero in the space.

	You	Spouse	
a Social Security	<input type="text"/>	<input type="text"/>	per month
b Railroad Retirement.....	<input type="text"/>	<input type="text"/>	per month
c Veterans Administration	<input type="text"/>	<input type="text"/>	per month
d Other pensions and annuities.....	<input type="text"/>	<input type="text"/>	per month
e Other income not listed above....	<input type="text"/>	<input type="text"/>	per month

15 Have any of the amounts listed in Lines 14a, 14b, 14c, 14d, or 14e decreased in the last two years?

You: yes no

Spouse (If living together): yes no

c: Step 2 (continued)

– Social Security income for disability or blindness

	You		Spouse	
16 a Do you get Social Security benefits for a disability?	yes <input type="radio"/>	no <input type="radio"/>	yes <input type="radio"/>	no <input type="radio"/>
b Do you get Social Security benefits because you are blind?	yes <input type="radio"/>	no <input type="radio"/>	yes <input type="radio"/>	no <input type="radio"/>
c If "yes" for either Lines 16a or 16b and you pay for special transportation, personal attendant services, or adaptive equipment to work, list how much you pay each month	<input type="text"/>		<input type="text"/>	

Schedule C: Step 3

- Claimant signature
- Spouse signature
- Preparer name

Step 3: 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 and the Social Security Administration permission to get records from anyone concerning information on this form. As permitted by law, and subject to resource availability, I 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.

17 X _____ / /
Claimant's signature Date

19 _____
Preparer's name (Please print or type.) Phone number

18 X _____ / /
Spouse's signature (If living together) Date

FORM IL-1363

Schedule B



People with
Disabilities
Ride Free

Seniors
Ride Free

LICENSE

Schedule B:

Who is a qualified Additional Resident?

A qualified additional resident is an individual, other than your spouse,

- Who lived with you in the same residence in 2011 and in 2012 at the time you file your 2011 Form IL-1363; and
- For whom you, or you and your spouse, provided more than half of that person's total financial support in 2011; and
- Who is not filing a separate 2011 Form IL-1363

FORM IL-1363

Schedule B: Step 1

Step 1- Qualified Additional Resident Information

1 Social Security number

2 Name _____
First MI Last

3 Birth date
Month Day Year



Attach proof of age (first-time filer).

4 Check if requesting Illinois Cares Rx drug coverage.



If the person listed in Line 2 is younger than 65 years of age and the box in Line 4 is checked, attach proof of disability.

For your QAR's Illinois Cares Rx benefits. (See instructions)

5 Is your QAR a U.S. citizen or qualified noncitizen?

Note Your QAR may still qualify for Illinois Cares Rx Basic even if no box is checked above.

6 **Illinois Cares Rx Benefits.** Your QAR can choose help paying for prescriptions.

a Does your QAR have Medicare? **yes** **no**

b Does your QAR have HIV/AIDS? **yes** **no**

FORM IL-1363

Schedule B: Step 2

– Claimant's signature

Under penalties of perjury, I certify that the individual listed in Step 1 is a qualified additional resident for whom I, or my spouse and I, provided more than half of their total financial support in 2011, and that this individual lived with me in the same residence in 2011 and in 2012 at the time I filed my 2011 Form IL-1363.

7

Claimant's signature

__/__/__

Date

8

--	--	--	--	--	--	--	--	--	--

Claimant's Social Security number

FORM IL-1363

Schedule B: Step 3

- Qualified Additional Resident Signature

STEP 3: QAR sign below.  (Attach proof of authority if someone else signs for you.)

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 and the Internal Revenue Service (3) citizenship and identification information maintained by the Illinois Secretary of State and the United States Citizenship and Immigration Services (USCIS); 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.

10

Signature of person named on Line 2 (QAR)

Date

11

Signature of Authorized Representative for the QAR
(If younger than 18, see instructions.)

Date

FORM IL-1363

Schedule P



People with
Disabilities
Ride Free

Seniors
Ride Free

LICENSE

Who should file a Schedule P ?

You should file a Schedule P if an event has occurred that has decreased your income to a qualifying level (see instructions) and you want to apply for the following reason:

- To receive IL Cares Rx drug coverage because you do not qualify on your 2011 Form IL-1363.



Schedule P: Section A

- Reason for filing
- Date of event

SECTION A: Tell us why you are filing this schedule.

A Tell us the reason there has been a decrease in your income since 2011. For example, the death of a spouse, a divorce, the onset of a disability, retirement, or you or your spouse entered a nursing home.



You must attach proof. See instructions.

B The date that the event, described on Line A, occurred.

____/____/____
Month Day Year

C Did you file a Form IL-1363 for the year 2011? Yes No



If no, complete and attach 2011 Form IL-1363 to this schedule. Your benefits may be delayed if you did not complete Sections F and H (Section G for your spouse) on Form IL-1363.

FORM IL-1363

Schedule P: Section B

– Personal information about claimant

1 Social Security number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	6 Birth date	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
			Month Day Year
2 Name	_____	7 Marital status (✓ only one box)	
	First MI Last		
3 Address	_____ Apt. _____	<input type="checkbox"/> 1 Single, widow(er), or divorced	
4 City	_____ State _____ ZIP _____	<input type="checkbox"/> 2 Married and living together	
		<input type="checkbox"/> 3 Married, but not living together	
5 Phone (_____) _____ - _____		8 Are you <input type="checkbox"/> Male <input type="checkbox"/> Female	
	Area Code		

FORM IL-1363

Schedule P: Section C

–Tell us about your spouse

SECTION C: Tell us about your spouse (husband or wife). If none or deceased, go to Section D.

9 Your spouse's Social Security number

--	--	--	--	--	--	--	--	--	--

10 Your spouse's name

First		MI		Last			
Month		Day		Year			

11 Your spouse's birth date

Schedule P: Section E

– Income for claimant and spouse

SECTION E: Tell us your projected income.

Note Write the projected income amounts based on the 12-month period of time, starting with the month following the date on Section A, Line B (include your income and your spouse's income if living together).


	Projected Income
13 Social Security, SSI benefits. Include Medicare deductions (yearly total)	13
14 Railroad Retirement benefits. Include Medicare deductions (yearly total)	14
15 Civil Service benefits (yearly total).....	15
16 Annuity benefits (yearly total)	16
17 Other pensions (yearly total)..... a nontaxable <input type="text"/>	17
18 Veterans' benefits (yearly total)	18
19 Human Services and other cash public assistance benefits (yearly total).....	19
20 Wages, salaries, and tips from work (yearly total)	20
21 Interest and dividends received (yearly total)	21
22 Net farm, business or rental income or (loss). If loss, attach copy of U.S. 1040.	22
23 Net capital gain or (loss). If loss, attach copy of U.S. 1040 and Schedule D.	23
24 Other income, (loss) or (deductions). If loss or deductions, attach copy of U.S. 1040.	24
25 Total your projected income. Add Lines 13 through 24 and write the result.....	25

Note See instructions to determine if your projected income is within qualifying income limits.

Schedule P – Section F

-Claimant's signature
-Spouse's Signature

-Preparer's Signature

SECTION F: Sign below.  (Attach proof of authority if someone else signs for you or your spouse.)

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 and the Internal Revenue Service (3) citizenship and identification information maintained by the Illinois Secretary of State and the United States Citizenship and Immigration Services (USCIS); 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.

26 _____ **28** _____
Claimant's signature Date Preparer's name (Please print or type.) Phone number

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

FORM IL-1363

Schedule P:

- Address
- Web site
- Phone numbers

Mail your completed Schedule P
and any required attachments to



ILLINOIS DEPARTMENT ON AGING
P.O. BOX 19021
SPRINGFIELD, IL 62794-9021

If you need additional information about this form,

- visit our Web site at www.cbrx.il.gov
- call us at **1-800-624-2459** or **1-888-206-1327 (TTY)**
- to find a local agency serving seniors, call the Senior HelpLine at **1-800-252-8966**

FORM IL-1363

ADAD-16



People with
Disabilities
Ride Free

Seniors
Ride Free

LICENSE

WHO SHOULD FILE THE ADAD-16?



State of Illinois
Illinois Department on Aging

Application for Illinois Cares Rx

After Form IL-1363 has been filed in a claim year

Clerk ID

Official use only

Complete this application only if you want help paying for drugs **and** did not make this request on your previously filed 2011 Form IL-1363, Application for Circuit Breaker and Illinois Cares Rx.



ADAD-16 Step 1

STEP 1: Claimant Information.

1 Social Security number

2 Name _____
First MI Last

3 Address _____ Apt. _____

City _____ State _____ ZIP _____

4 Are you Male Female

For your Illinois Cares Rx Benefits.

5 Are you a U.S. citizen or qualified noncitizen? (See instructions.)

Note You may still qualify for Illinois Cares Rx Basic even if no box is checked above.

6 **Illinois Cares Rx Benefits.** You can choose help paying for prescriptions.

a Do you have Medicare? yes no (If "no," go to Line 7.)

b Do you have HIV/AIDS? yes no (See instructions for additional benefits.)

ADAD-16 Step 2

STEP 2: For your Spouse's Illinois Cares Rx Benefits.

Note Spouse includes parties to a civil union.

7 Spouse's Social Security number

--	--	--	--	--	--	--	--	--	--

8 Spouse's Name

First

MI Last

--	--	--	--	--	--	--	--

9 Spouse's birth date

Month Day Year

--	--	--	--	--	--	--	--

10 Is your spouse a U.S. citizen or qualified noncitizen? (See instructions.)

Note Your spouse may still qualify for Illinois Cares Rx Basic even if no box is checked above.

11 **Illinois Cares Rx Benefits.** Your spouse can choose help paying for prescriptions.

a Does your spouse have Medicare? **yes** **no** (If "no," go to Line 12.)

b Does your spouse have HIV/AIDS? **yes** **no** (See instructions for additional benefits.)

ADAD-16 Step 3

STEP 3: Additional Information required for Illinois Cares Rx Benefits.

Note Failure to complete this section will delay the processing of your application

12 If you are **married and living with your spouse**, do you have savings, investments or real estate worth more than \$25,260? If you are **not married or you do not live with your spouse**, is the value more than \$12,640?

Do not count the home you live in, vehicles, personal possessions, burial plots, irrevocable burial contracts or back payments from Social Security or SSI.

yes no **Note** If you marked **no**, you **must** complete Schedule C.

Parties to a civil union must each complete a separate Schedule C.



ADAD-16 Step 4

STEP 4: For your Qualified Additional Resident's (QAR) Illinois Cares Rx Benefit

(See instructions.)

Note A QAR must be at least 16 years of age to qualify. QAR's between 16 and 64 years of age must attach a copy of proof of disability and proof of age.

13 QAR's Social Security number

14 QAR's Name _____
First MI Last

15 QAR's birth date (See instructions.)
Month Day Year

16 Is your QAR a U.S. citizen or qualified noncitizen? (See instructions.)

Note Your QAR may still qualify for Illinois Cares Rx Basic even if no box is checked above.

17 **Illinois Cares Rx Benefits.** Your QAR can choose help paying for prescriptions.

a Does your QAR have Medicare? **yes** **no** (If "no," go to Line 18.)

b Does your QAR have HIV/AIDS? **yes** **no** (See instructions for additional benefits.)



ADAD-16 Step 5

STEP 5: Sign below.



(Attach proof of authority if someone else signs for you or your spouse.)

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 and the Internal Revenue Service; (3) citizenship and identification information maintained by the Illinois Secretary of State and the United States Citizenship and Immigration Services (USCIS); 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.

18 _____

Signature of person named on Line 2

Date

____/____/____

19 _____

Signature of person named on Line 8

Date

____/____/____

20 _____

Signature of person named on Line 14
(If younger than 18, see instructions.)

Date

____/____/____



If the QAR is under 18 years of age or unable to sign, a parent or legal representative must sign the QAR's name and indicate the relationship to the QAR such as Mother, Father, Guardian.

If you are signing as legal representative for the QAR you must attach proof of your legal status.

ADAD-16 Step 6

STEP 6: Send us the completed application form.

Mail this application to:

ILLINOIS DEPARTMENT ON AGING

PO BOX 19021

SPRINGFIELD IL 62794-9021



Amended Application IL 1363X



People with
Disabilities
Ride Free

Seniors
Ride Free

LICENSE

Who should File an Amended Application?

An individual who has made an error in reporting any figures on the IL 1363 should use the Amended Application IL 1363X to report a correction.

FORM IL-1363

You should **NOT** use the Amended Application to:

- Correct your name, address or phone number
- Apply for IL Cares Rx

FORM IL-1363

Section A Claimant Information



State of Illinois
Illinois Department on Aging

20 **IL-1363-X**

Amended Application for Form IL-1363 Benefits

Official use only

SECTION A: Tell us about yourself (claimant). Please print.

1 Social Security number

5 Birth date
Month Day Year

2 Name _____
First MI Last

6 Marital status (✓ only one box)

3 Address _____ Apt. _____

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

City _____ State _____ ZIP _____

4 Phone (_____) _____ - _____
Area Code

7 Are you Male Female

FORM IL-1363

Section B Spouse Information

SECTION B: Tell us about your spouse. **Note** → Spouse includes parties to a civil union.

Complete this section if you checked Marital status 2.

8 Your spouse's Social Security number.8

--	--	--	--	--	--	--	--

9 Your spouse's name.9

First MI Last

--	--	--	--	--	--	--	--

10 Your spouse's birth date.10

Month Day Year

Section C Income Information

SECTION C: Write only the claimant's and spouse's total income for 20__.

You must include your spouse's income (if married and living together).

11	Social Security, SSI benefits. Include Medicare deductions (yearly total)	11	<input type="text"/>	<input type="text"/>	<input type="text"/>
12	Railroad Retirement benefits. Include Medicare deductions (yearly total)	12	<input type="text"/>	<input type="text"/>	<input type="text"/>
13	Civil Service benefits (yearly total)	13	<input type="text"/>	<input type="text"/>	<input type="text"/>
14	Annuity benefits (yearly total)	14	<input type="text"/>	<input type="text"/>	<input type="text"/>
15	Other pensions (yearly total)	a nontaxable	<input type="text"/>	<input type="text"/>	<input type="text"/>
		b taxable	<input type="text"/>	<input type="text"/>	<input type="text"/>
16	Veterans' benefits (yearly total)	a nontaxable	<input type="text"/>	<input type="text"/>	<input type="text"/>
		b taxable	<input type="text"/>	<input type="text"/>	<input type="text"/>
17	Human Services and other cash public assistance benefits (yearly total)	17	<input type="text"/>	<input type="text"/>	<input type="text"/>
18	Wages, salaries, and tips from work (yearly total) <input type="text"/> <small>Claimant</small> + <input type="text"/> <small>Spouse</small> =	18	<input type="text"/>	<input type="text"/>	<input type="text"/>
19	Interest and dividends received (yearly total)	19	<input type="text"/>	<input type="text"/>	<input type="text"/>
20	Net farm, business or rental income or (loss). If loss, attach copy of U.S. 1040.	20	<input type="text"/>	<input type="text"/>	<input type="text"/>
21	Net capital gain or (loss). If loss, attach copy of U.S. 1040 and Schedule D.	21	<input type="text"/>	<input type="text"/>	<input type="text"/>
22	Other income, (loss) or (deductions). If loss or deductions, attach copy of U.S. 1040.	22	<input type="text"/>	<input type="text"/>	<input type="text"/>
23	Add Lines 11 through 22. This is your total income. ----->	23	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Do not include Lines 15a and 16a in your total.				

24 If you **rented out** any part of your home to someone else, complete Lines 24a and 24b.

a Number of rooms in your home. a

b Number of rooms you **rented out** to someone else. b

Go to SECTION D →
Form IL-1363-X (R-12/11) • 1 of 4

Section C (continued)

- Line 11 through Line 23 - should be filled in correcting the lines that have changed. If a line has not changed write in the original number. If the original application had nothing on a line and has not changed, enter zero on the line.
 - Changes on any of these lines require documentation to be attached to this form.

FORM IL-1363

Section C (continued)

- Lines 24a and 24b – Only fill in these lines if the claimant rented out rooms in his home to another individual.

If the claimant does fill in these lines then they should also be claiming rent as income.

Section D

SECTION D: Tell us how many persons you are reporting for the year for which you are filing this amended application. (See instructions for more information.)

25 Household size (add the number of persons on Lines 2 and 9 and on Schedule B, Line 2)

- Enter the number of individuals that are being claimed. This includes the claimant, spouse and any Qualified Additional Residents.

FORM IL-1363

Section E - Property Tax and Rent

SECTION E: Tell us about the Illinois property tax or rent you paid in the year for which you are filing this amended application.

26 Property tax you paid or was payable in 2011 (total of both installments). 26

27 Mobile home tax you paid (yearly total). 27


28 Rent you paid in 2011 (yearly total). Did your rent include food? yes no 28

a To whom did you pay rent in 2011?

Name _____ Phone (_____) _____ - _____

Address _____ City _____ State _____ ZIP _____

b How many months did you rent here?

b _____  Attach page if other rentals.

Note Do not include amounts paid by a "Section 8" program. Do not include amounts you did not pay. If you now live in public housing, but last year lived in private housing, see the instructions for Line 28. Failure to complete this section will delay the processing of your application.


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

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

Name _____ Phone (_____) _____ - _____

Address _____ City _____ State _____ ZIP _____

b How many months did you live here?

b _____  Attach page if other rentals.

Note Do not include amounts paid by Human Services.

30 Have you been claimed as a dependent on someone else's tax return for the year you are amending?

yes no

Section E (continued)

- Lines 26 through 29 – Fill in rental and/or property tax figures. The landlord information should be filled out completely and only amounts that the individual actually paid should be reported.
- Line 30 – Answer yes if you were claimed as a dependent on someone else's tax return for the year you are amending or no if you were not claimed as a dependent.

FORM IL-1363

Section F Signatures

SECTION F: 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 and the Internal Revenue Service (3) citizenship and identification information maintained by the Illinois Secretary of State and the United States Citizenship and Immigration Services (USCIS); 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.

31	X	_____	____/____/____	33	_____	_____																		
		Claimant's signature	Date		Preparer's name (Please print or type.)	Phone number																		
32	X	_____	____/____/____	<table border="1"><tr><td colspan="6">Official use only</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td colspan="3">SHAP</td><td colspan="3">County/Sub-Area Code</td></tr></table>			Official use only												SHAP			County/Sub-Area Code		
Official use only																								
SHAP			County/Sub-Area Code																					
		Spouse's signature (if living together)	Date																					

- Line 31 and 32 – Claimant/spouse signatures
- Line 33 – Preparer's signature

FORM IL-1363

Where to mail this application

Mail your completed form to:

Circuit Breaker, Illinois Department on Aging

P.O. Box 19003

Springfield, Il 62794-9003

FORM IL-1363

For Help

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).

FORM IL-1363