State of Illinois
Rod R. Blagojevich, Governor
Illinois Department on Aging

2007 IL-1363

Application for Circuit Breaker and Illinois Cares Rx

Official use only

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

1 Social Security number

2 Name ______ First MI Last

3 Address ______ Apt. ______

City ______ State ____ ZIP ______

4 Phone (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Area code

5 ☐ **Yes**, I want help paying for my drugs or a monthly rebate. See instructions for more information.

6 Birth date Month Day Year

7 Marital status (✓ only one box)

☐ 1 Single, widow(er), or divorced
☐ 2 Married and living together
☐ 3 Married, but not living together

8 Are you ☐ Male ☐ Female

Step 2: Tell us about your spouse (husband or wife). Complete this step if you checked Marital status 2.

9 Write your spouse's Social Security number. 9

10 Print your spouse's name. .... 10 ______ First MI Last

11 Write your spouse's birth date. .... 11 Month Day Year

12 ☐ **Yes**, I want help paying for drugs for my spouse or a monthly rebate. See instructions for more information.

Step 3: Write only the claimant's and spouse's total income for 2007.

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 ______ ...... **b** taxable 17 ______

18 Veterans' benefits **(yearly total)** .... **a** nontaxable ______ ...... **b** taxable 18 ______

19 Human Services and other cash public assistance benefits **(yearly total)** .... 19 ______

20 Wages, salaries, and tips from work **(yearly total)** ______ Claimant + ______ Spouse = 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 Add Lines 13 through 24. **This is your total income.** ➔ ➔ ➔ ➔ 25 ______
Do not include Lines 17a and 18a in your total.

26 If you rented out any part of your home to someone else, complete Lines 26a and 26b.

a Write the number of rooms in your home. **a** ______

b Write the number of rooms you rented to someone else. **b** ______

Postmark deadline for filing is December 31, 2008.

Step 4: Does your total income allow you to file this application?

27 Write household size (add the number of persons on Lines 2 and 10, and on Schedule B, Line 9). ..... **27** ☐

See instructions for more information.

Step 5: Tell us about the Illinois property tax or rent you paid in 2007.

28 Property tax you paid or was payable in 2007 **(total of both installments).** .... **28** ______

29 Mobile home tax you paid in 2007 **(yearly total).** .... **29** ______

30 Rent you paid in 2007 **(yearly total).** Does your rent include food? **yes** ◯ **no** ◯ **30** ______

a To whom did you pay rent in 2007?

Name ______________________ Phone (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Address ______________________ City ______________ State ____ ZIP __________

b How many months did you rent here in 2007? **b** __________ Attach page if other rentals.

Note **Do not** include amounts paid by a Section 8 program.
If you now live in public housing, but last year lived in private housing, see the instructions for Line 30.

31 Nursing, retirement, or shelter care home charges you paid in 2007 **(yearly total).** .... **31** ______

a To whom did you pay nursing, retirement, or shelter care home charges in 2007?

Name ______________________ Phone (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Address ______________________ City ______________ State ____ ZIP __________

b How many months did you live here in 2007? **b** __________ Attach page if other charges.

Note **Do not** include amounts paid by Human Services.

Step 6: For your prescription drug benefits or monthly rebate.

32 Are you a ☐ U.S. citizen or ☐ qualified noncitizen? See instructions for more information.

Note You may still get some drug coverage, a grant, and a license plate discount even if no box is checked above.

33 Are you eligible for Medicare Part A and/or Part B for your hospital or doctor expenses? **yes** ◯ **no** ◯

If "**no**," go to Line 34.

a If you are already enrolled in a Medicare Part D plan, what is the name of your plan?

- ☐ 1 AARP Medicare Rx Preferred
- ☐ 2 Essence
- ☐ 3 Erickson
- ☐ 4 Evercare
- ☐ 5 First Health Part D – Premier
- ☐ 6 Group Health Plan (GHP)
- ☐ 7 Health Alliance Medical Plans
- ☐ 8 HealthSpring
- ☐ 9 Humana
- ☐ 10 OSF HealthPlans
- ☐ 11 PersonalCare
- ☐ 12 SecureHorizons by United Healthcare
- ☐ 13 SilverScript
- ☐ 14 UnitedHealth Rx Basic
- ☐ 15 WellCare
- ☐ 16 Other: ______________

b Have you applied with Social Security for "extra help" under Medicare Part D? **yes** ◯ **no** ◯

c Do you have HIV/AIDS? **yes** ◯ **no** ◯ See instructions for added "wrap around" benefits.

d Print the name and claim number as it appears on your Medicare card or Railroad Retirement card.

First name ______ Last name ______ Claim number ☐☐☐☐☐☐☐☐☐☐☐

(Step 6 continued.)

34 You can choose to receive a $25 monthly rebate **instead of** help paying for prescriptions.

a Do you have private, creditable health insurance, Veterans Administration benefits, or a non-coordinating Medicare Part D plan that pays for prescription drugs? **yes** ◯ **no** ◯ If "**no**," go to Step 7.

b Can you enroll in Medicare Part D without losing your private, creditable health insurance? **yes** ◯ **no** ◯

c Do you want a $25 monthly rebate **instead of** help paying for prescriptions? **yes** ◯ **no** ◯

Note **Do not** mark "**yes**" if you are receiving prescriptions through a coordinating Medicare Part D plan and need "wrap around" benefits under Illinois Cares Rx.

Step 7: For your spouse's prescription drug benefits or monthly rebate.

35 Is your spouse a ☐ U.S. citizen or ☐ qualified noncitizen? See instructions for more information.

Note Your spouse may still get some drug coverage even if no box is checked above.

36 Is your spouse eligible for Medicare Part A and/or Part B for his or her hospital or doctor expenses? **yes** ◯ **no** ◯ If "**no**," go to Line 37.

a If your spouse is already enrolled in a Medicare Part D plan, what is the name of your spouse's plan?

- ☐ 1 AARP Medicare Rx Preferred
- ☐ 2 Essence
- ☐ 3 Erickson
- ☐ 4 Evercare
- ☐ 5 First Health Part D – Premier
- ☐ 6 Group Health Plan (GHP)
- ☐ 7 Health Alliance Medical Plans
- ☐ 8 HealthSpring
- ☐ 9 Humana
- ☐ 10 OSF HealthPlans
- ☐ 11 PersonalCare
- ☐ 12 SecureHorizons by United Healthcare
- ☐ 13 SilverScript
- ☐ 14 UnitedHealth Rx Basic
- ☐ 15 WellCare
- ☐ 16 Other: ____________________

b Has your spouse applied with Social Security for "extra help" under Medicare Part D? **yes** ◯ **no** ◯

c Does your spouse have HIV/AIDS? **yes** ◯ **no** ◯ See instructions for added "wrap around" benefits.

d Print the name and claim number as it appears on your spouse's Medicare card or Railroad Retirement card.

First name ____________ Last name ____________ Claim number ☐☐☐☐☐☐☐☐☐☐☐

37 Your spouse can choose to receive a $25 monthly rebate **instead of** help paying for prescriptions.

a Does your spouse have private, creditable health insurance, Veterans Administration benefits, or a non-coordinating Medicare Part D plan that pays for prescription drugs? **yes** ◯ **no** ◯ If "**no**," go to Step 8.

b Can your spouse enroll in Medicare Part D without losing his or her private, creditable health insurance? **yes** ◯ **no** ◯

c Does your spouse want a $25 monthly rebate **instead of** help paying for prescriptions? **yes** ◯ **no** ◯

Note **Do not** mark **"yes"** if your spouse is receiving prescriptions through a coordinating Medicare Part D plan and needs "wrap around" benefits under Illinois Cares Rx.

Step 8: For your or your spouse's prescription drug benefits or monthly rebate.

Complete the following information only if you or your spouse are eligible for Medicare for hospital or doctor expenses.

38 Do you, your spouse (if married and living together), or both of you own any of the following items:

- Bank accounts (checking, savings and certificates of deposit);
- Stocks, bonds, savings bonds, mutual funds, individual retirement accounts and similar investments;
- Real estate (other than your home); **or**
- Any other cash at home or elsewhere?

yes ◯ **no** ◯

If yes,

a Single: Is the total value of the items listed above worth more than $11,990? **yes** ◯ **no** ◯

b Married and living together: Is the total value of the items listed above worth more than $23,970?

yes ◯ **no** ◯

Note If you answered "**no**" on Line 38, Line 38a or 38b, you **must** complete Schedule C.

Step 9: 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 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 (3) citizenship and identification information maintained by the Illinois Secretary of State, 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.

39 X________________________ ___/___/___
Claimant's signature Date

41 ____________________ ____________
Preparer's name (Please print or type.) Phone number

40 X________________________ ___/___/___
Spouse's signature (If living together) Date

Official use only

SHAP ___ – County/Sub-Area Code ___

If you need additional assistance

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

If applying for ALL Form IL-1363 benefits — including Illinois Cares Rx

CIRCUIT BREAKER/ILLINOIS CARES RX
ILLINOIS DEPARTMENT ON AGING
PO BOX 19022
SPRINGFIELD IL 62794-9022

If ONLY applying for a grant and/or license plate discount

CIRCUIT BREAKER
ILLINOIS DEPARTMENT ON AGING
PO BOX 19003
SPRINGFIELD IL 62794-9003

Postmark deadline for filing is December 31, 2008.

This form is authorized as outlined by the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act. Disclosure of this information is REQUIRED. Failure to provide information could delay your grant and/or prescription coverage. IL-402-1093

Illinois Department on Aging

2007 Schedule C Pharmaceutical Benefits

Attach to the claimant's Form IL-1363.

If you marked "**no**" on Line 38a or 38b of Form IL-1363, you **must** complete Schedule C if you or your spouse are eligible for Medicare and want help paying for prescription drugs or the $25 monthly rebate available through Illinois Cares Rx.

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

1a Claimant's Social Security number

b Claimant's Birth date __ __/__ __/__ __ __ __
Month Day Year

2a Claimant's Name ______________________
First MI Last

b Address ______________________ Apt.______

c City ______________________ State____ ZIP ______

d Phone (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

e Marital status (✓ only one box)

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

3a Spouse's Social Security number

b Spouse's Birth date __ __/__ __/__ __ __ __
Month Day Year

4 Spouse's Name ______________________
First MI Last

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

5 Did you work in 2007 or 2008?

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

6 List your expected wages before taxes **in 2008**. 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 2008**. 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)**:** ___ ___ / ___ ___ ___ ___

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. .... ☐

11 a Does anyone provide or help you or your spouse pay for your food, mortgage, rent, heat/gas, electricity, water or property taxes? **Do not** count: food stamps, house repairs, help from a housing agency (Section 8), an energy assistance program, Meals on Wheels, or help with medical treatment and drugs. yes ◯ no ◯

b If **"yes,"** how much help do you get each **month**? If the amount changes from month to month or you do not receive it every month, tell us the average monthly amount for the past year. .... ______

This form is authorized as outlined by the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act. Disclosure of this information is REQUIRED. Failure to provide information could delay your grant and/or prescription coverage. IL-402-1096

12 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**

13 **a** Do you own life insurance policies with a total face value **greater** than $1,500? If "**no**" for both of you, go to Line 14.

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

b If "**yes**" for either of you, list the amount you would get by cashing in your life insurance policies. ....

Note This is **not** the face value of your policies. You may need to call your insurance company to help answer this question.

14 Do you plan to use any of the savings or resources on Lines 12a, 12b, 12c, and 13 to pay for funeral and burial expenses for yourself or your spouse?

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

15 Other than your home and the property on which it is located, do you or your spouse own any real estate?
yes ◯ no ◯

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

	You	**Spouse**	
a Social Security			per month
b Railroad Retirement			per month
c Veterans Administration			per month
d Other pensions and annuities ...			per month
e Other income not listed above ..			per month

17 Have any of the amounts listed in Lines 16a, 16b, 16c, 16d, or 16e decreased in the last two years?

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

	You	**Spouse**
18a Do you get Social Security benefits for a disability?	yes ◯ no ◯	yes ◯ no ◯
b Do you get Social Security benefits because you are blind?	yes ◯ no ◯	yes ◯ no ◯
c If "**yes**" for either Lines 18a or 18b **and** you pay for special transportation, personal attendant services, or adaptive equipment to work, list how much you pay each **month**.		

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.

19 X________________________________ ___/___/___
Claimant's signature Date

21 ________________________________ ________________
Preparer's name (Please print or type.) Phone number

20 X________________________________ ___/___/___
Spouse's signature (If living together) Date

Line-by-line instructions for Schedule C

Complete Schedule C if you or your spouse are eligible for Medicare and want help paying for prescription drugs or the $25 monthly rebate available through Illinois Cares Rx.

If you mark "**no**" on Line 38a or 38b of Form IL-1363 you must complete Schedule C. If you mark "**yes**" on Line 38a or 38b, you do not need to complete Schedule C.

Note It is important that you complete your "extra help" application and send it to Social Security for a decision even if you do not think you will be eligible.

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

1 through 4
Complete the requested identification information for you and your spouse.

Note Complete Lines 3a, 3b, and 4 only if you checked Marital status 2, "Married and living together," on Line 2e. Otherwise, if you do not have a spouse, if your spouse is deceased, or if you are not living in the same household with your spouse, go to Step 2.

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

5 Mark "**yes**" if you worked in 2007 or 2008. Otherwise, mark "**no**".

6 List the amount you expect to earn in wages, before taxes, in 2008. If none, place a zero in the space.

7 List the amount of your expected earnings or losses from self-employment in 2008. If none, place a zero in the space.

8 Mark "**yes**" if the amounts listed on Lines 6 or 7 have decreased in the last two years. Otherwise, mark "**no**".

9 List the month and year that you recently stopped working (or you plan to stop working).

10 List the number of relatives who 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 box.

11a Mark "**yes**" if anyone provides or helps you or your spouse pay for food, mortgage, rent, heat/gas, electricity, water or property taxes. Otherwise, mark "**no**" and go to Line 12.

Note **Do not** count: food stamps, house repairs, help from a housing agency (Section 8), an energy assistance program, Meal on Wheels, or help with medical treatments and drugs.

11b If "**yes,**" list how much help you get each month. If the amount changes from month to month or you do not receive it every month, tell us the average monthly amount for the past year.

12 List the savings and resources owned by you or your spouse.

12a List the total amount of bank accounts (checking, savings and certificates of deposit).

12b List the total amount of stocks, bonds, savings bonds, mutual funds, individual retirement accounts and similar investments.

12c List the total amount of any other cash you or your spouse have at home or elsewhere.

Note For Lines 12a, 12b, and 12c, if you and your spouse **do not** own an item listed, place a zero in the space.

13a Mark "**yes**" if you own life insurance policies with a total face value greater than $1,500. (You may need to call your insurance company to help answer this question). Otherwise, mark "**no**", and go to Line 14.

13b List the amount you would get by cashing in your life insurance policies. Cash value is different than the face value. (You may need to call your insurance company to help answer this question).

14 Mark "**yes**" if you plan to use any of the savings or resources on Lines 12a, 12b, 12c, and 13b to pay for funeral and burial expenses for yourself or your spouse. Otherwise, mark "**no**".

(Continued on next page.)

Line-by-line instructions for Schedule C

15 Mark "**yes**" if you or your spouse own real estate other than your home and the property on which your home is located. Otherwise, mark "**no**".

16 List the monthly income for each of the items. If none, place a zero in the space.

16a List the monthly amount you get from Social Security (include Medicare deductions).

16b List the monthly amount you get from the Railroad Retirement Board (include Medicare deductions).

16c List the monthly amount you get from the Veterans Administration.

16d List the monthly amount you get from any other pensions or annuities.

Note For Lines 16a, 16b, 16c, and16d, use the amount on your annual cost-of-living adjustment letter. This is the amount before any deductions.

16e List the monthly amount you get from any other source, including alimony, net rental income, worker's compensation, etc. If the amount changes from month to month or you do not receive it every month, tell us the average monthly income for the past year. **Do not** count: wages, self-employment, interest, public assistance, medical reimbursement, or foster care payments.

17 Mark "**yes**" if any of the amounts listed on Lines 16a, 16b, 16c, 16d, or 16e have decreased in the last two years. Mark "**no**" if there has been no decrease.

18a Mark "**yes**" if you get Social Security benefits for a disability. Otherwise, mark "**no**".

18b Mark "**yes**" if you get Social Security benefits because you are blind. Otherwise, mark "**no**".

18c If "**yes**" for either Line 18a **or** 18b **and** you pay for special transportation, personal attendant services, or adaptive equipment to work, list how much you pay each **month**. If this amount is not the same each month, tell us the average monthly amount for the past year.

Step 3: Sign below.

19 Claimant's signature

You, the claimant (the person named on Line 2a), must sign this schedule.

20 Spouse's signature

Your spouse (the person named on Line 4) must sign this schedule.

21 Preparer's name

If someone other than you or your spouse, such as a son, daughter, or legal representative, prepares this schedule for you, that person should print or type his or her name and telephone number on Line 21.