



CareLink

Application for Financial Assistance

Information You Should Know

I certify that I lived in Cook County within 30 days prior to this application for assistance. I did not move to Cook County for the sole purpose of seeking medical care through the CareLink assistance program.

I agree to inform Cook County Health & Hospitals System (CCHHS) of any changes in my financial situation, insurance benefits, settlement proceeds, third party payers or other resources that are, or may become available to me within 14 days of the change. I hereby assign to Cook County Health & Hospitals System such benefits, settlement proceeds or other resources to pay for service(s) rendered by Cook County Health & Hospitals System.

I acknowledge that I realize and approve the fact that I will be rescreened upon every visit to Cook County Health & Hospitals System (CCHHS) for potential eligibility for Medicaid program.

I authorize Cook County Health & Hospitals System to verify my residency, identity, income, assets, marital status, or any other information deemed necessary (including Credit Report verification) in processing this application for CareLink assistance.

I acknowledge that it is my responsibility to provide the information and documentation necessary to support my statements. Failure to do so will affect my eligibility in the CareLink program.

I acknowledge that if the information I provide on this application is false, I may be subject to criminal prosecution for fraud to the fullest extent of the law.

Applicant Information

1. RESIDENCY

Name _____
Last
First
Middle

Date of Birth _____ - _____ - _____ Social Security Number _____ - _____ - _____

Address _____ Apt Number _____

City _____ County _____ State _____ Zip Code _____

Home Telephone Number _____ - _____ - _____ Work Number _____ - _____ - _____ Cell Number _____ - _____ - _____

2. IDENTITY

Drivers license Number _____ State _____ Expiration Date _____

Other Picture ID-Issuing Authority _____ Expiration Date _____

If no Photo ID 2 other forms of ID are required 1. _____ 2. _____

Marital Status: Single Married Divorced Separated

3. HOUSEHOLD INFORMATION

Fill in the information below for all the members of your household (spouse and children).

Name (Last, First, Middle)	Social Security Number	Relationship	Date of Birth	Age	Sex

4. INCOME

What is your monthly gross household income? \$ _____

Applicant's Employer	Address	Employer Phone #
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Are you paid weekly _____, bi-weekly _____, twice a month _____ or monthly _____

Spouses Employer	Address	Employer Phone #
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Is your spouse paid weekly _____, bi-weekly _____, twice a month _____ or monthly _____

5. THIRD PARTY COVERAGE

Do you or your spouse have access to any type of health insurance coverage? _____ Yes _____ No

Have you applied for any state or federal assistance, Medicaid, Medicare, or SSI? _____ Yes _____ No if yes, provide the following information:

Who applied?	When?	Where?	Status?
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6. MONTHLY EXPENSES

Does anyone help you pay these expenses? _____ Yes _____ No

If Yes, Who? _____

Rent/Mortgage	Electric	Gas	Telephone	Car Payment	Credit Cards	Water	Total
\$	\$	\$	\$	\$	\$	\$	\$

7. FINANCIAL ASSETS

List the values of your financial assets below:

Checking	Savings/Money Market	CD's	IRA	Annuities/Stocks Bonds	Vehicles	Properties (other than home)	Total
\$	\$	\$	\$	\$	\$	\$	\$

IMPORTANT INFORMATION

Any change(s) to the information provided on this application, must be reported to Cook County Health & Hospitals System within 14 days of the change(s). Failure to do so will result in loss of eligibility in the CareLink program. _____ Initials

Applicants providing false information will be disqualified from receiving medical assistance through CareLink program and will be just cause for Cook County Health & Hospitals System to pursue prosecution to the fullest extent of the law. _____ Initials

I, the undersigned, certify that I understand the above statements and that the information I have provided is true and correct to the best of my knowledge. _____ Initials

Signature of Applicant, Guardian or Representative

_____-_____
Date

Signature of Interviewer / Financial Counselor

_____-_____
Date