



FUNERAL AND BURIAL REIMBURSEMENT CLAIM 4(3 YEARS)

CLAIMANT IDENTIFICATION		COMPLETE ALL ITEMS Enter "NA" if an item is not applicable	See instructions on reverse side. Print or Type all entries except signatures
1. SSN:	2. Type:		5. Submit 3 copies to local office located at:
3. Name, Address, Zip Code:			6. Attention:
4. Relationship to Decedent:			

CLIENT IDENTIFICATION		
7. Case Name:	8. Case Number:	9. Date of Death:
10. Decedent's Name:	11. Social Security Number:	12. DOB:
13. Funeral Home:	14. Cemetery:	

CHARGES	DOCUMENT AMOUNTS SHOWN	ASSETS			
15. Funeral Cost: <input type="text"/>	Attach copies of contracts, purchase records, and receipts. Show amounts paid, the payor and the payee.	19. Responsible Relative Payments: <input type="text"/>			
16. Burial Cost: <input type="text"/>		20. Estate Fund: <input type="text"/>			
17. Total Cost: <input type="text"/>		21. Death Benefits: <input type="text"/>			
18. Total Cost Paid: <input type="text"/>		22. Total Amount of Resources: <input type="text"/>			
23. MAXIMUM REIMBURSEMENT may not exceed this standard, the cost of service or the total amount paid, WHICH EVER IS LESS.		24. Maximum Reimbursement: <input type="text"/>			
REIMBURSEMENT		25. Total Amount of Resources: <input type="text"/>			
Funeral	Burial	Total	Effective Date	Anatomical Gifts	26. Allowable Reimbursement: <input type="text"/>
\$1073	\$537	\$1610	07/01/06	Limited to \$142.00	
\$1103	\$552	\$1655	07/01/07		

<p>27. LOCAL OFFICE CLAIM REVIEW This is to certify that this claim is accurate and complete, that it complies with the Rules and Regulations, and that PAYMENT is hereby Approved.</p> <p>Local Office Signature: _____</p> <p>Date: _____</p> <p>Central Ofc. Signature: _____</p> <p>Date: _____</p> <p>CO Use Only:</p>	<p>28. This is to certify that the above information is true, accurate, and complete; that I have assumed responsibility for payment in full of the above identified decedent's funeral and burial expenses. I understand that this claim may be amended to comply with the Rules and Regulations of the Department of Human Services. I further understand that payment is made from State Funds and falsification of a material fact may lead to appropriate legal action.</p> <p>Claimant Signature: _____</p> <p>Date: _____</p> <p>Claimant Telephone Number: _____</p>
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FUNERAL AND BURIAL REIMBURSEMENT CLAIM 4(3 YEARS)

INSTRUCTIONS FOR COMPLETION OF IL 444-0094

(Review form for completion to eliminate delay in processing)

This form is used to reimburse the person who has assumed full responsibility for the funeral and burial expense of a deceased Department of Human Services recipient. When two or more persons have been party to the arrangements, one must be designated to file the claim for reimbursement since only one claim will be accepted.

The following identified persons will **NOT** be reimbursed.

1. A beneficiary of the decedent's life insurance, unless insurance proceeds are less than the appropriate reimbursement standard.
2. The decedent's spouse.
3. A parent of a decedent under 18 years of age.

Time Limitations

1. A written explanation must accompany claims not submitted in 30 days of death.
2. Claims not submitted in 180 days of death will be denied.
3. Claims returned to claimants will be denied if not resubmitted in 90 days.

INSTRUCTIONS FOR COMPLETION OF ITEMS

Items

- 1-4. Enter claimant information. **Leave item 2 blank.**
- 5-6. Enter information regarding the local DHS Office.
- 7-12. Enter client information.
- 13-14. Enter funeral home and cemetery names.
- 15-17. Enter total funeral cost and burial costs. Item 17 will be calculated based on entries for items 15 and 16.
18. Enter actual total cost paid by claimant for funeral and burial.
- 19-22. Enter amounts to offset funeral costs from listed sources. Item 22 will be calculated.
24. Enter total allowable reimbursement amount as listed in item 23.
25. Amount will be repeated from item 22 above.
26. Allowable reimbursement will be calculated.
27. Local Office review and certification block. Must be signed and dated by appropriate local office staff.
28. Claimant certification block. Claimant must sign, date and enter a valid telephone number.

ATTACH SEPARATE SHEET TO EXPLAIN UNUSUAL CIRCUMSTANCES

Distribution - Original and one copy to Funeral and Burial Unit, Bureau of Local Office Transactions and Support Service
Claimant - copy
Local Office - copy