State of Illinois
Department of Human Services

4(3YEARS)

AUTHORIZATION FOR REPAYMENT OF INTERIM ASSISTANCE

Case Name: _____ Social Security Number: _____

Case Number: _____ Township FEIN Number: _____

Township/Commission Name: _____ Telephone Number: _____
(if applicable)

Township/Commission Address: _____ Fax Number: _____
(if applicable)

This authorization is for an (check one) Initial Claim ☐ Initial Post Eligibility Payment ☐

CLIENT'S AGREEMENT

For and in consideration of payment of State assistance furnished to or on behalf of me for Supplemental Income financed from State funds for basic needs during the period in which my SSI application is pending, I hereby authorize the Commissioner of the Social Security Administration (SSA), to send my initial or initial post-eligibility payment of Supplemental Security Income (SSI) benefits to the Illinois Department of Human Services (IDHS) or an amount equal to the amount of reimbursable public assistance the State gave to me when the law restricts the manner in which my SSI can be released to me.

I authorize the IDHS to deduct from my initial or initial post-eligibility payment an amount equal to the sum of all public assistance benefits (not including assistance payments financed wholly or partly with Federal funds) made to or on behalf of me by the IDHS beginning with the day of the month I am found eligible for an SSI payment and ending the month my SSI payments begin or the month my SSI benefits are reinstated after a period of suspension or termination, and ending with (and including) the month my SSI benefits resume; provided that such reimbursement 1) shall not exceed, for any given month, the retroactive SSI benefit paid for that month; and 2) shall only cover interim assistance paid during months in which SSI benefits were granted under the SSI application pending when this authorization was signed. An SSI application is “pending” for purposes of this authorization from the date it is filed until the date the State receives the retroactive SSI payment or the date I begin to receive SSI regular payments, whichever is sooner, or until the date SSA denies the application and the denial is final and unappealable.

I understand that after making the above deductions from my first payment, the IDHS shall pay to me the balance, if any, no later than 10 working days from the date the IDHS receives my initial or initial post eligibility payment from the Commissioner of the SSA.

I understand that I have the right to a fair hearing before the IDHS if I feel that I have been aggrieved by any action taken by the State pursuant to this Authorization including but not limited to whether the amount deducted from my initial payment of SSI benefits or my initial post-eligibility benefit was more than the amount of public assistance benefits paid to or on behalf of me by the IDHS.

I understand that this authorization is effective for one (1) year from the date I sign it (the IDHS receives this signed form). If the IDHS does not notify SSA within thirty (30) calendar days of the date that I signed this authorization, the authorization is not binding on IDHS or me. This form will cease to have effect at the end of one (1) year from that date or at the end of the maximum period permitted under regulations at Subpart N of 20 CFR within which to request administrative or judicial review of the determination by the Commissioner of the SSA to suspend or terminate my SSI benefits, whichever period of time is longer, unless I file for SSI within that time or one of the following events occurs earlier, in which case the authorization will cease to have effect as of the date of such an event:

the Commissioner of the SSA makes an initial payment on my claim;
the Commissioner of the SSA releases the retroactive payment on my claim or record which has been reinstated to payment after period of suspension or termination, or
the Commissioner of the SSA makes a final determination on my claim and no timely request for review is filed by me; or
the State and I agree to terminate the authorization.

I understand that signing this authorization form means I want to file for SSI benefits; that I must file an SSI application with the Social Security office for the Social Security Administration to decide if I am eligible for SSI benefits; that if I am found eligible for SSI benefits, my eligibility for SSI can begin as early as the date the IDHS receives this signed form if I file the SSI application within 60 days from that date.

I agree that if I receive directly the initial or initial post-eligibility payment of Supplemental Security Income Benefits I will promptly reimburse the IDHS for any duplicated interim assistance advanced to me while my application for SSI was pending. Failure to reimburse the IDHS will result in recovery and/or recoupment action.

Applicant's Signature: _____ Date: _____

IDHS/Township/Commission Representative Signature: _____ Date: _____

Distribution: Original to SSA, 1 copy to IDHS Office of Fiscal Services, PO Box 19407, Springfield, 62794-9407, 1 copy to case file and 1 copy to client