State of Illinois
Department of Human Services - Division of Rehabilitation Services

Home Services Program Financial Data Sheet

Customer's Name: _____

I. Medicaid/Medicaid Spend Down Eligibility (Check, if applicable)

☐ Medicaid Case Number: _____

☐ Medicaid Recipient Number: _____

II. Assets

☐ 1. Customer age 18 or over ☐ 2. Customer under age 18 - Family Assets

Assets	Customer Only (Age 18 or over)	Family Assets (Customer under 18)
Savings Account		
Checking Account		
Cash on Hand		
Stocks		
Bonds		
Savings Certificate		
Trust Funds		
Life Insurance (cash value)		
Other		
Real (other than homestead)		
Specify		
Total Assets		
	$17,500 Limit	$35,000 Limit

Asset Transfer ☐ I have ☐ I have not transferred assets to another party within the 36 months prior to my application for services to DHS-DRS Home Services Program. If I have transferred assets, I certify I have received fair market value and will provide proof of this upon request by DHS-DRS. If the information is requested, I understand no eligibility determination will be made until this information is provided by me.

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III. Income

Income	Family Unit Income		
	Customer	Family	
Salary			
Social Security			
SSI			
SSDI			
Veterans Benefits			
Workers Compensation			
Railroad Retirement			
Other Pensions			
Other Income			
Total			

Total Family Unit Income: _____

IV. Certification (COMPLETE FOR ALL INDIVIDUALS)

I certify that the information provided is correct and complete to the best of my knowledge. I understand the information will be disclosed only for the purposes of administration of services, and I may be asked to further verify or document the information I have provided. I understand I have the right to object to any adverse action and to request an appeal. If it is determined that I have made false statments in order to receive services, I agree to reimburse DHS-DRS for the cost of those services.

Signature of Customer or Authorized Representative: _____ Date: _____

I have verified the above information as correct and complete, as appropriate.

Signature of Counselor/Case Manager: _____ Date: _____

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