State of Illinois
Department of Human Services

1 (PERMANENT)

Request for Cash Assistance - Medical Assistance - Supplemental Nutrition Assistance Program (SNAP) (please print clearly)

Last Name: _____ First Name: _____ MI: ___ Maiden Name: _____

Present Address: _____

Apartment Number: _____

City: _____ State: _____ Zip Code: _____ County: _____

Are you homeless? ☐ Yes ☐ No

Mailing Address (if different from above)

Present Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Previous Address

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Telephone number(s) where we may get in touch with you

Home: _____ Work: _____ Other: _____

Signature: _____ Date: _____

Signing here will start your application. You must sign Page 11 before we approve you for any benefits.

Instructions to person(s) applying for Cash - Medical, and/or SNAP benefits

1. Please print all of your answers on the application form so that we can read and understand your answers.
2. You have the right to immediately file the application as long as the top of this page (page 1) is completed with your name, address and signature. The filing of this signed page (page 1) starts the application processing timetable.
3. Read pages 8 & 9 to know your rights and responsibilities for SNAP benefits.
   Read pages 9 & 10 to know your rights and responsibilities for Cash and Medical.
4. **Before you can get any benefits, you must sign page 11.**
5. If applying for SNAP benefits, a decision on your eligibility will be made within 30 days. If determined eligible, SNAP benefits will be issued from the date the application is filed.
6. You may be entitled to receive SNAP benefits right away if:
   * your gross nonexempt income and liquid assets are less than your monthly rent or mortgage payment and the appropriate utility standard: or,
   * you have assets of $100 or less **and**
     - your gross monthly income for the month of application is less than $150; or
     - at least one person applying is a migrant who is "out of funds."
7. You may complete this form at home and mail or bring it to a Department of Human Services (DHS) office, or another member of the household or an adult who knows you may complete and return the form to us. If someone else completes this form for the household, they are to answer the questions for the person(s) they are applying for, not himself or herself. You have the right to choose the office where you apply. Once you submit your application to an office it will be processed by that office.
8. If you want to register to vote, fill out the enclosed Illinois Voter Registration Application (SBE R-19) and give it to your DHS office or your local election official. For help filling it out or for translation services, contact your DHS Family Community Resource Center. You may also call the Helpline at 1-800-843-6154, or 1-800-447-6404 (for TTY). For information online, see www.dhs.state.il.us or www.elections.il.gov/.

   Filling out the Voter Registration Application as part of this application is optional. Registering to vote is your choice and will not affect the amount of benefits you get from this agency.

Last Name: _____ First Name: _____ MI: ___ Maiden Name: _____

Address: _____

Citizenship/Immigration Status

You must complete this section before you complete the rest of the application.

If you or any other person is not applying because you do not wish to provide information about your immigration status, you do not have to give us that information. The failure to provide immigration information will not affect processing the application for the remaining persons. However, any person who is applying for benefits for himself or herself has to provide information on their immigration status.

Are all persons U.S. citizens? ☐ Yes ☐ No

Complete the following information for any non-citizens who are applying for benefits. If you need more room, attach another sheet of paper.

Name	Age	Arrival Date in the United States	Registration Number
1.			
2.			
3.			
4.			
5.			
6.			

If there are any persons who are not applying for SNAP benefits and/or cash benefits because they do not wish to provide proof of their immigration status, please list them below. **We will only ask questions about their income and assets.**

Name (Last) (First) (MI)	Name (Last) (First) (MI)
1.	4.
2.	5.
3.	6.

The following questions are for informational purposes only. Answering the questions will not affect your benefits.

1. Are you Hispanic or Latino? ☐ Yes ☐ No

2. What is your race? (Select one or more)
   ☐ American Indian/Alaskan Native ☐ Asian
   ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

3. Does the adult member of your household who will usually discuss your case with DHS and/or HFS speak English fluently? ☐ Yes ☐ No

Does the adult member of your household who will usually receive mail or written information from DHS and/or HFS read English fluently? ☐ Yes ☐ No

If you checked either one of the above questions "No", what language do you speak? _____

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1. How many people live with you? (include yourself) _____

2. Are you or is anyone who lives with you blind? ☐ Yes ☐ No Disabled? ☐ Yes ☐ No
   If yes, who: _____

3. Do you or does anyone who lives with you receive any kind of assistance from DHS now? ☐ Yes ☐ No
   If yes, who: _____

4. Have you or has anyone who lives with you received any kind of assistance from DHS before? ☐ Yes ☐ No
   If yes, who: _____

5. Have you or has anyone who lives with you recently applied for assistance in this or any other local office? ☐ Yes ☐ No
   If yes, who: _____

6. Are you or is anyone in your household pregnant? ☐ Yes ☐ No
   If yes, who: _____ Expected Date of Delivery: _____

ARE YOU APPLYING FOR SNAP BENEFITS?

☐ No: Go to page 5.

☐ Yes: Complete the rest of this page and page 4.

We will interview you within 14 days - right away if you qualify for an expedited SNAP interview.

How many people who live with you buy and prepare food with you? (Include yourself) _____

Please complete the following:

☐ I am able to come to an office interview.

☐ I must be interviewed by phone because:

○ I am applying for SNAP

- ☐ And someone in my household is employed.
- ☐ Problems with health, transportation, caring for a child or disabled adult, ongoing severe weather or educational activities conflict with office hours.

○ I am applying for cash assistance

- ☐ Hours of work or educational activities conflict with office hours.
- ☐ Problems with health, transportation, caring for a child or disabled adult, ongoing severe weather or educational activities conflict with office hours.

I can be reached by phone Monday - Friday between 8:30 and 5:00 at: _____

Please complete the section below only if you are applying for SNAP benefits, have little or no income, and need SNAP benefits right away. Your answers should include everyone who lives with you.

How much money do you or anyone who lives with you have in cash, checking, and/or savings? _____

What is the monthly **gross income** (income of all sources before any deductions) for you and everyone who lives with you? _____

How much money have you or anyone who lives with you received or expect to receive from any source in the month of application?

$ _____ When? _____ Who: _____ Source: _____

Is this a SNAP unit of migrant or seasonal farm workers? ☐ Yes ☐ No If yes, did the income recently stop? ☐ Yes ☐ No

Are you or is anyone who lives with you expecting to receive more than $26 in income from a new source within the next 10 days?

☐ Yes ☐ No

Complete this page if applying for SNAP benefits.

Shelter Costs

1. How much are you charged each month for your rent or mortgage? _____
   (For mortgage include property taxes and insurance.) Do you share this expense with anyone? ☐ Yes ☐ No

2. Are you receiving, or expecting to receive Low Income Home Energy Assistance Program (LIHEAP), (in Chicago paid through CEDA)?
   ☐ Yes ☐ No

3. If No, are you billed separately from rent or mortgage for: **A.** Heat or air conditioning? ☐ Yes ☐ No

   B. Excess cost for heat or air conditioning? ☐ Yes ☐ No **NOTE:** Air conditioning is a window air or central air conditioning unit.

   C. Does anyone outside of your SNAP unit pay or help pay for your housing costs? ☐ Yes ☐ No

   D. Does anyone outside of your SNAP unit pay your utility expenses? ☐ Yes ☐ No

If yes, please list the bills and the amounts paid: _____

Please complete the following information if you answered (NO), to question (2 or 3) and are not billed for heat or air conditioning separately

Expenses	Amount	How Often Due	Amount You Pay	Paid By Others
Electricity				
Water and/or Sewerage				
Garbage				
Cooking Fuel				
Basic Phone Service (including cell phone)				
Septic Tank Installation Maintenance				
Well Installation /Maintenance				
A Fee for Starting Utility Service (Specify what utilities you pay)				
A Flat Amount for Utilities (Specify what utilities you pay)				

Explain: _____

State of Illinois
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Request for Cash Assistance - Medical Assistance - Supplemental Nutrition Assistance Program (SNAP)

1 (PERMANENT)

(please print clearly)

You must complete this page for all programs

What is your full name and birthdate and the full name and birth dates of all the people who live with you? Include people who are temporarily absent from the home (do not use nicknames). Also include people who live with you for whom you are not requesting assistance. List in this order: Yourself Your husband or wife Children Other relatives Non-relatives	Enter one of the words below to show the relationship of each person to you. Self / Husband Son / Wife Daughter / Father Grandson / Mother Granddaughter / Sister Stepbrother / Brother Stepdaughter / Aunt Stepson / First Cousin Stepmother / Nephew Stepfather / Niece Related Some Other Way Not related. This person's relationship to me is:	A determiniation of your eligibility under any of the programs administered by the Department will be made unless you do not want to be considered for a particular program(s). Indicate below what type of benefits you do or do not want to apply for by checking "Yes" or "No".	Enter the social security number of each person requesting benefits.
1. Person Making Application First Name: _____ Middle Initial: _____ Last Name: _____ Birthdate: _____	Self	Cash ☐ Yes ☐ No Medical ☐ Yes ☐ No SNAP ☐ Yes ☐ No	
2. First Name: _____ Middle Initial: _____ Last Name: _____ Birthdate: _____		Cash ☐ Yes ☐ No Medical ☐ Yes ☐ No SNAP ☐ Yes ☐ No	
3. First Name: _____ Middle Initial: _____ Last Name: _____ Birthdate: _____		Cash ☐ Yes ☐ No Medical ☐ Yes ☐ No SNAP ☐ Yes ☐ No	
4. First Name: _____ Middle Initial: _____ Last Name: _____ Birthdate: _____		Cash ☐ Yes ☐ No Medical ☐ Yes ☐ No SNAP ☐ Yes ☐ No	
5. First Name: _____ Middle Initial: _____ Last Name: _____ Birthdate: _____		Cash ☐ Yes ☐ No Medical ☐ Yes ☐ No SNAP ☐ Yes ☐ No	
6. First Name: _____ Middle Initial: _____ Last Name: _____ Birthdate: _____		Cash ☐ Yes ☐ No Medical ☐ Yes ☐ No SNAP ☐ Yes ☐ No	

Please attach an additional page if there are more persons

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Complete this page if you are applying for cash or medical benefits Complete #2 through #5 for SNAP benefits only.

1.	Person #1	Person #2	Person #3
Is this person covered by health or hospital insurance (including Medicare) now or in the last three months? If yes, complete the following.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
a. Date Coverage Began (month/year)	a.	a.	a.
b. Has Insurance Ended? If yes,why? Date coverage ended (month/year)	☐ Yes ☐ No b.	☐ Yes ☐ No b.	☐ Yes ☐ No b.
c. Name of Insurance Company	c.	c.	c.
d. Name of Policyholder	d.	d.	d.
e. Policyholder's SSN (optional)	e.	e.	e.
f. Employer Name and Phone Number	f.	f.	f.
g. Policy Number and Group Number	g.	g.	g.

2. Is any adult, parent, stepparent, spouse or pregnant woman named on this form currently employed? ☐ Yes ☐ No
   If yes, complete the following and **attach proof** for the last month. Is anyone self-employed? ☐ Yes ☐ No

   Name of Person: _____ Employer: _____

   Employer Address: _____ Employer Phone: _____

   Number of Hours Worked Weekly: _____ Amount Paid (including tips) before taxes $ _____ How Often Paid: _____

   Name of Person: _____ Employer: _____

   Employer Address: _____ Employer Phone: _____

   Number of Hours Worked Weekly: _____ Amount Paid (including tips) before taxes $ _____ How Often Paid: _____

3. Does anyone named on this form GET money from any source other than employment (such as Social Security, child support, spousal support, rental property, unemployment benefits, pensions, retirement, trusts)?
   ☐ Yes ☐ No

   If yes, complete the following and **attach proof** for the last month.

   Name of Person: _____ Source: _____ Monthly Amount $ _____

   Name of Person: _____ Source: _____ Monthly Amount $ _____

   If this income is from rental property, is this person receiving the income also the property manager? ☐ Yes ☐ No

4. Does anyone named on this form PAY child support or spousal support? ☐ Yes ☐ No
   If yes, complete the following and **attach proof** for the last month.

   Name of Person: _____ Source: _____ Monthly Amount $ _____

   Name of Person: _____ Source: _____ Monthly Amount $ _____

5. Does anyone named on this form PAY for day care so they can work? ☐ Yes ☐ No
   If yes, complete the following and **attach proof** for the last month.

   Name of child in Day Care: _____ Name of Care Giver: _____

   Name of child in Day Care: _____ Name of Care Giver: _____

   Person paying Day Care: _____ Monthly Amount $ _____

   Relationship of care giver to child (if any): _____

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All Kids/Family Care Insurance Rebate Form

A rebate is a monthly amount we will pay you if you already pay for health insurance for yourself, your spouse or your children. If you choose to get rebates, you will use your current insurance card to get health care.
Only families who have health insurance can get rebate payments. Also, only families with a certain amount of income can get rebates.

- ☐ Have the policy holder complete Part A;
- ☐ Have the policyholder's employer or personal insurance agent complete Part B and return it with you; and
- ☐ Return the completed pages to your local office.

Part A - The main person whose name is on the insurance must sign this part of the form. Often this person is called the policyholder. This person may get the health insurance from a job.

Policyholder's Last Name: _____ Policyholder's First Name: _____

Home Address: _____ Apartment Number: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ Telephone Number: _____

(We must have the Social Security Number so we can pay the rebate to this person.)

Tell us the names of family members you want a rebate for: _____

I agree to call the All Kids/Family Care Unit right away if this health insurance ends, someone is added or taken off the health insurance, the amount paid for the insurance changes, covered benefits change or someone else becomes the policyholder.
I authorize my employer, plan adminstrator and insurance company to provide the information requested in PART B for the purpose of determining whether I qualify for All Kids/Family Care. I also authorize my employer, plan administrator and insurance company to verify my coverage and any of the information below for any time when I get All Kids/Family Care Rebate.

Signature of Employee/Policyholder: _____

Part B - This part of the form must be completed by the employer providing the health insurance or the insurance agent.

Note to Employer Insurance Agent: The employee/policyholder named above on this form is applying for help to cover the cost of their family's health insurance premiums. Please assist them by completing the information below and returning the form to the employee/policyholder as soon as possible. (As used below, "employee" applies to an employee or private policyholder.) For help in completing this form, call toll-free 1-877-805-5312.

Employer (if employer policy): _____

Employer address: _____

City: _____ State: _____ Zip Code: _____

Person completing this form: _____ Phone: _____ Fax: _____

Insurance Company: _____ Policy Number: _____ Group Number: _____

What benefits are covered? Check all that apply: ☐ Physician Services ☐ Hospital Inpatient Services

Amount of premium paid by employee: $ _____ . (Include amounts paid for dental, vision, and prescription coverage.)

Premiums are paid: ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ monthly ☐ semi-annually ☐ annually ☐ quarterly

Persons covered by the employee premium contribution: _____

Does the employer pay 100% of the cost of the employee's coverage: ☐ Yes ☐ No
If No, how much of the amount listed above is for coverage of the employee only (single rate)?

$ _____ (Include amounts paid for dental, vision, and prescription coverage.)

Enrollment Period of Policy: _____

Date of Premium Listed Above Began/Begins: _____

Date of Next Scheduled Change in Premium: _____

Authorized Signature of Employer/Agent: _____ Date: _____

Return the completed rebate form to the employee for submission with the All Kids/Family Care application. Need Help? Visit allkidscovered.com or call toll free 1-866-ALL-KIDS (1-866-255-5437) If you use a Text Telephone, call 1-877-204-1012.

SNAP - CLIENT RIGHTS AND RESPONSIBILITIES

Read carefully before signing this application on page 11. Ask your caseworker to explain anything you do not understand.

Federal law requires a social security number (SSN) for every member of your household who is applying for SNAP benefits. We do not require a social security number for any member of your household who is not eligible for the SNAP program or who does not wish to apply. If you or any member of your household wants to apply for SNAP benefits, but does not have a SSN, we can help you to apply for one. The SSN will be used in the administration of the SNAP program to check the identity of household members, prevent duplicate participation, and to facilitate making mass changes. The SSN will also be used in computer matching and program reviews or audits and to make sure the household is eligible for SNAP benefits, other federal assistance programs, and federally assisted state programs, such as school lunch, TANF, and Medicaid. This may result in criminal or civil action or administrative claims against persons fraudulently participating in the SNAP program.

At this application you must report:

* Child care expenses
* Utility expenses
* Rent or mortgage payment, property taxes and insurance

You must report **and** verify:

* Medical expenses
* Child support paid to a non-SNAP Unit member

Child support payments are subject to verification by computer matching with the records of the Division of Child Support Enforcement.

Failure to report or verify above expenses will be seen as a statement by your SNAP Unit that you do not want to receive a deduction for the unreported expenses.

Penalty Warning

The information on this form is subject to verification by federal, state, and local officials. If any information is found to be inaccurate, you may be denied SNAP benefits, and/or be subject to criminal prosecution for knowingly providing false information.

Individuals found guilty in a court of law of trading SNAP benefits for firearms, ammunition, explosives, or controlled substances will be barred from the SNAP program: 1) 24 months for the first offense and permanently for the second offense involving the sale of a controlled substance for SNAP benefits, and 2) permanently for the first offense involving the sale of firearms, ammunition, or explosives for SNAP benefits.

A person found guilty of trafficking SNAP benefits will be permanently barred from the SNAP program.

A person who is found to have made a fraudulent statement or representation about identity and residence to get multiple benefits at the same time will be barred for 10 years.

Persons who are fleeing felons or probation/parole violators are ineligible for SNAP benefits.

Any member of your SNAP unit who intentionally breaks any of the following rules can be barred from the SNAP program for 12 months after the first violation, 24 months for the second violation, and permanently for the third violation. The person can also be fined up to $250,000, imprisoned up to 20 years, or both. The person may also be subject to further prosecution under other applicable federal laws.

Do not give false information or hide information to get or continue to get SNAP benefits.

SNAP benefits may not be traded or sold. SNAP benefits may be used for food products only and may not be used to buy ineligible items, such as alcoholic drinks and tobacco.

Do not use someone else's SNAP benefits for your SNAP unit.
I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules listed in the penalty warning. By signing, I swear that under penalty of perjury the answers are true and correct to the best of my knowledge.

I understand that documents may have to be provided to prove what I've said. I agree to do this. If documents are not available, I agree to give the name of a person or organization the FCRC may contact to obtain the necessary proof.

SNAP - CLIENT RIGHTS AND RESPONSIBILITIES - (continued)

I understand that while my application is pending and once it is approved, I must report any changes in my SNAP unit's circumstances within 10 days of the date the change occurs, unless otherwise notified. If I have any doubt about whether to report a change, I will ask my Human Services caseworker.

I understand that if approved for SNAP benefits and I receive more benefits than I am entitled to, whether it be an error on my part or an agency error, the amount of overpaid benefits is subject to recoupment/recovery.

Right to appeal
A fair hearing may be requested either orally or in writing if there is disagreement with any action taken on this case. The SNAP unit's may be presented at the hearing by any person chosen by the SNAP unit.

Non-Discrimination
In accordance with Federal Law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, disability, religion or political belief.

To file a complaint of discrimination, contact the Department of Human Services (DHS), USDA, or HHS, Write DHS at, Department of Human Services, Bureau of Civil Affairs, 401 South Clinton St, 7th Floor, Chicago, Illinois, 60607. Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W. Washington, D.C. 20250-9410, or call (800) 795-3272 (Voice) or (202) 720-6382 (TTY). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W. Washington, D.C. 20201 or call (202) 619-0403 (Voice) or (202) 619-3257 (TTY). DHS, USDA and HHS are equal opportunity providers and employers.

Cash/Medical Assistance - CLIENT RIGHTS AND RESPONSIBILITIES (continued)

Read carefully before signing this application on page 11. Ask your caseworker to explain anything you do not understand.

I understand that by signing this application form, I consent to any investigation made by the Department to verify or confirm the information I have given or any other investigation made by them in connection with my request for public assistance. I understand that I must cooperate in these efforts to verify information.

When I file an application for cash or medical assistance, a determination of my eligibility under any of the programs administered by the Department will be made unless I do not want to be considered for a particular program(s). If I do not want to be considered for a particular program, the Department will not consider my eligibility for that program(s).

I agree to inform the agency within 10 days of any change in my household's size, income, property, living arrangements, school attendance, or address.

I understand that if approved for cash benefits, and I receive more benefits than I am entitled to, whether it be an error on my part or an agency error, the amount of overpaid benefits are subject to recoupment/recovery.

I understand that if I am mentally and physically able to apply and I want someone else to apply for cash and/or medical benefits for me, I must attach a written statement that gives the person permission. The statement must include the person's name, address, and phone number. The statement must say that I am still responsible for the information provided by the person .

I understand that the Department secures and uses information about all clients through the income and eligibility verification system. This includes such information as receipt of social security benefits, unemployment insurance, unearned income (such as interest and dividends) and wages from employment. Any information obtained will be used in determining eligibility for assistance and the amount of assistance provided for all programs. When discrepancies are found, verification of this information may be obtained through contacts with a third party, such as employers, claims representatives, or financial institutions. This information may affect your eligibility for assistance and the amount of assistance provided.

The information provided on this form will be subject to verification by Federal, State, and Local officials. If any information is found to be inaccurate, I may be denied cash benefits and/or the MediPlan Card. I understand that anyone who knowingly misuses the health benefits card issued by the State of Illinois may be committing a crime.

All information related to the establishment of paternity and child support enforcement has been provided to the best of my knowledge.

If my application is approved, I give the State of Illinois the right to recover under the terms of any private or public health care coverage any amount for which I or a member of my family may be eligible.

Cash/Medical Assistance - CLIENT RIGHTS AND RESPONSIBILITIES (continued)

I understand that the State of Illinois will release information concerning medical services I have received for any reason authorized by law.

I understand that if the children I am applying for are approved for All Kids Share or All Kids Premium, I am responsible for paying the premiums and copayment amounts.

I understand that if the children I am applying for are approved for All Kids Rebate, the State of Illinois is not responsible for additional premiums, deductibles or copayments required by the employer's or private health insurance policy.

I declare under penalty of perjury, that the statements I have made regarding the citizenship or immigration status of each person applying for medical benefits are true and correct.

I understand the Department will not share any information about immigration or any persons who do not have an Alien Registration Number. The Department will verify the immigration status of any person I give an Alien Registration Number for. To do that, the Department will check the number with the U.S. Citizenship and Immigration Service (USCIS). The Department may send other information to USCIS, such as copies of proof I give of an Alien Registration Number and the person's Social Security Number, if they have one.

As a condition of eligibility, if I am approved for TANF Cash and/or medical assistance for myself and my children, I understand that I may be required to cooperate with child support enforcement. Cooperation includes establishment of paternity and/or support enforcement and modification of child support orders. I assign and give all my rights, title and interest of child support and medical support to the Illinois Department of Healthcare and Family Services as long as I receive TANF Cash/or medical assistance. I understand and agree that any child support payments paid through the clerk of the circuit court and through the State Disbursement Unit (SDU) may be forwarded to the Illinois Department of Healthcare and Family Services as long as I receive TANF Cash.

I understand that if I apply for TANF Cash and/or medical assistance for my children only, I am not required to cooperate with child support enforcement, but I may request services.

If I am approved for TANF Cash and/or medical benefits for myself and my children, and the State of Illinois pays medical bills for me, I give my right to collect medical support payments to the State of Illinois. I understand I must help to obtain medical support payments for members of my family unless I have a good reason not to. My children can get health insurance even if I do not help when the Department asks me to.

Property Lien - AABD

If I am approved for Aid to the Aged, Blind, or Disabled for cash and/or medical assistance. I understand that the Department may have the right to place a lien on my home or other real property I own. The amount of the lien is the amount of assistance the Department has provided to me.

For GA applicants only

The Department of Human Services is requesting your social security number and the number(s) of any other person(s) for whom you are applying in the administration of the general assistance (GA) program. Providing your number or the number(s) of any other person(s) for whom you are applying or receiving assistance is voluntary. If you do not wish to provide the social security number(s) you provide in the administration of the GA program as described above.

All Cash Applicants:

Have you or any other person applying for Cash been convited of a felony involving drugs on or after 08/22/96? ☐ Yes ☐ No

Name of Person _____

If the drug-related felony conviction was NOT Class X or Class I, did the felony take place more than 2 years ago, or has the person completed a drug treatment program, or is the person in a drug treatment program now? ☐ Yes ☐ No

I understand that a person convicted of a Class X or Class I felony or a comparable federal law, for acts that occurred on or after 08/22/96 involving possession, use, or distribution of a controlled substance is ineligible to receive Cash assistance. I understand that a person convicted of drug-related felony, other than a Class X or Class I, under Illinois or any comparable federal law an act that occurred on or after 08/22/96, is ineligible for Cash assistance for 2 years following the date of the conviction, unless they are in drug treatment or aftercare, or successfully participated in and completed drug treatment and/or aftercare subsequent to their conviction.

Right to Appeal

I understand that if I am not satisfied with the action taken on my application that I have the right to a fair hearing. I understand that I can ask for a fair hearing by getting in touch with the office where I applied or by writing to: The Bureau of Assistance Hearing, 401 South Clinton Street, Chicago, Illinois 60607, or by calling 1-800-435-0774.

Applicant Signature

I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil or both. I certify under the penalty of perjury that the information I have provided on this application form is the truth to the best of my knowledge.

Applicant: _____ Date: _____

Spouse: _____ Date: _____

Signature: Applicant Makes a Mark (X)

☐ If you have made your mark (X) instead of signing your name, one witness must sign here:

Signature of Witness: _____ Date: _____

Signature: Applicant Blind

☐ Applications based on blindness must be attested to by two witnesses.

Signature of Witness: _____ Date: _____

Signature of Witness: _____ Date: _____

APPROVED REPRESENTATIVE SIGNATURE

If the application is initiated by someone else for the applicant, they must sign below. If an approved representative completes and signs this application, written authorization from the applicant is required.

I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil or both. I certify under the penalty of perjury that the information I have provided on this application form is the truth to the best of my knowledge.

Signature of Approved Representative: _____ Relationship: _____

Home Address: _____ Apt. Number: _____

Telephone Number: _____

ILLINOIS VOTER REGISTRATION APPLICATION

Suggested, August 2008,
SBE R-19

FOR ILLINOIS RESIDENTS ONLY

TO VOTE YOU MUST:

- Be a United States citizen
- Be at least 18 years old
- Live in your election precinct at least 30 days
- Not be convicted and in jail
- Not claim the right to vote anywhere else

TO VOTE IN THE NEXT ELECTION:

- **Mail or deliver this application to your County Clerk or Board of Election Commissioners** no later than 28 days before the next election. **(click here for County Clerk/Election Board listings) or go to www.elections.il.gov**

IMPORTANT INFORMATION:

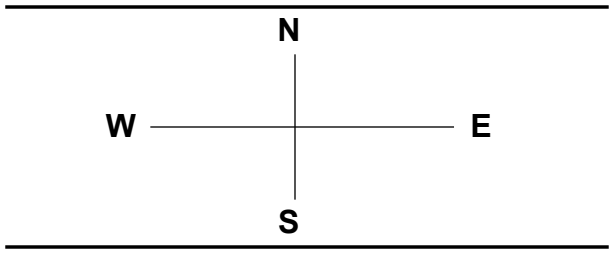
- If you do not have a driver's license, State Identification Card or social security number, and this form is submitted by mail, and you have never registered to vote in the jurisdiction you are now registering in, then you must send, with this application, either (i) a copy of a current and valid photo identification, or (ii) a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows the name and address of the voter. If you do not provide the information required above, then you will be required to provide election officials with either (i) or (ii) described above the first time you vote at a voting place or by absentee ballot.
- If you change your name you must re-register.
- If you register at a public service agency, any information regarding the agency that assisted you will remain confidential as will any decision not to register.
- If you do not receive a Notice within 2 weeks of mailing or delivering this application, call your County Clerk or Board of Election Commissioners.

TO COMPLETE THIS FORM:

- Box 1-If you do not have a middle name, leave blank.
- Box 3-If mailing address is same as Box 2, write "same".
- Box 4-If you have never registered before, leave blank. If you do not remember your former address; provide as much information as possible.
- Box 5-If you have not changed your name, leave blank.
- Box 9-If you have an Illinois Driver's License or Secretary of State ID, check the first box and fill in the number. If you do not have a Driver's License or SOS ID, check the second box and fill in the last four digits of your Social Security Number. If you do not have a SSN, check the third box and send a copy of the appropriate document (as described in the "Important Information" section) along with this form.
- 10-Read, date and personally sign your name or make your mark in the box.

IF YOU HAVE NO STREET ADDRESS,

below describe your home: list the name of subdivision; cross streets; roads; landmarks; mileage and/or neighbors names.



If you have questions about completing this form, please call the State Board of Elections at (217)782-4141 or (312)814-6440 (or webmaster@elections.il.gov).

TYPE OR PRINT CLEARLY IN BLACK OR BLUE INK

Are you a citizen of the United States of America? (check one) ◯ Yes ◯ No

Will you be 18 years of age on or before election day? (check one) ◯ Yes ◯ No

If you checked "no" in response to either of these questions, then do not complete this form.

Office Use

You can use this form to: (Check One) ◯ apply to register to vote in Illinois ◯ change your address ◯ change your name

1. Last Name | First Name | Middle Name or Initial | Suffix (Jr. Sr. II III IV)

2. Address where you live (House No., Street Name, Apt. No.) | City/Village/Town | Zip Code | County | Township

3. Mailing address (P.O Box) | City/Village/Town, State | Zip Code

4. Former Registration Address: (include City and State and Zip Code) | Former County

5. Former Name: (if changed)

6. Date of Birth: MM/DD/YY

7. Sex (check one) ◯ Male ◯ Female

8. Home telephone number including area code (optional)

9. ID number - check the applicable box and provide the appropriate number
   - ☐ IL Driver's License or, if none, Sec. of State ID or
   - ☐ Last 4 digits of Social Security Number
   - ☐ I have none of the above-listed identification numbers.

10. Voter affidavit - Read all statements and sign within the box to the right. This is my signature or mark in the space below.

I swear or affirm that

- I am a citizen of the United States;
- I will be at least 18 years old on or before the next election;
- I will have lived in the State of Illinois and in my election precinct at least 30 days as of the date of the next election
- The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, then I may be fined, imprisoned, or if I am not a U.S. citizen, deported from or refused entry into the United States.

Today's Date: _____

11. If you cannot sign your name, ask the person who helped you fill in this form to print their name, address and telephone number.

Name of person assisting. | Full Address | Telephone No.

YOUR ADDRESS

PUT FIRST CLASS STAMP HERE

MAIL TO:

CHANGE OF ADDRESS

PCT	WARD	CODE	ADDRESS	CITY	ZIP	COUNTY	DATE	CLERK

SUSPENSION, CANCELLATION AND REINSTATEMENT

DATE	EXPLAIN	CLERK	DATE	EXPLAIN	CLERK

To Election Judges	Voting Record	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
For Primary, mark	Primary																			
D for Democrat	General																			
R for Republican	NonPartisan																			
for all other elections markV	Special																			