State of Illinois
Department of Human Services

3 (PERMANENT)

VERIFICATION OF PREGNANCY

Date: _____

9d035824-22e3-43da-8ada-2bf4db8b88fd

Case Number: _____

Office Name: _____

Office Address: _____

_____

Phone: _____

TTY: _____

Fax: _____

NAME: _____
ADDRESS: _____
ADDRESS: _____
CITY, ST. ZIP _____

Tenemos este aviso en español. Para solicitar avisos en español, por Internet vaya al sitio ABE-MMC o llame al 1-800-843-6154 (TTY 1-866-324-5553 TTY/ Nextalk, 711 TTY Relay).

You can manage your account online at abe.illinois.gov

_____ has applied for assistance based on her pregnancy. Please examine her and determine if she is pregnant. Client Date of Birth _____

Is she pregnant? ☐ YES ☐ NO

If YES, please provide the following information which will be used in determining her eligibility for assistance.

Expected date of delivery _____

If a multiple birth is anticipated, please indicate the number of potential births _____ .

_____ _____ _____
Signature Title Date

I consent to have the information requested on this form released to the Department of Human Services.

_____
Applicant's signature

_____ _____
Witness Date

Please return this form to the Local Office named above.