State of Illinois
Department of Human Services

PROOF OF RECEIPT OF PROGRAM BENEFITS

Date: _____

Case Number: _____

Case Name: _____

Address: _____

City, ST., ZIP: _____

TO WHOM IT MAY CONCERN:

The following persons are currently receiving certain (means-tested) benefits administered by the Illinois Department of Human Services. Receipt of a (means-tested) benefit is indicated with a (Yes) or (No) for each person listed and shown with the program type, the current benefit receipt month, the date benefits were approved, and the date benefits will end or must be renewed.

NAME OF PERSON RECEIVING BENEFITS	TYPE OF BENEFITS RECEIVING				CURRENT BENEFIT RECEIPT MONTH	DATE BENEFIT APPROVED	DATE BENEFIT ENDS OR MUST BE RENEWED
	Medicaid Only	*Supplemental Nutrition Assistance Program (SNAP)*	*Temporary Assistance to Needy Families (TANF-Cash/ Medical)*	*Aid to the Aged, Blind, and Disabled (AABD-Cash/ Medical)*			

_____
IDHS Employee (Printed Name)

_____
Name of FCRC

_____ _____
Address City, ST., ZIP

_____ _____
IDHS Employee (Signature) Date