



# 2011 Schedule B Qualified Additional Resident (QAR)

Attach to claimant's Form IL-1363. (A separate Schedule B must be completed for each QAR.)

## Who is a qualified additional resident?

A qualified additional resident is an individual, other than your spouse,

- who lived with you in the **same residence** in 2011 **and** in 2012 at the time you file your 2011 Form IL-1363; and
- for whom you, or you and your spouse, provided **more than half** of that person's total financial support in 2011; and
- who is not filing a separate 2011 Form IL-1363.

## STEP 1: Tell us about your qualified additional resident. Please print.

1 Social Security number

2 Name  First  MI  Last

3 Birth date          
Month Day Year

Attach proof of age (first-time filer).

4 Check if requesting Illinois Cares Rx drug coverage.

If the person listed in Line 2 is younger than 65 years of age and the box in Line 4 is checked, attach proof of disability.

## For your QAR's Illinois Cares Rx benefits. (See instructions)

5 Is your QAR a  U.S. citizen or  qualified noncitizen?

**Note** Your QAR may still qualify for Illinois Cares Rx Basic even if no box is checked above.

6 Illinois Cares Rx Benefits. Your QAR can choose help paying for prescriptions.

- a Does your QAR have Medicare? **yes**  **no**
- b Does your QAR have HIV/AIDS? **yes**  **no**

## STEP 2: Claimant sign below.

Under penalties of perjury, I certify that the individual listed in Step 1 is a qualified additional resident for whom I, or my spouse and I, provided more than half of their total financial support in 2011, and that this individual lived with me in the same residence in 2011 and in 2012 at the time I filed my 2011 Form IL-1363.

7  /  /  Date           8 Claimant's Social Security number

## STEP 3: QAR sign below. (Attach proof of authority if someone else signs for you.)

Under penalties of perjury, I state that I have examined this form and, to the best of my knowledge, it is true, correct, and complete. I give the state of Illinois permission to get records from anyone concerning information on this form. As permitted by law, and subject to revocation, I authorize disclosure of the following information to, by, and between the Illinois Department on Aging and the Illinois Department of Healthcare and Family Services for the Circuit Breaker/Illinois Cares Rx Programs: (1) citizenship, identification, and HIV/AIDS status information maintained by the Illinois Department of Public Health; (2) tax return information maintained by the Illinois Department of Revenue and the Internal Revenue Service; (3) citizenship and identification information maintained by the Illinois Secretary of State and the United States Citizenship and Immigration Services (USCIS); and (4) identification information for ride programs offered by mass transit authorities, for the limited purposes of confirming my eligibility for applicable benefits and related outreach enrollment efforts through the end of the appropriate audit period. If resource availability permits, I also authorize the state of Illinois to apply on my behalf for any federal drug benefits I may be eligible to receive under the Medicare program. I assign to the state of Illinois my right to any benefits, including reimbursement, under any private plan of assistance, public assistance program, insurance plan, or from any liable third party, for prescription drugs that I receive through the Illinois Cares Rx program. I also agree that if I receive any such payments or other payments or benefits under the programs on this form in error, or that I was not entitled to, I will repay them to the state of Illinois. I authorize release of medical and pharmaceutical records for audit and verification purposes, and exchange of health care information between any drug utilization review service authorized by the state of Illinois and any of my physicians and pharmacists to the extent necessary for the operation of a drug utilization review service.

9  /  /  Date           10  /  /  Date  
Signature of person named on Line 2 (QAR) Signature of Authorized Representative for the QAR (If younger than 18, see instructions.)

# Line-by-line instructions for Schedule B

Complete this schedule if you (the claimant) are reporting any Qualified Additional Residents (QAR) on Form IL-1363. Your spouse (spouse includes parties to a civil union) is not a qualified additional resident and should not be listed on this schedule. A separate Schedule B must be completed for each Qualified Additional Resident (QAR).

## STEP 1: Tell us about your qualified additional resident.

**1 Social Security number.** Write the Social Security number of your qualified additional resident. Your qualified additional resident must have his or her own Social Security number. It cannot be the same as yours.

**2 Name.** Print your qualified additional resident's first name, middle initial, and last name.

**3 Birth date.** Write the month, day, and year of your qualified additional resident's birth.



**Attach proof of age (first-time filer)**

**4 Check** if requesting Illinois Cares Rx drug coverage.

Check the box if your qualified additional resident is applying for Illinois Cares Rx drug coverage.

To be eligible for Illinois Cares Rx, your qualified additional resident must:

- be age 65 or older before January 1, 2012; or
- become age 65 during 2012; or
- be age 16 or older before January 1, 2012, and totally disabled; and



**If the person listed in Line 2 is younger than 65 years of age and the box in Line 4 is checked, attach proof of disability.**

**5** Check the first box if your QAR is a U.S. citizen. Check the second box if the QAR is a qualified noncitizen.

**6** Your QAR can choose help paying for prescriptions.

**a** Mark "yes" if your QAR is currently eligible for Medicare Part A and/or Part B. If the QAR is not eligible for Medicare, mark "no" and go to Line 7.

**b** Mark the appropriate circle for the QAR. The answer will be kept confidential. You may qualify for additional assistance if you have Medicare.

## STEP 2: Claimant sign below.

**7** You, the claimant (the person named on Line 2 of Form IL-1363), must sign this schedule.

**8** Write your Social Security number (same as Line 1 on Form IL-1363).

## STEP 3: QAR signature line

**9** Signature of person named on Line 2 (QAR). If the QAR is under 18 years of age or unable to sign, a parent or legal representative must sign the QAR's name.

**10** If the QAR is under 18 years of age, the QAR's parent or legal representative must sign and indicate the relationship to the QAR such as Mother, Father, Guardian.



**If you are signing as a legal representative for the QAR, you must attach proof of your authorized representation for signature.**

## Mailing:

If returning the completed Schedule A **separate** from your Form IL-1363, mail to:

Illinois Department on Aging

P.O. Box 19003

Springfield Illinois 62794-9003.

Schedule B Instructions (IL-1363)  
(R-12/11) IOCI 0853-11

This form is authorized as outlined by the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act. Disclosure of this information is REQUIRED. Failure to provide information could delay your grant and/or prescription coverage. IL-402-1095