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State of Illinois
Illinois Department of Healthcare and Family Services

iHW ILLINOIS HEALTHY WOMEN

Application for Illinois Healthy Women

Family Planning (Birth Control) Services

Whether to use birth control is each woman's personal decision. Women who qualify under Illinois Healthy Women can get free birth control of their choice and related reproductive healthcare to help them plan their families. When pregnancy is planned, babies and their moms are often healthier.

This application is only for women who want birth control.

Illinois Healthy Women is a family planning healthcare program for women ages 19 - 44. Illinois Healthy Women only covers family planning services (birth control, including natural methods). You cannot qualify if you are pregnant, if you had your tubes tied or you had a hysterectomy.

You can find out more about Illinois Healthy Women at **www.illinoishealthywomen.com** or by calling **1-800-226-0768**. The call is free.

If you are pregnant, do not continue completing this application. You can apply for Moms & Babies online at **www.allkids.com** or call **1-866-All-Kids (1-866-255-5437)**. The call is free.

If you use a TTY, call **1-877-204-1012** for information about Illinois Healthy Women or Moms & Babies. The call is free.

If you need help completing this application, visit www.illinoishealthywomen.com or call 1-800-226-0768. If you use a TTY, call 1-877-204-1012. The call is free.

Please print in ink. If you need more space for any answer, use an extra sheet of paper.

1. Tell us about yourself.

Name ____
Last First

Mailing Address ______________________________ **Apt. #** __________

City ____________________ **State** _____ **Zip** _________ **County you live in:** __________

Birth date ___ ___/___ ___/___ ___ ___ ___ (m m/ d d/ y y y y) **Social Security Number** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

- If you do not have a Social Security number, you must send a signed statement from the Social Security Administration that you have applied for one.

Phones: (_______) ____________________ (_______) ____________________
Home Work

(_______) ____________________ (_______) ____________________
Cell Another phone where you can be reached

What language do you use the most? ☐ English ☐ Spanish ☐ Other (Specify) ______________

2. You can help by telling us your ethnic group and race, but you do not have to tell us.

(Mark all that apply.)

Are you of Hispanic or Latino origin? ☐ Yes ☐ No

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown

3. Are you a U.S. citizen? ☐ Yes ☐ No

If yes, tell us where you were born: ______________________________
City State

- **If yes,** provide one of the following documents:
  - U.S. Passport
  - Certificate of Naturalization (N-550 or N-570)
  - Certificate of U.S. Citizenship (N-560 or N-561)

If you do not have one of the above documents, you need to provide one document from EACH list below.

Papers that show place of birth:
- Certified copy of a birth certificate from the state or county where the person was born
- Final Adoption Decree
- Official military record that shows a place of birth
- Papers showing the person was employed by the U.S. government before 1976

ID card with photo or other information that identifies the person:
- Driver's license
- State issued ID card
- School ID
- U.S. military ID
- U.S. military dependent card
- Other government ID (city, county or U.S. state issued)

Read page 6 for more information on how to get your birth certificate.

If you are not a U.S. citizen, enter your Alien Registration Number: ______________________________

- Send a copy of one of the items listed below as proof of the Alien Registration Number.
  - Alien Registration Receipt Card, Permanent Resident Card or Green Card
  - Passport with the following stamps or attachments: Arrival-Departure Record (I-94) including the stamp showing status, Resident Alien Form (I-551) or Temporary Resident Card (I-688)
  - A court-ordered notice for asylees
  - Other proof of lawful immigration status

NOTE: Proof of U.S. citizenship and identity or legal immigration status is only needed for the woman who is applying for this program.

4. Are you pregnant now? ☐ Yes ☐ No

If yes, you are not eligible for Illinois Healthy Women. You may qualify for Moms & Babies. Apply online at www.allkids.com or by calling 1-866-255-5437. If you use a TTY, call 1-877-204-1012. The call is free.

5. How many people live with you? ________ (Include only your husband and your children and stepchildren 18 years or younger, but not yourself.)

List their names, dates of birth and relationship to you. (Use a blank piece of paper if you need more room.)

Name:	Date of Birth (mm/dd/yyyy):	Relationship:

6. a. Are you employed? ☐ Yes ☐ No

If yes, what is your pay each pay period before taxes (including tips)? $ ____________

How often are you paid? ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ monthly

b. If you are married, is your husband employed? ☐ Yes ☐ No ☐ Not married ☐ Not living together

If yes, what is your husband's pay each pay period before taxes (include tips)? $ ____________

How often is he paid? ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ monthly

- If the answer to 6a or 6b is "yes," send a copy of one pay stub (including tips) received in the last 30 days from each job for each person. If anyone is self-employed, provide 30 days of detailed business records that include income and expenses.

7. Do you or your husband (if you are married and he is living with you) receive money from any other source — such as Social Security, spousal support, rental property, unemployment benefits, pensions, trusts? ☐ Yes ☐ No

If yes, complete the following.

- Send proof of one payment received in the last 30 days for each source of income you list.

Name: ____________ Source: ____________

Payment amount: $ ____________ How often paid: ____________

If this is rental property income, does the person receiving the income manage the property? ☐ Yes ☐ No

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8. Do you or your husband (if you are married and he is living with you) pay child or spousal support?

☐ Yes ☐ No **If yes,** how much is paid? $ ____________ How often? ____________

- Send proof of one payment made in the last 30 days.

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☐ Yes ☐ No **If yes,** how much is paid? $ ________ How often? ________

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9. Do you or your husband (if you are married and he is living with you) pay for child care in order to work? ☐ Yes ☐ No **If yes,** complete the following for each child for whom child care is paid:

Name of child in child care: ____________________ Name of care giver: ____________________

Payment amount: $ __________ How often paid __________ Relationship of care giver to child (if any): __________

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Payment amount: $ __________ How often paid __________ Relationship of care giver to child (if any): __________

(Use a blank piece of paper if you need more room.)

10. Do you have other health insurance coverage for birth control? ☐ Yes ☐ No

If yes, please provide the following:

Policyholder's Name ____________________ Policyholder's Social Security No. ___ ___ ___ - ___ ___ - ___ ___ ___ ___ (Optional)

Insurance Company ____________________ Policy No. __________

11. If you are married, please provide the following information even if your husband is not living with you. You can help us by answering, but you do not have to tell us.

Husband's Name ____________________ Social Security No. ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Husband's Employer (if employed) ____________________ ☐ Full-time ☐ Part-time

Read and Sign

- We will keep what you tell us private as required by law.
- I know that this application is limited to family planning/birth control services for women ages 19 - 44.
- I need family planning services.
- I know that if I want full medical benefits, cash or food stamps, I must file a different application.
- I agree to report any change of my address within 10 days of the change.
- Be sure to answer the questions correctly. We may check all information on this form. You must help us if we ask you to prove that your information is right.
- I know that anyone who knowingly misuses the Illinois Healthy Women card may be committing a crime.
- I know that I could be penalized if I knowingly give false information.

I declare under penalty of perjury that I have read all statements on this form and the information I give is true, correct and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information.

Applicant's Signature ____________________ Date __________
(Make a mark and have another adult sign next to your mark if you cannot sign your name.)

If you completed this application on behalf of the applicant, sign and complete the following:

Signature ____________________ Date __________ Phone (_____) __________

Name (print) ____________________ Relationship to Applicant __________