

State of Illinois
Department of Children and Family Services

FIRST NOTICE

FINAL NOTICE

Date: _____

Child's Name: _____

Child's ID #: _____

In order for the Department to certify your child's status for continued Medicaid eligibility, you must complete the enclosed Medicaid Information Form and return it to the address listed below within 30 days of the date specified above. Failure to do so may result in suspension of the child's Medicaid card.

If "Final Notice" is checked above, please return the enclosed Medicaid Information Form immediately as failure to do so will result in suspension of the child's Medicaid card.

If you have any questions or need help in the completion of the Medicaid Information Form, please contact your subsidy worker.

Return the Medicaid Information Form and any supporting documentation to:

Enclosure: Medicaid Information Form