



INDIVIDUAL CARE GRANT (ICG)

APPLICATION PACKET

Updated: September 2016

Individual Care Grant (ICG) Application

The Individual Care Grant (ICG) is a program managed by the Illinois Department of Healthcare and Family Services (HFS). ICG provides access to mental health services and supports for children with severe mental illness. Questions regarding the ICG program may be directed to HFS via phone (217-557-1000) or email (HFS.CBH@illinois.gov).

Eligibility Criteria: Children may be eligible for the ICG program if:

- The parent/guardian is a resident of the State of Illinois.
- The complete application packet is submitted before the child reaches the age of 17 years and six months.
- The child is not under the guardianship of a State agency or in the legal custody of a State agency.
- The child is enrolled in an Illinois State Board of Education (ISBE) approved educational setting at the elementary/high school level at the time of application.
- The parent/guardian agrees to participate fully in the child's treatment.
- The child has a severe mental illness.
- The child has previously received an appropriate trial of inpatient, outpatient and/or community-based treatment efforts.
- The child demonstrates a clinical need for subsequent services.

Application Submission: The ICG application will be considered complete once all of the documentation listed in the ICG Application Checklist (page 3) is gathered and submitted to HFS for review. ICG Applications may be submitted to HFS via email (HFS.CBH@illinois.gov) or fax (217-782-5672) using the subject line "ICG Application for Review." Applications may also be mailed to the following address:

Illinois Department of Healthcare and Family Services
Attn: Children's Behavioral Health Unit
Bloom Building, 3rd Floor
201 S. Grand Avenue East
Springfield, IL 62763

Families are strongly encouraged to submit ICG applications through the ICG Coordinator at the child's local Screening Assessment and Support Services (SASS) agency who is trained to facilitate this application process. A list of SASS agencies can be found on the [HFS SASS Provider webpage](#).

A determination of the child's eligibility for the ICG program will be made within 30 days of submission for all completed applications. The eligibility determination will be communicated to the parent/guardian within 5 days after the determination is made.

ICG Application Checklist

ICG applications are considered complete when the required documentation below has been submitted and the parent/guardian has signed the final page of the application form, attesting that the parent/guardian has reviewed the entire application and consents to submission to HFS for the purpose of determining eligibility for the ICG program.

1. Completed application checklist (this page).
2. Completed ICG application form, including each of the following components:
 - Section 1, General Information (p. 4).
 - Section 2, Family Financial Information (p. 5), including:
 - Copy of the parent/guardian's tax returns for the last calendar year, if filed.
 - Copy of the child's tax returns for the last calendar year, if filed.
 - Section 3, Child's Behavioral Health Treatment History (p. 6-7).
 - This section must cover at least the last 12 months of mental health services, substance use services, and medications the child received.
 - Section 4, Request for Eligibility Determination (p. 8), including:
 - Signatures from the parent/guardian and the child (if the child is 12 years of age, or older), as appropriate, verifying they have reviewed the application for accuracy and completion; and,
 - Signature from the child's ICG Coordinator if the ICG Coordinator is submitting the application.
3. Copy of the child's Social Security card.
4. Copy of the child's birth certificate.
5. Court order defining custody and/or non-parental guardianship, if applicable.
6. Psychiatric evaluation dated within 90 days of the submission of the application that includes: a mental status examination, a specific principal diagnosis and all other diagnoses, medications, a treatment summary and recommendations.
7. Psychological evaluation dated within the past 18 months, describing both intellectual and personality functioning.
8. Copy of the child's current Mental Health Assessment, or other documentation, providing a comprehensive social and developmental history from early childhood to present.
9. Proof the child is currently enrolled in an Illinois State Board of Education (ISBE) program at the elementary or high school level, as verified through one of the following types of documentation:
 - A copy of the child's current Individual Education Plan (IEP);
 - A current report card issued within the current school semester; or,
 - A letter from the administrator of the school confirming the child is currently enrolled.
10. (Optional) A completed Childhood Severity of Psychiatric Illness (CSPI) screening tool, dated within 14 days of the submitted application.

ICG APPLICATION FORM

1. GENERAL INFORMATION

Child Name		Medicaid ID #	Social Security #:	Date of Birth		
Age (Years/Months)	Gender	Primary Language	Phone Number <input type="checkbox"/> N/A	Has the child been adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Child's Address		City	State	ZIP Code		
Race		Ethnicity				
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American		<input type="checkbox"/> Hawaiian Native/Other Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> White		<input type="checkbox"/> Multi-Race <input type="checkbox"/> Other: <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		
Child's Marital Status		Child: US Citizen?	Child's Method of Communication			
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> No interpreter services required <input type="checkbox"/> TDD/TYY <input type="checkbox"/> American Sign Language <input type="checkbox"/> Spoken Language: _____ <input type="checkbox"/> Other: _____			
Parent/ Guardian Information	Name	Relationship to Child:		Phone Number		
	Address	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other		_____		
		City	State	Zip Code		
				County		
Parent/ Guardian Information	Name	Relationship to Child:		Phone Number		
	Address	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other		_____		
		City	State	Zip Code		
				County		
Emergency Contact Information	Name	Relationship to Child		Phone Number		
	Address	_____		_____		
		City	State	Zip Code		
Residential Arrangement	<input type="checkbox"/> Homeless <input type="checkbox"/> Independent Living <input type="checkbox"/> Lives with parent(s), relative(s), or guardian(s) <input type="checkbox"/> State operated facility (mental health/dev. disability) <input type="checkbox"/> Jail or correctional facility		<input type="checkbox"/> Residential/Institutional Setting (residential treatment center, nursing home) <input type="checkbox"/> Foster Care <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown			
			Household Size			

Education Level (last completed)	<input type="checkbox"/> Never attended school	<input type="checkbox"/> Grade 2	<input type="checkbox"/> Grade 5	<input type="checkbox"/> Grade 8	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Preschool/Kindergarten	<input type="checkbox"/> Grade 3	<input type="checkbox"/> Grade 6	<input type="checkbox"/> Grade 9	<input type="checkbox"/> High school diploma	
	<input type="checkbox"/> Grade 1	<input type="checkbox"/> Grade 4	<input type="checkbox"/> Grade 7	<input type="checkbox"/> Grade 10	<input type="checkbox"/> GED certificate	
School Information	Name	General Phone Number		Principal Name		
	_____	_____		_____		
	Principal Phone Number	School Address		City	Zip Code	
	_____	_____		_____	_____	
SASS Provider Information	Agency Name		ICG Coordinator Name		ICG Coordinator Phone	
	_____		_____		_____	
	Agency Address		City	Zip	County	
	_____		_____	_____	_____	

2. FAMILY FINANCIAL INFORMATION

Please complete this section in its entirety, to the best of your ability. Attach additional pages to this application packet as necessary.

Child's Insurance Coverage (list all types of insurance, including Medicaid/All Kids coverage, when applicable)

Name of Insurance Company/Companies _____ **Policy Number(s)** _____

Premium Costs: \$ _____ Weekly Every two weeks Twice a month Quarterly Yearly

Is this a retiree health plan? Yes No Unknown **Is this a COBRA plan?** Yes No Unknown **Does the plan cover at least 60% of benefit costs?** Yes No Unknown

Please list any properties the parent/guardian or child owns, such as home, vacation home, time share, building or land.

Owner Name	Address	Type	Current Value	Amount Owed

Does the parent/guardian or child own any of the following resources? Check all that apply.

Business Inheritance Savings Account Mineral/Oil Rights Promissory Note/Loan
 Life Estate Funeral/Burial Plan Checking Account Money Market Account Deferred Comp
 Annuity Mutual Funds Certificates of Deposit Trust Funds Government Bonds
 Burial Plot(s) IRA/401K Stocks, Bonds Nursing Home Account Reverse Mortgage
 Other Financial Resources: Please List _____

Owner Name	Type of Resource	Account/Policy #	Current Value	Name of Bank, Company, etc.

Family Income

Child's income for last calendar year: _____ AGI Net **Child's anticipated income for this year:** _____ AGI Net

Child's most recent federal tax return attached No federal return filed on behalf of the child

Parent/guardian(s) income for last calendar year: _____ AGI Net **Parent/guardian(s) anticipated income for this year:** _____ AGI Net

Parent/guardian(s)' most recent federal tax return(s) attached No federal return filed

Please list any public benefits currently received on behalf of the child, not including Medical Assistance (All Kids) or Medicare.

Type	Effective Date	Monthly Benefit Amount	Payee
Social Security			
Supplemental Security Income			
State Cash Assistance (i.e. TANF)			
Adoption Subsidy			
Other: _____			
Other: _____			

Please summarize how the parent/guardian receives its income annually.

Type	Current Amount	Recipients/Payees	Description
Employment			
Investments			
Public Benefits			
Other: _____			

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4. REQUEST FOR ELIGIBILITY DETERMINATION

By signing below, I confirm that:

- I have read all of the information in this application.
- To the best of my knowledge, all of the information in this application is correct.
- I understand that incomplete applications will be returned without being reviewed for eligibility.

(Choose One)

- I have decided to complete this application WITHOUT the assistance of my ICG Coordinator. I am submitting this application and all required supporting documentation to Healthcare and Family Services in order to make a determination of eligibility for the ICG program. I understand that I may withdraw this application at any time by informing HFS.
- I have decided to complete this application with the assistance of my ICG Coordinator and all the following are true:
- My ICG Coordinator has gone over the eligibility criteria on page 2 with me;
 - I have had a chance to ask my ICG Coordinator questions about the ICG program and the application process;
 - I have been informed that I have the right to inspect and copy the information in this application; and
 - I ask that my ICG Coordinator submit this application and all required supporting documentation on my behalf to Healthcare and Family Services in order to make a determination of eligibility for the ICG program.
 - I understand that I may withdraw this application at any time by informing HFS or my ICG Coordinator.

Signatures

Child, if over age 12 (print name)	Signature	Date
Parent/Legal Guardian (print name)	Signature	Date
ICG Coordinator (print name)	Signature	Date

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ITEM # 3

COPY OF THE CHILD'S SOCIAL SECURITY CARD

Section Title Page.

Place this title page in front of the content: Social Security Card

ITEM # 4

COPY OF THE CHILD'S BIRTH CERTIFICATE

Section Title Page.

Place this title page in front of the content: Birth Certificate

ITEM # 5

**COURT ORDER DEFINING CUSTODY AND/OR NON-
PARENTAL GUARDIANSHIP (IF APPLICABLE)**

Section Title Page.

Place this title page in front of the content: Court Order

ITEM # 6

PSYCHIATRIC EVALUATION

Section Title Page.

Place this title page in front of the content: Psychiatric Evaluation

ITEM # 7

PSYCHOLOGICAL EVALUATION

Section Title Page.

Place this title page in front of the content: Psychological Evaluation

ITEM # 8

COMPREHENSIVE SOCIAL AND DEVELOPMENTAL HISTORY

Section Title Page.

Place this title page in front of the content: Social and Developmental History

ITEM # 9

PROOF OF CURRENT SCHOOL ENROLLMENT

Section Title Page.

Place this title page in front of the content: Proof of Current School Enrollment

ITEM # 10

(OPTIONAL) COPY OF A COMPLETED CSPI

Section Title Page.

Place this title page in front of the content: Completed CSPI