W-1ER (Rev. 6/14)

State Of Connecticut
Department Of Social Services
Renewal Of Eligibility

Head Of Household
Client ID Number
_____

This renewal form is only for current DSS clients who get one or more of the following:

- Supplemental Nutritional Assistance Program (SNAP)
- Cash Assistance (including boarding home payments)
- Medical Insurance (HUSKY) **only** if you are:
  - (1) 65 years old or older;
  - (2) on Medicare;
  - (3) determined disabled by DSS and are working;
    or
  - (4) receiving Long-Term Care

If you get HUSKY and you are not in one of these four groups then you cannot renew with this form. You must renew online at www.CONNECT.ct.gov or by phone with our partner Access Health CT at (855) 805-4325. You can also call (855) 805-4325 and ask for a paper form. Renewing online is fastest.

This form is only to renew eligibility for the benefits you get now or to add new members of your household. You must fill out the form and sign and date page 6 for it to be complete.

Call us if you need help filling out this form or getting proof: (855) 626-6632. To apply for help that you do not get now, apply online at www.CONNECT.ct.gov. You can also ask us to mail you a paper application.

Do you need a reasonable accommodation or extra help getting benefits because of a disability or impairment? ☐Y ☐N. If yes, what kind of assistance do you need? _____

_____

Section 1: Head Of Household (you)

First Name	Middle Name	Last Name	(Maiden Name)	Best Phone #	Other Phone #

Home Street Address	City	State	Zip Code

Mailing Address (If Different)	City	State	Zip Code

Section 2: Household Members

- List members of your household starting with you.
- If you want to add a person to your household, list them here and in Section 4.

Name (First, Middle, Last)	Date of Birth	How Related to You	Gender (M or F)	Marital Status*	Buy/cook food with you?	Renew or Add household member
1 Myself		Self				☐Renew ☐Add
2					☐Y ☐N	☐Renew ☐Add
3					☐Y ☐N	☐Renew ☐Add
4					☐Y ☐N	☐Renew ☐Add
5					☐Y ☐N	☐Renew ☐Add
6					☐Y ☐N	☐Renew ☐Add

*Marital Status: N = never married M = married D = divorced S = separated W = widowed

Section 3: Other People Living With You

- List anyone else who lives with you but is not applying for help.

Name (First, Middle, Last)	Relationship to You	Does this person (check all that apply):		Total they pay you
		☐Share expenses ☐Buy/cook food with you	☐Pay for room and meals ☐Pay for room only	$
		☐Share expenses ☐Buy/cook food with you	☐Pay for room and meals ☐Pay for room only	$

Section 4: New Household Members

- Use this section to add new members to your household.
- Providing optional race and ethnicity data will not affect eligibility or benefit amount – it will only be used to make sure that everyone has the same access to benefits. Check all that apply.

1 First Name | Middle Name | Last Name | (Maiden Name) | Social Security #

U.S. citizen? ☐Y ☐N *If no*, date entered U.S.: | I-94 #

Member or spouse ever serve in armed forces? ☐Y ☐N | Last grade completed in school:

Racial Heritage (*Optional*): ☐White ☐Black or African American ☐American Indian or Alaska Native ☐Hispanic or Latino/a ☐Asian Indian ☐Chinese ☐Filipino ☐Japanese ☐Korean ☐Vietnamese ☐Other Asian ☐Native Hawaiian ☐Samoan ☐Guamanian or Chamorro ☐Other Pacific Islander

Ethnicity if Hispanic or Latino/a (*Optional*): ☐Mexican ☐Mexican-American ☐Chicano/a ☐Cuban ☐Puerto Rican ☐Other Hispanic, Latino/a or Spanish

2 First Name | Middle Name | Last Name | (Maiden Name) | Social Security #

U.S. citizen? ☐Y ☐N *If no*, date entered U.S.: | I-94 #

Member or spouse ever serve in armed forces? ☐Y ☐N | Last grade completed in school:

Racial Heritage (*Optional*): ☐White ☐Black or African American ☐American Indian or Alaska Native ☐Hispanic or Latino/a ☐Asian Indian ☐Chinese ☐Filipino ☐Japanese ☐Korean ☐Vietnamese ☐Other Asian ☐Native Hawaiian ☐Samoan ☐Guamanian or Chamorro ☐Other Pacific Islander

Ethnicity if Hispanic or Latino/a (*Optional*): ☐Mexican ☐Mexican-American ☐Chicano/a ☐Cuban ☐Puerto Rican ☐Other Hispanic, Latino/a or Spanish

3 First Name | Middle Name | Last Name | (Maiden Name) | Social Security #

U.S. citizen? ☐Y ☐N *If no*, date entered U.S.: | I-94 #

Member or spouse ever serve in armed forces? ☐Y ☐N | Last grade completed in school:

Racial Heritage (*Optional*): ☐White ☐Black or African American ☐American Indian or Alaska Native ☐Hispanic or Latino/a ☐Asian Indian ☐Chinese ☐Filipino ☐Japanese ☐Korean ☐Vietnamese ☐Other Asian ☐Native Hawaiian ☐Samoan ☐Guamanian or Chamorro ☐Other Pacific Islander

Ethnicity if Hispanic or Latino/a (*Optional*): ☐Mexican ☐Mexican-American ☐Chicano/a ☐Cuban ☐Puerto Rican ☐Other Hispanic, Latino/a or Spanish

Section 5: Students In Your Household

- List everyone in your household who goes to school.

Name of person in school	Name of school	Grade	Part-time or Full-time	Graduation Date

Section 6: Felon Status

- Tell us about anyone you listed who (1) has been convicted of a felony, (2) is fleeing authorities to avoid going to court or jail for a felony crime, or (3) is violating a condition of parole or probation.

Name	If convicted, crime and date convicted:	Fleeing from authorities? ☐Y ☐N Violating parole/probation? ☐Y ☐N
Name	If convicted, crime and date convicted:	Fleeing from authorities? ☐Y ☐N Violating parole/probation? ☐Y ☐N

Section 7: Earned Income (Attach Proof)

- Tell us about money the people in your household made from working. Include wages, salaries, tips, and commissions from jobs. Include self-employment income such as money you get from your own business or for doing odd jobs or any other work you do for money. Include any income from job-training programs.
- List each job separately.
- If you have no earned income, list the last job held by each person since the last review.
- You must provide proof of your income. Examples of proof are your last 4 weeks of paystubs or, if self-employed, your most recent business records.

1	Name of person working: _____ Is this job self-employment? ☐Y ☐N *If no*, list place of work (name, address and phone #): Start date ___/___/___ End date ___/___/___ If left job: 1. Explain why:_____ 2. Did you apply for Unemployment Benefits? ☐Y ☐N	Gross pay (before deductions): $ _____ every: ☐ Hour ☐ Week ☐ Two Weeks ☐ Twice a month ☐ Month	If paid hourly, hours worked per week: _____ If you get tips, how much each week: $_____
2	Name of person working: _____ Is this job self-employment? ☐Y ☐N *If no*, list place of work (name, address and phone #): Start date ___/___/___ End date ___/___/___ If left job: 1. Explain why:_____ 2. Did you apply for Unemployment Benefits? ☐Y ☐N	Gross pay (before deductions): $ _____ every: ☐ Hour ☐ Week ☐ Two Weeks ☐ Twice a month ☐ Month	If paid hourly, hours worked per week: _____ If you get tips, how much each week: $_____
3	Name of person working: _____ Is this job self-employment? ☐Y ☐N *If no*, list place of work (name, address and phone #): Start date ___/___/___ End date ___/___/___ If left job: 1. Explain why:_____ 2. Did you apply for Unemployment Benefits? ☐Y ☐N	Gross pay (before deductions): $ _____ every: ☐ Hour ☐ Week ☐ Two Weeks ☐ Twice a month ☐ Month	If paid hourly, hours worked per week: _____ If you get tips, how much each week: $_____

Has anyone in your household quit a job in the last 90 days? ☐Y ☐N If yes, who?_____

Why did that person quit? _____ Date of last check _____

Section 8: Other Income (Attach Proof)

- List any money that people in your household get from places other than work.
- Examples of non-work money (also called unearned income): child support, alimony, Social Security benefits, SSI, unemployment compensation, educational loans and grants, VA benefits, pensions, workers compensation, stocks, bonds, annuities, rental property, roomers, boarders, money from friends or relatives, any other source.

Type of Income	Who Gets the Income?	Gross Monthly Amount (before any deductions)
		$
		$
		$
		$
		$

Section 9: Assets (Attach Proof)

- List any assets or resources that people in your household own.
- Assets are things you own or are buying that can be sold, traded, or converted to cash held by others. An asset does not include personal property such as furniture or clothing. Examples of assets:

-Cash	-Trusts / trust funds	-Prepaid funeral contracts	-Life estate / Life use
-Bank accounts	-Stocks / mutual funds	-Houses / Condos / Buildings	-Motor vehicles
-Life insurance	-Bonds / US savings bonds	-Land (including out-of-state)	-Boats / Campers
-Death benefits	-Money market accounts / CDs	-Real estate / property	-Motorcycles
-Annuities	-Retirement accounts	-Limited partnerships	-Other assets

Asset	Who Owns	Location or Account/Policy #	Value
			$
			$
			$
			$
			$
			$

Section 10: Asset Transfers

Has anyone in your household (1) sold, traded, given away, or transferred ownership of any assets since your last review, or (2) had assets transferred through the probate court or surrogate court in any state since your last review? ☐Yes ☐No *If yes to either question, list below.*

Asset Transferred	Transferred To Whom?	Date of Transfer	Value Received
			$
			$

Section 11: Medical Insurance

- Tell us if anyone in your household is covered by medical insurance other than HUSKY. Include information about medical insurance provided to a child by an absent parent.

Insurance Type	Covered Members	Policy or Claim #	Insurance Company	Premium Amount
Medicare A (Hospital)				
Medicare B (Medical)				
Other Hospital / Medical Coverage (such as Tricare, Blue Cross/Blue Shield, union coverage)				
Long-Term Care (pays for nursing home care, adult day care, assisted living care, and is separate from hospital/medical coverage)				

Section 12: Community Spouse (Attach proof of income and expenses)

- Complete this section if you are married and (1) you get long-term care at home but your spouse does not, or (2) if you get long-term care in a facility and your spouse lives in the community.

What is your spouse's gross monthly income (before taxes or deductions)? $ _____ per month
List your spouse's monthly shelter expenses below:

Rent	Mortgage	Condo Fees	Homeowner's Ins.	Fire/Hazard Ins.	Property Tax	Other Fees
$	$	$	$	$	$	$

Section 13: Special Eating Arrangement

- Complete this section only if someone in your household is blind, disabled, or over age 65, and renewing State Supplement cash or HUSKY C medical benefits.

Does anyone in your household eat at least one meal a day at a restaurant? ☐Yes ☐No
Does anyone in your household have a special diet? ☐Yes ☐No *If yes, why?*_____

Section 14: Lawsuits

- List household members who are suing others.

Person With Lawsuit	Attorney's Name And Address

Section 15: Inheritance

- List household members who received an inheritance since your last review.

Name of Recipient	Date of Inheritance	Amount of Inheritance

Section 16: Child Support

- List household members who pay court-ordered child support for children who are not household members.

Person Who Pays	Monthly Payment Owed	Monthly Amount Paid
Person Who Pays	Monthly Payment Owed	Monthly Amount Paid

Section 17: Dependent Care

- Tell us about household costs for day care for a child or adult with a disability.

1	Person Who Gets Daycare	Amount Household Pays $_____ per week	Amount Paid by State or Other Source $_____ per week
	Provider Name, Address And Phone #		
2	Person Who Gets Daycare	Amount Household Pays $_____ per week	Amount Paid By State Or Other Source $_____ per week
	Provider Name, Address And Phone #		
3	Person Who Gets Daycare	Amount Household Pays $_____ per week	Amount Paid By State Or Other Source $_____ per week
	Provider Name, Address And Phone #		

Section 18: Medical Expenses (Attach proof)

- Complete this section if anyone in your household is 60 years old or older, or is a person with an SSI/SSD disability, and has medical expenses such as medical insurance (premiums, deductibles and co-pays), transportation cost for medical appointments or dental bills.

Person With Expense	Type Of Expense	Amount Of Expense
		$
		$
		$

Section 19: Monthly Expenses

- Tell us how much your household pays each month.

Rent	Mortgage	Homeowner's Ins.	Property Tax	Fire/Hazard Ins.	Other Fees
$	$	$	$	$	$

Person or Company You Pay Rent / Mortgage To:

Address and Phone Number of Person or Company You Pay Rent / Mortgage To:

What utilities does your household pay for **separately** from your rent or mortgage? (check all that apply)
☐Heat ☐Cooling ☐Electric (not heat) ☐Gas ☐Water ☐Sewer ☐Garbage ☐Home/Cell Phone

Does another person or agency help you pay for all or part of these expenses? ☐Yes ☐No *If yes:*
What expense? _____ Who pays? _____ How much? $ _____
What expense? _____ Who pays? _____ How much? $ _____
What expense? _____ Who pays? _____ How much? $ _____

How do you heat your home? _____
Did you get a check from the energy assistance program during the past year at your address? ☐Y ☐N
Do you plan to apply for energy assistance this year? ☐Y ☐N

CERTIFICATION AND SIGNATURES

- I have read this form, including the rights and responsibilities provided with this form, or have had it read to me in a language that I understand.
- I understand and certify that I continue to be bound by the rights and responsibilities provided with this form, and as are set forth in law.
- I certify under penalty of perjury that all of the information given on this form is true and complete to the best of my knowledge.
- I certify that I have specific knowledge of the identity of all children for whom I am asking for help on this form and that the information I gave about these children is accurate to the best of my knowledge.
- I certify that I and everyone for whom I am applying for help is either a United States citizen or a non-citizen for whom I have provided true and accurate (correct) information.
- I certify that the information I gave concerning the felon status of members of my household is complete and accurate.
- I understand that I can be criminally or civilly prosecuted under state or federal law if I knowingly give incorrect information or fail to report something I should report.
- I authorize DSS to contact other persons or entities as needed to help prove that I am eligible.
- I authorize DSS to verify any information given on this form.

Any person who helped you complete this form or completed this form for you must also sign.

Applicant's Signature	Date	Other Adult Applicant's Signature	Date
Helper Or Representative's Signature	Date	Relationship To Applicant	
Witness' Signature If Applicant Signed With "X"	Date	Interpreter's Signature	Date

Permission To Share Information

I permit the Department of Social Services to share information about my renewal with the following individuals, agencies or institutions:		
1	Name: Address:	Phone #
2	Name: Address:	Phone #
Signature of Applicant or Authorized Representative		Date

Non-Discrimination Statement:

This institution is prohibited from discriminating on the basis of race, color, national origin, disability age, sex and in some cases religion and political beliefs. The U.S. Department of Agriculture (USDA) also prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination with USDA, complete the USDA Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or by email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish).

For other information dealing with the Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish, or call the State Information/Hotline Numbers available at http:/www.fns.usda.gov/snap/contact_info/hotlines.htm

To file a complaint of discrimination regarding a program receiving federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

USDA and HHS are equal opportunity providers and employers.

You may also file discrimination complaints or request reasonable accommodations as follows:

You have the right to make a discrimination complaint if you think we have taken action against you because of your race, color, religion, sex, gender identity or expression, marital status, age, national origin, ancestry, political beliefs, sexual orientation, intellectual disability, mental disability, learning disability, or physical disability, including, but not limited to, blindness.

An individual with a disability may request and receive a reasonable accommodation or special help from the Department of Social Services when it is necessary to allow the individual to have an equal and meaningful opportunity to participate in programs administered by the Department.

If you asked for an accommodation or special help and we refused to provide it, you may make a complaint to the Department's Affirmative Action Division Director or any of the agencies listed below:

Commissioner of Social Services
Attn: Affirmative Action Division Director/ADA Coordinator

25 Sigourney Street, Hartford, CT 06106-5033
Ph: 1-860-424-5040 Toll free: 1-800-842-1508
TDD: 1-800-842-4524 Fax: 1-860-424-4948

Connecticut Commission on Human Rights and Opportunities
25 Sigourney Street, Hartford, CT 06106

Ph: 1-860-541-3400 Toll free: 1-800-477-5737
TDD: 1-860-541-3459 Fax: 1-860-246-5265
Web: http://www.ct.gov/chro/site/default.asp

U.S. Dept. of Health and Human Services
Office for Civil Rights

JFK Federal Building, Room 1875, Boston, MA 02203
Ph: 1-617-565-1340 Toll free: 1-800-368-1019
TDD: 1-800-537-7697 Fax: 1-617-565-3809
Web: http://www.hhs.gov/ocr/office/file/index.html

DO YOU WANT TO REGISTER TO VOTE?

Federal and State laws require the Department of Social Services (DSS) to give you the chance to register to vote. Please answer the questions below and print and sign your name in the space provided.

- Are you registered to vote? ☐ Yes, I am already registered ☐ No
- If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

You can register online at https://voterregistration.ct.gov/OLVR, or you can complete a paper voter registration application form and leave it at DSS or mail it in. The form is included with DSS applications and renewals that we mail to you, and you can also get one at all DSS offices. You can mail your completed form to DSS in the enclosed envelope or send it directly to your Town Hall. If you need help, please call 1-855-626-6632.

Print Your Name	Sign Here	Date

Your Address (#, Street, Apt #)	City	State	Zip Code

For DSS Worker's Use Only

Date _____ ☐ No boxes checked ☐ Voter Registration Card Sent

Worker Name_____ Worker Number_____

(Tear Here and Keep)

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preferences, you may file a complaint with: State Elections Enforcement Commission, 20 Trinity Street, Hartford, CT 06106; 860-256-2940, toll-free 866-733-2463, TDD: 1-800-842-9710; or online at SEEC@ct.gov