Premium Assistance Contributions

Allied Community Resources Or Sunset Shores

PO Box 479 67 Bridgeport Avenue

East Windsor, CT 06088 Milford, CT 06460-3931

Email: [ACR@alliedgroup.org](mailto:ACR@alliedgroup.org)  Email:[PremiumAssistance@sunsetshoresfi.com](mailto:PremiumAssistance@sunsetshoresfi.com)

Department of Social Services (DSS) Or Department of Developmental Services (DDS)

**APPLICATION SUBMISSION INSTRUCTIONS**

**ALLIED**: ***Electronic / Fillable Form Submission* SUNSET SHORES: Hard copy (faxed or emailed)**  
Complete the application online & upload the denial letter Complete hard copy and fax/email with denial letter

[https://form.jotform.com/223605680164050](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fform.jotform.com%2F223605680164050&data=05%7C01%7CDenise.Paladino%40ct.gov%7Cb81dea6b522e40d2ee5508daf03a2e2d%7C118b7cfaa3dd48b9b02631ff69bb738b%7C0%7C0%7C638086429910970211%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=DZ%2Fp55v4IBrA5il5PEdva0q5wxFeY%2FKmIu4y%2FA3rtWA%3D&reserved=0) Email: [PremiumAssistance@sunsetshoresfi.com](mailto:PremiumAssistance@sunsetshoresfi.com)

Toll free fax 1-866-380-0149

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| --- | --- | --- |
| **Employee Name** | **Employer of Record Name** | **Date** |
|  |  |  |
| **Employee Phone Number** | **Employer of Record Phone Number** |  |
|  |  |  |
| **Employee Email Address** | **Consumer Name**  **(if different than Employer of Record)** |  |

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| --- |
| I certify the FOLLOWING:  I have been employed for a full 6 months and earned a wage under the consumer-employer indicated above.  I am employed and have “actively worked” defined as: receive a wage or is an identified support on a care plan/individual plan under the consumer-employer indicated above.  I currently do not have medical coverage options through any other entity, for example, through another job or through a spouse and have attached the required attestation form.  I attached proof of documentation that I have applied for and been denied coverage through both [Medicaid](https://portal.ct.gov/HUSKY/How-to-Qualify) (Husky) and [Covered](https://www.accesshealthct.com/3-things-every-resident-should-know-about-the-new-covered-connecticut-program/) CT I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , am self-attesting that I am not currently enrolled or eligible for enrollment in health insurance coverage under my spouse and or any other employment source.  I understand that this self-attestation is required for access to the Collective bargaining Agreement (CBA) Article 13A, Premium Assistance Contribution. The Premium Assistance Contribution benefit will provide up to a maximum of $5000 and is calculated at 6% of my total wages earned over the previous 6 months of active employment per each individual consumer-employer. If I have not worked a full 6 months, then I will not be eligible until a full six (6) months have been worked. I hereby certify that the statements I have attested to above are true and accurate |

**Employee Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

THIS SECTION COMPLETED BY FI  
Was proof of denial for Medicaid (Husky) and Covered CT provided with application? Y \_ N \_  
  
Has the employee been actively employed by the individual consumer-employer for 6 months? Y\_ N\_

Name of Fiscal Intermediary Employee Recording Information and Certification from Employee Requesting Premium Assistance

FI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_