W-1LINST
(New. 07/22)

State of Connecticut
Department of Social Services

W-1LTSS Application for Long-Term Services and Supports

Apply Faster Online!

Visit www.connect.ct.gov instead of using this form.

Use this form to apply for care in a facility, for community homecare, or room and board payment for a residential care home/rated housing.

Read the instructions on the following pages and complete the form as directed.

Persons who are deaf or hard of hearing and have a TDD/TTY device can contact DSS at 1-800-842-4524.
Persons who are blind or visually impaired can contact DSS at 1-860-424-5040.

ATTENTION!
If you speak another language, language assistance services, free of charge, are available to you.
Call 1-855-626-6632 or TTY: 1-800-842-4524.

Spanish (Español):

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-855-626-6632 (TTY: 1-800-842-4524).

Chinese (繁體中文):

注意：如果蕑使用繁體中文，蕑可以免費獲得語言援助服務。
請致電 1-855-626-6632 (TTY: 1-800-842-4524)。

Vietnamese (Tiếng Việt):

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-855-626-6632 (TTY: 1-800-842-4524).

Korean (한국어):

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-626-6632
(TTY: 1-800-842-4524) 번으로 전화해 주십시오.

Tagalog (Filipino):

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa 1-855-626-6632 (TTY: 1-800-842-4524).

Russian (Русский):

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-855-626-6632 (телетайп: 1-800-842-4524).

Creole (Kreyòl Ayisyen):

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.
Rele 1-855-626-6632 (TTY: 1-800-842-4524).

Hindi (िहदी):
ध्यान दंः यिद आप िहदी बोलते हैं तो आपके िलए मुफ्त में भाषा सहायता सवाएं उपलब्ध हैं।
1-800-855-6632 (TTY: 1-800-842-4524) पर कॉल करें।

French (Français):

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-855-626-6632 (TTY: 1-800-842-4524).

Polish (Polski):

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.
Zadzwoń pod numer 1-855-626-6632 (TTY: 1-800-842-4524).

Portuguese (Português):

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Ligue para 1-855-626-6632 (TTY: 1-800-842-4524).

Italian (Italiano):

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.
Chiamare il numero 1-855-626-6632 (TTY: 1-800-842-4524).

Albanian (Shqip):

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.
Telefononi në 1-855-626-6632 (TTY: 1-800-842-4524).

Greek (ελληνικά):

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν.
Καλέστε 1-855-626-6632 (TTY: 1-800-842-4524).

Arabic (العربية):

ةظوحلم: اذإ تنك تدجتت ركذا ةغللا، نإف تامدخ ةدعاسلا ةيوغللا رفاوتت لك ناجلاب. لصتا مقرب 1-855-626-6632
(مقر فتاهلا مصلا مكبلاو: 1-800-842-4524)

Do not return these instruction pages with your application form. Keep for your records or recycle.

Apply Faster Online

Apply faster online at **connect.ct.gov.** We will get your application sooner. If you apply online, any supporting documents or proofs must still be mailed to the office handling your application. See the "**Do you have your proof documents?**" and "**What happens next?**" sections for more details.

What can I apply for using this application form?

Help with paying for care in a nursing or chronic disease facility, community homecare, or room and board payment for a residential care home/rated housing.

When will I know if I am eligible?

We will tell you our decision within 45 days of when you apply as long as all supporting documents and proofs have been provided, except in unusual circumstances. If your eligibility is based on disability, we will make our decision within 90 days from when you apply.

If you do not give us required proof or if you do not ask for more time by the 30th day, then we may deny your application.

Who can use this application form?

You can use this application if you need long-term care services and supports.

What happens next?

Application packets with as much documentation as possible should be mailed directly to the appropriate Long-Term Services and Supports Application Center. If you are applying online, you will still need to send your supporting documents or proofs to the appropriate application center. To determine where to mail your application or supporting documents, please see the "**Where do I send my completed W-1LTSS applications and proofs?**" section in these instructions.

Note: We cannot accept applications by fax or email because of the size and volume of most LTSS applications.

If you are applying for help with paying for care in a nursing or chronic disease facility, mail your application to the appropriate DSS Office by finding your town name in the "**Where do I send my completed W-1LTSS applications and proofs?**" section of the instructions below.

If you are applying for help paying for community home care, mail your application to the Greater Hartford Community Options Applications Unit. You can find the address for the Community Options Applications Unit in the section below.

More information regarding the Long-Term Services and Supports application process can be found at: https://portal.ct.gov/dss/health-and-home-care/long-term-care/long-term-care/apply

Do you have your proof documents?

You may have to provide us with copies of certain proofs (sometimes we call these verifications) for assets, income, expenses and any other information you report to us. As you fill out the application, take note of the documents mentioned as required for each section and send in copies. Providing us proof can help you receive your benefits sooner. You can also bring copies of your proofs in person to a DSS office.

If you do not have copies of all the documents listed below, **DO NOT WAIT TO APPLY**, send us what you have when you apply.

In general, copies of the following documents are needed from you and your spouse to determine if you are eligible for Long-Term Care help from DSS:

Income:
- Quarterly tax returns
- Last four paystubs
- Tax returns for self-employment
- Privately held promissory notes
- Current gross (the amount before taxes or deductions) monthly income from all sources including:
  - Social Security
  - Railroad Retirement
  - VA pensions
  - Private pensions
  - Annuities (a copy of the original annuity contract in addition to the statements)
  - Note: A direct deposit to a bank is not proof of gross income. A copy of the pension stub, 1099 or current letter from the pension company is required.
- Proof of applying for any benefits

Expenses:
- Unpaid medical bills from last 6 months
- Monthly homeowner's insurance premium bill
- Mortgage bills
- Utility bills
- Rent bills
- Property tax bills if not included in your mortgage
- Monthly utility bills
- Receipts for tools or materials required
- Mandatory union dues
- Equipment installation and maintenance bills
- FICA
- Mandatory retirement plan dues

Medical Insurance:
- Private health insurance cards including Medicare (copy of both sides)
- Health insurance premium amounts - copy of the bill or payment coupon
- Long Term Care Insurance Policy
- CT Partnership Service Summary

Assets:
- Trusts and annuities (including appendices, schedules, annual accountings, the trust document, annuity contracts, and amendments for the past 5 years)
- Checking accounts - statements
- Savings accounts - statements
- Stocks - brokerage account statements
- Bonds
- Money market funds - statements
- Certificates of deposit - statements or printouts from bank or financial institution
- Mutual funds, treasury and other notes
- Face and cash value of life insurance policies:
  - Life insurance current annual statement
  - Current letter from the life insurance company
- Retirement, IRA and Keogh account statements
- Burial contracts (irrevocable and revocable)
- Burial plot deeds
- Vehicle Titles
- Vehicle Registrations
- Vehicle Lease

Continued on next page...

Do not return these instruction pages with your application form. Keep for your records or recycle.

Do you have your proof documents? continued

Real Property:
- Reverse mortgage documents or home equity line of credit - monthly/quarterly statements are required for the 60 month look back
- Real estate transactions:
  - Real Estate Closing documents
  - Housing and Urban Development HUD-1 statement
- Quit claim documents:
  - Life use documents

Other Proofs:
- Spouse's death certificate, divorce decree
- Will and probate Inventory, if your spouse died in the past 5 years
- Power of attorney documents (if any)
- Conservator documents, initial inventory and all probate accountings that were submitted in the last 5 years.
- Legal guardianship documents

Federal law requires DSS to review 5 years of bank and financial statements on all accounts owned and co-owned by you and your spouse. DSS does this by reviewing 2 full years of statements from the date of application including the current month and statements for December of the remaining 3 years showing the year to date interest. If you cannot provide the statements for the 3 remaining years you can provide your federal tax returns. You must also provide proofs for any deposits or withdrawals of $5,000.00 or more. DSS has the right to ask for transactions of any amount and copies of all statements within the lookback period if needed.

A 24-month income and asset review is required for residents of rated housing/RCH. You must provide proofs for any deposits or withdrawals of $500 or more.

Send copies of these proofs in along with your application form. Providing us proof can help you receive your benefits sooner. You can also bring them in person to a DSS office.

For help with domestic violence, or to talk to someone, please call the Connecticut Coalition Against Domestic Violence hotline at 1-888-774-2900.

Where do I send my completed W-1LTSS applications and proofs?

If you are applying for Community Home Care (HCBS) only, mail your application here:

Greater Hartford - Community Options Applications Unit
20 Meadow Road
Windsor, CT 06095

If you are applying for help with paying for the cost of your stay at a nursing home, chronic disease facility, residential care home, or other rated housing facility, find your town on the next page and send your application to the listed DSS office.

While you are not required to utilize an attorney, obtaining legal advice prior to completing this application for Long-Term Services and Supports may help protect your finances and rights.

Do not return these instruction pages with your application form. Keep for your records or recycle.

Where do I send my completed W-1LTSS applications and proofs? continued

New Haven Office - LTSS Application Unit
50 Humphrey Street
New Haven, CT 06513

Andover	Ansonia	Ashford	Bethany	Bolton	Bozrah	Branford	Brooklyn	Canterbury
Chaplin	Chester	Clinton	Colchester	Columbia	Coventry	Cromwell	Deep River	Derby
Durham	Eastford	East Haddam	East Hartford	East Hampton	East Haven	East Lyme	East Windsor	Ellington
Enfield	Essex	Franklin	Glastonbury	Griswold	Groton	Guilford	Haddam	Hamden
Hampton	Hebron	Killingly	Killingworth	Lebanon	Ledyard	Lisbon	Lyme	Madison
Manchester	Mansfield	Marlborough	Meriden	Middlefield	Middletown	Milford	Montville	New Haven
New London	North Branford	North Haven	North Stonington	Norwich	Plainfield	Pomfret	Portland	Preston
Putnam	Old Lyme	Old Saybrook	Orange	Salem	Scotland	Seymour	Shelton	Somers
South Windsor	Sprague	Stafford	Sterling	Stonington	Storrs	Tolland	Thompson	Union
Vernon	Voluntown	Wallingford	Waterford	Westbrook	West Haven	Willington	Windham	Woodbridge
				Woodstock				

If you live in one of the above towns, mail your application to the New Haven office.

Bridgeport Office - LTSS Application Unit
925 Housatonic Avenue
Bridgeport, CT 06606

Barkhamsted	Bethel	Bethlehem	Bridgeport	Bridgewater	Brookfield	Canaan	Colebrook	Cornwall
Danbury	Darien	Easton	Fairfield	Goshen	Greenwich	Hartland	Harwinton	Kent
Litchfield	Morris	Monroe	New Canaan	New Fairfield	New Hartford	New Milford	Newtown	Norfolk
North Canaan	Norwalk	Redding	Ridgefield	Roxbury	Salisbury	Sharon	Sherman	Stamford
Stratford	Thomaston	Torrington	Trumbull	Warren	Washington	Weston	Westport	Wilton
				Winchester	Woodbury			

If you live in one of the above towns, mail your application to the Bridgeport office.

Waterbury Office - LTSS Application Unit
249 Thomaston Avenue
Waterbury, CT 06702

Avon	Beacon Falls	Berlin	Bristol	Bloomfield	Burlington	Canton	Cheshire	East Granby
Farmington	Granby	Hartford	Middlebury	Naugatuck	Newington	New Britain	Oxford	Plainville
Plymouth	Prospect	Rocky Hill	Simsbury	Southbury	Southington	Suffield	Waterbury	Watertown
		West Hartford	Wethersfield	Windsor Locks	Windsor	Wolcott		

If you live in one of the above towns, mail your application to the Waterbury office.

Do not return these instruction pages with your application form. Keep for your records or recycle.

W-1LTSS
(Rev. 01/23)

State of Connecticut
Department of Social Services
W-1LTSS Application for Long-Term Services and Supports

Apply Faster Online!

Visit www.connect.ct.gov instead of using this form.

What kind of help are you applying for? Check all that apply.

- ☐ Help with paying for care in a nursing or chronic disease facility
- ☐ Help paying for community homecare
- ☐ Room and Board payment for a Residential Care Home/ Rated Housing

Have you ever stayed in an institution, long-term care facility, or hospital?

☐ Yes ☐ No If yes, please complete the following.	Name and address of facility	Date entered	Date discharged

If you are applying for community homecare, have you worked with any of the following organizations on an assessment or screening of your long-term care needs? Check all that apply.

☐ Not applying for community homecare.

Organization	Types of Programs
☐ Department of Social Services (DSS)	· Connecticut Home Care Program for Elders · Katie Beckett Waiver · Personal Care Attendant (PCA) Waiver · Acquired Brain Injury (ABI) Waivers · Autism Waiver · Money Follows the Person (MFP)
☐ Department of Mental Health and Addiction Services (DMHAS)	· Mental Health Waiver
☐ Department of Developmental Services (DDS)	· Comprehensive Waiver · Individual and Family Supports Waiver · Employment and Day Supports Waiver

☐ None of the Above

If you checked off "None of the Above" on the previous question, and you are requesting care in your home, you will need to complete an assessment with one of these organizations. Please contact one of the following:
Department of Social Services Community Options Unit - 1-800-445-5394
Department of Mental Health and Addiction Services Waiver Unit - 1-866-548-0265
Department of Developmental Services Waiver Unit - 1-866-737-0330
Connecticut Money Follows the Person Program - 1-888-992-8637

Completing a homecare needs assessment with one of these organizations prior to submitting this application may get you help faster.

Person 1 Tell us about the people in your household, starting with yourself.

My name (first, middle, last, suffix)		Legal, maiden or other name (if different)
Client ID (if known)	Case ID (if known)	Social security number
Gender	Preferred spoken language	Do you need an interpreter? ☐ Yes ☐ No
Date of birth	Best phone number	Phone type ☐ Home ☐ Work ☐ Cell

Person 1 continued

☐ Yes ☐ No Do you currently live in a facility?

If no, do you plan to move to a facility? ☐ Yes ☐ No

If you answered yes to either of these questions, what is the name and address of the facility?

☐ If no home address	Home street address	City	State	Zip
Mailing address (if different)	Mailing street address	City	State	Zip

Marital Status

☐ Never married ☐ Married living with spouse ☐ Separated _____ (date of separation) Is this a legal separation? ☐ Yes ☐ No

☐ Married living apart ☐ Divorced _____ (date of divorce) ☐ Widowed _____ (date of death)

Military Status (Check all that apply)

☐ Active duty ☐ Veteran - honorably discharged ☐ Child of deceased veteran ☐ Spouse of deceased veteran ☐ Veteran-other ☐ No military status

Providing race and ethnicity data is optional, does not affect eligibility or benefit amount, and is used to make sure everyone has the same access to benefits.

Ethnicity (optional)

☐ Not of Hispanic origin ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Cuban ☐ Puerto Rican ☐ Other Hispanic, Latino/a or Spanish

Race (optional)

☐ White ☐ Black or African American ☐ Filipino ☐ Vietnamese ☐ Chinese ☐ Asian Indian ☐ Japanese ☐ Korean

☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Other Asian ☐ American Indian or Alaska Native ☐ Samoan ☐ Native Hawaiian

Citizenship Status

☐ US citizen ☐ Permanent resident ☐ Other non-citizen City/state/country of birth

If you are not a US citizen, fill out the following | When did you enter the United States? | I-94 or alien registration # | Immigration status

Do you plan to remain in CT? ☐ Yes ☐ No

Date moved to CT

Do you have a disability or impairment? ☐ Yes ☐ No If yes, explain.

Previous addresses

☐ **Yes** ☐ **No** In addition to the addresses listed above, did you own any real property or have life use of any property in the last 5 years? If yes, please list the addresses below and provide copies of closing papers, deeds, rental agreements, etc.

Address 1	Home street address / City	State / Zip	Address start date / Address end date	Did you (or your spouse) ever own this property? ☐ Yes ☐ No	Did you ever have life use of this property? ☐ Yes ☐ No
Address 2	Home street address / City	State / Zip	Address start date / Address end date	Did you (or your spouse) ever own this property? ☐ Yes ☐ No	Did you ever have life use of this property? ☐ Yes ☐ No
Address 3	Home street address / City	State / Zip	Address start date / Address end date	Did you (or your spouse) ever own this property? ☐ Yes ☐ No	Did you ever have life use of this property? ☐ Yes ☐ No

Authorized Representative. You may appoint other people to help you with your application form and to help you get, use, or keep your benefits. If you want to appoint a person to help you, complete this section. Complete this section if you would like someone else to receive copies of your medical or application information.

☐ **General authorized representative / responsible person** to help me apply for all DSS programs (SNAP, medical, cash) and to assist me with all aspects of the application and eligibility process, which includes reporting changes and getting notices on my behalf. This person knows my circumstances well enough to answer questions and will act in my best interest.

This is a: ☐ Responsible Person ☐ Facility or Organization ☐ Other _____

Name	Phone number	Email

Address (street, city, state, zip)

☐ **Medical Filing Representative.** Just to help me fill out my application form for medical assistance to pay for my medical bill, and/or ask for a hearing if medical assistance is denied.

Name	Phone number	Email

Address (street, city, state, zip)

AGREEMENT OF AUTHORIZED REPRESENTATIVE: As the Authorized Representative, I agree to (1) complete and submit application form and renewal forms; (2) receive copies of notices and other communications from DSS; and (3) act on behalf of the applicant in all matters with DSS. I agree to fulfill all of these - responsibilities to the same extent as the person I represent, and that I may be held responsible for wrong information I give DSS while acting as an authorized representative. I also agree to maintain, or be legally bound to maintain, the confidentiality of any information I get from DSS regarding the person.
I agree to act as the authorized representative until the applicant tells DSS, in writing or verbally, that he or she no longer wants me to do so, or until I tell DSS, in writing or verbally, that I no longer want to act as the authorized representative.

For a provider, staff member or volunteer of an organization (for Medicaid): I affirm that I will follow the regulations in part 431, subpart F of Title 42 of the Code of Federal Regulations (CFR) and at 45 CFR 155.260(f) (relating to confidentiality of information) and 42 CFR 447.10 (relating to the prohibition against reassignment of provider claims), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

Have any authorized representative(s) print their names, sign and date below.

Print full name	Signature	Date

Persons who are deaf or hard of hearing and have a TTD/TTY device can contact DSS at 1-800-842-4524. Persons who are blind or visually impaired can contact DSS at 1-860-424-5040.

Person 2. Tell us about your spouse, even if this spouse does not currently live with you.

Name (first, middle, last, suffix)	Client ID #	
Social security number	Gender	Date of birth

Does this person live with you? ☐ Yes ☐ No If no, explain.

Military Status (Check all that apply): ☐ Active duty ☐ Veteran - honorably discharged ☐ Child of deceased veteran ☐ Spouse of deceased veteran ☐ Veteran-other ☐ No military status

Providing race and ethnicity data is optional, does not affect eligibility or benefit amount, and is used to make sure everyone has the same access to benefits.

Ethnicity (optional): ☐ Not of Hispanic origin ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Cuban ☐ Puerto Rican ☐ Other Hispanic, Latino/a or Spanish

Race (optional): ☐ White ☐ Black or African American ☐ Filipino ☐ Vietnamese ☐ Chinese ☐ Asian Indian ☐ Japanese ☐ Korean ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Other Asian ☐ American Indian or Alaska Native ☐ Samoan ☐ Native Hawaiian

Citizenship Status: ☐ US citizen ☐ Permanent resident ☐ Other non-citizen | City/state/country of birth

If he/she is not a US citizen, fill out the following | When did he/she enter the United States? | I-94 or alien registration # | Immigration status

☐ Yes ☐ No Does this individual have a disability or impairment? If yes, explain.

☐ Yes ☐ No Would you like this person to receive copies of your DSS notices? If Yes, fill out the Authorized Representative section on Page 3 of this application with this person's information. If you do not complete this section, this person may be unable to receive copies of your DSS notices.

☐ Yes ☐ No Does this person plan to remain in CT? | Date moved to CT

Person 3. Tell us about any dependent children currently residing in your household. Give as much information as you know.

Name (first, middle, last, suffix)	Client ID #	
Social security number	Gender	Date of birth

Relationship to you? | Does this person live with you? ☐ Yes ☐ No If no, explain.

Marital Status: ☐ Never married ☐ Married living with spouse ☐ Separated _____ (date of separation) | Is this a legal separation? ☐ Yes ☐ No

☐ Married living apart ☐ Divorced _____ (date of divorce) ☐ Widowed _____ (date of death)

Military Status (Check all that apply): ☐ Active Duty ☐ Veteran - Honorably discharged ☐ Child of deceased veteran ☐ Spouse of deceased veteran ☐ Veteran-Other ☐ No military status

Providing race and ethnicity data is optional, does not affect eligibility or benefit amount, and is used to make sure everyone has the same access to benefits.

Ethnicity (optional): ☐ Not of Hispanic origin ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Cuban ☐ Puerto Rican ☐ Other Hispanic, Latino/a or Spanish

Race (optional): ☐ White ☐ Black or African American ☐ Filipino ☐ Vietnamese ☐ Chinese ☐ Asian Indian ☐ Japanese ☐ Korean ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Other Asian ☐ American Indian or Alaska Native ☐ Samoan ☐ Native Hawaiian

Citizenship Status: ☐ US citizen ☐ Permanent resident ☐ Other non-citizen | City/state/country of birth

If he/she is not a US citizen, fill out the following | When did he/she enter the United States? | I-94 or alien registration # | Immigration status

Person 3 continued

☐ Yes ☐ No Does this individual have a disability or impairment? If yes, explain.

☐ Yes ☐ No Would you like this person to receive copies of your DSS notices? If Yes, fill out the Authorized Representative section on Page 3 of this application with this person's information. If you do not complete this section, this person may be unable to receive copies of your DSS notices.

☐ Yes ☐ No Does this person plan to remain in CT? | Date moved to CT

Non-Citizen Information. Answer these questions if you or anyone in your household is not a US citizen.

☐ **Yes** ☐ **No** Does any non-citizen in the household have a sponsor?

Name(s) of non-citizen(s)	Name(s) of sponsor(s)

Sponsor's relationship to you	Do you live with the sponsor(s)? ☐ Yes ☐ No	If no, explain.

Are you working with a Resettlement Agency? ☐ Yes ☐ No | If yes, please provide the name of your Resettlement Agency.

Pregnancy. Tell us about anyone in your household who is pregnant.

☐ **Yes** ☐ **No** Are you or is anyone in your household pregnant?	If yes, who?	How many babies are expected?	Due date

Past Benefits. Tell us about anyone in your household who has received cash, medical or food help from Connecticut or other states in the last 90 days.

☐ **Yes** ☐ **No** Has anyone in your household received cash, medical or food help in the last 90 days?

Type of help	Name of person	Amount	Date help ended
		$	
		$	
		$	

☐ **Yes** ☐ **No** Has anyone in your household received cash assistance for families since 1996?	If yes, who?	Which state(s)?

Medical Insurance. Tell us about anyone in your household who has Medicare or other medical insurance.

☐ **Yes** ☐ **No** Do you or your spouse have medical or dental insurance? If yes, fill out the tables below.

Policy 1	Policy holder		Insurance company		Start date
	Policy #	Type of coverage	Premium $	How often paid	End date
Policy 2	Policy holder		Insurance company		Start date
	Policy #	Type of coverage	Premium $	How often paid	End date
Policy 3	Policy holder		Insurance company		Start date
	Policy #	Type of coverage	Premium $	How often paid	End date

Medical Insurance continued

☐ Yes ☐ No Is one of your listed insurance policies a long-term care policy approved under the Connecticut Partnership for Long-Term Care Program? | If yes, which one?

☐ Yes ☐ No Do you or your spouse have Medicare? If yes, list below.

What type of Medicare does this person have? Check off all appropriate boxes.

Person 1

☐ A Start date	☐ B Start date	☐ D Start date	Premium $
Person on medicare	Claim #	How often paid	

Person 2

☐ A Start date	☐ B Start date	☐ D Start date	Premium $
Person on medicare	Claim #	How often paid	

Send proof of any medical insurance you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application. Some examples below:

· Private health insurance cards including Medicare (copy of both sides) · Health insurance premium amounts

Cash, bank accounts and other assets.

Tell us about any cash, savings accounts, checking accounts, or other assets owned by you or your spouse within the last 5 years, including stocks, trusts, annuities, CDs, promissory notes, bonds, investment accounts and loans you made on which you are entitled to repayment.

Cash	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Cash on hand $		
Checking Account 1	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Name of bank or institution		
		Current balance $	Account #	Date opened	Date closed
Checking Account 2	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Name of bank or institution		
		Current balance $	Account #	Date opened	Date closed
Savings Account 1	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Name of bank or institution		
		Current balance $	Account #	Date opened	Date closed
Savings Account 2	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Name of bank or institution		
		Current balance $	Account #	Date opened	Date closed
Bonds	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Name of bank or institution		
		Current balance $	Account #	Date opened	Date closed
Certificate of Deposit 1	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Name of bank or institution		
		Current balance $	Account #	Date opened	Date closed

Cash, bank accounts and other assets continued

Certificate of Deposit 2	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Name of bank or institution		
		Current balance $	Account #	Date opened	Date closed
Stocks	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Name of bank or institution		
		Current balance $	Account #	Date opened	Date closed
Trust	Do you own or are you a beneficiary of this type of asset? ☐ Yes ☐ No	Owner(s) / Beneficiary (ies) - List all	Name of bank or institution		
		Current balance $	Account #	Date opened	Date closed
Annuity	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Name of bank or institution		
		Current balance $	Account #	Date opened	Date closed
Mutual funds, treasury or other notes	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Name of bank or institution		
		Current balance $	Account #	Date opened	Date closed
Medical savings account	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Name of bank or institution		
		Current balance $	Account #	Date opened	Date closed
Achieving a Better Life Experience (ABLE)	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Name of bank or institution		
		Current balance $	Account #	Date opened	Date closed
Crowdfunding Accounts (i.e., GoFundMe)	Do you own or are you a beneficiary of this type of asset? ☐ Yes ☐ No	Owner(s) / Beneficiary(ies) - List all	Name of bank or institution		
		Current balance $	Account #	Date opened	Date closed
Other (specify) _____	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Name of bank or institution		
		Current balance $	Account #	Date opened	Date closed
Other (specify) _____	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Name of bank or institution		
		Current balance $	Account #	Date opened	Date closed

Send proof of any assets you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application. Some examples below: · Checking accounts - statements · Savings accounts - statements · Stocks - brokerage account statements · Annuities (a copy of the original annuity contract in addition to the statements)

Tell us about whether you have been involved with a Continuing Care Retirement Community.

Have you paid an entrance fee to Continuing Care Retirement Community (CCRC)?	☐ Yes	☐ No
If yes, can the fees be used to pay for your care?	☐ Yes	☐ No
Can a refund be issued upon death or on leaving the CCRC?	☐ Yes	☐ No

Retirement accounts. Tell us about your household's retirement accounts, including any 403B, 457B, 401k, IRA, Roth IRA or Keogh accounts.

IRA	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Date opened
	Name of bank of institution	Account #	Current balance $
403B	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Date opened
	Name of bank of institution	Account #	Current balance $
457B	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Date opened
	Name of bank of institution	Account #	Current balance $
Keogh	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Date opened
	Name of bank of institution	Account #	Current balance $
401K	Do you own this type of asset? ☐ Yes ☐ No	Owner(s) - List all	Date opened
	Name of bank of institution	Account #	Current balance $

Send proof of any retirement accounts you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application. Some examples below:
· Retirement, IRA and Keogh account statements

Real Property. Tell us about real property owned by any household member. Real property can include a home, mobile home, or land.

☐ Yes ☐ No Did you own any real property or have life use of any property in the last 5 years or, for cash, 2 years? If yes, tell us below.

Property 1

Owner(s) list all			Is this a business asset? ☐ Yes ☐ No
Address (street, city, state, zip)			Does it generate income? ☐ Yes ☐ No
Type (home, rental property, etc.)	Property value $	Amount owed $	Did you ever have life use of this property? ☐ Yes ☐ No

Property 2

Owner(s) list all			Is this a business asset? ☐ Yes ☐ No
Address (street, city, state, zip)			Does it generate income? ☐ Yes ☐ No
Type (home, rental property, etc.)	Property value $	Amount owed $	Did you ever have life use of this property? ☐ Yes ☐ No

Do you have a reverse mortgage, home equity line of credit, or other home equity conversion plan on any of the above? If yes, please provide a copy of the note and/or repayment agreement. ☐ Yes ☐ No

Send proof of any real property you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application. Some examples below:
· Reverse mortgage documents or home equity line of credit - monthly / quarterly statements are required for 24 and 60 month look backs
· Housing and Urban Development HUD-1 Statement · Real estate closing documents

Life Insurance. Tell us about your household's life insurance policies.

☐ Yes ☐ No Do you own any life insurance? If yes, tell us below.

Insurance 1

Policy type (select one):	☐ Term life insurance	☐ Whole life insurance	
Owner(s) list all		Policy #	
Insurance company		Death benefit / face value $	Cash surrender value $

Insurance 2

Policy type (select one):	☐ Term life insurance	☐ Whole life insurance	
Owner(s) list all		Policy #	
Insurance company		Death benefit / face value $	Cash surrender value $

Send proof of any life insurance you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application. Some examples below:
· Current annual statement
· Current letter from the life insurance company showing policy number, face value and current CASH VALUE

Burial Contracts and Plots. Tell us about burial contracts or plots that your household has paid for.

☐ Yes ☐ No Do you own any burial contracts or plots? If yes, tell us below.

Contract 1

Owner(s) list all		Designated for
State where contract was issued	Funeral home or cemetery name	
Select one: ☐ Contract ☐ Plot ☐ Other (Specify) _____		Amount or value $

Burial Contracts and Plots. continued

Contract 2

Owner(s) list all	Designated for
State where contract was issued	Funeral home or cemetery name
Select one: ☐ Contract ☐ Plot ☐ Other (Specify) _____	Amount or value $

Contract 3

Owner(s) list all	Designated for
State where contract was issued	Funeral home or cemetery name
Select one: ☐ Contract ☐ Plot ☐ Other (Specify) _____	Amount or value $

Send proof of any burial contracts and plots you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application. Some examples below:
· Burial contracts (irrevocable and revocable) · Burial plot deeds

Vehicles. Tell us about any vehicles owned by your household. Vehicles include cars, mobile homes, recreational vehicles (RVs), motorcycles, snowmobiles, trailers, trucks, vans, boats or other watercraft.

☐ **Yes** ☐ **No** Do you own any vehicles? If yes, tell us below.

Vehicle 1

Owner(s) list all		Type of vehicle	
Make	Model	Year	Amount owed $
Used for work or school? ☐ Yes ☐ No	Used for medical appointments? ☐ Yes ☐ No	Is this a business asset? ☐ Yes ☐ No	

Vehicle 2

Owner(s) list all		Type of vehicle	
Make	Model	Year	Amount owed $
Used for work or school? ☐ Yes ☐ No	Used for medical appointments? ☐ Yes ☐ No	Is this a business asset? ☐ Yes ☐ No	

Send proof of any vehicles you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application. Some examples below:
· Title · Registration · Lease

Lawsuits and Inheritance. Tell us if anyone in your household has any lawsuits or inheritance pending.

☐ **Yes** ☐ **No** Has anyone in your household filed a lawsuit that is still pending?

If yes, who?	Attorney's name
Attorney's address (street, city, state, zip)	

☐ **Yes** ☐ **No** Does anyone in your household expect to receive an inheritance? — If yes, who?

Name of deceased person	Amount of inheritance $	Date expected

You must notify DSS within 10 days of receiving an inheritance, trust or settlement.

Sales or transfers. Tell us if anyone in your household has sold, traded, gifted or transferred ownership of any assets in the past.

☐ Yes ☐ No Have you (or your spouse) sold, traded, gifted or transferred ownership, including to a trust, of any real property, motor vehicles, life insurance, stocks, bonds, cash or other assets in the past 5 years or 2 years if applying for cash?

☐ Yes ☐ No Have you (or your spouse) had assets transferred through probate court/surrogate courts in or out of state in the past 5 years or 2 years if applying for cash?

If yes, complete the table below for each asset.

Item 1	What was sold, given away, etc.?	To who?	
	Type of transfer ☐ Sold ☐ Transferred ☐ Closed	Date of closing, sale, transfer or gift.	Amount / value $
Item 2	What was sold, given away, etc.?	To who?	
	Type of transfer ☐ Sold ☐ Transferred ☐ Closed	Date of closing, sale, transfer or gift.	Amount / value $
Item 3	What was sold, given away, etc.?	To who?	
	Type of transfer ☐ Sold ☐ Transferred ☐ Closed	Date of closing, sale, transfer or gift.	Amount / value $
Item 4	What was sold, given away, etc.?	To who?	
	Type of transfer ☐ Sold ☐ Transferred ☐ Closed	Date of closing, sale, transfer or gift.	Amount / value $
Item 5	What was sold, given away, etc.?	To who?	
	Type of transfer ☐ Sold ☐ Transferred ☐ Closed	Date of closing, sale, transfer or gift.	Amount / value $
Item 6	What was sold, given away, etc.?	To who?	
	Type of transfer ☐ Sold ☐ Transferred ☐ Closed	Date of closing, sale, transfer or gift.	Amount / value $
Item 7	What was sold, given away, etc.?	To who?	
	Type of transfer ☐ Sold ☐ Transferred ☐ Closed	Date of closing, sale, transfer or gift.	Amount / value $
Item 8	What was sold, given away, etc.?	To who?	
	Type of transfer ☐ Sold ☐ Transferred ☐ Closed	Date of closing, sale, transfer or gift.	Amount / value $

Sales or transfers continued

If you are applying for help paying for care in a nursing or chronic disease facility or community homecare and have transferred assets in the past 5 years, please answer the following:

Did you live with the person to whom you transferred the asset(s) without interruption for a period of at least 2 years that prevented their institutionalization? ☐ Yes ☐ No

What Activities of Daily Living were you capable of doing on your own during this time?

☐ Bathing ☐ Walking ☐ Toileting ☐ Maintaining Continence
☐ Dressing ☐ Feeding ☐ Grooming ☐ Transferring

If you were unable to do any of the above, who helped you do them?

During these two years, did the individual you transferred the asset(s) to work? ☐ Yes ☐ No

If yes, how many hours/days per week?

If yes, who was home with you while he/she was working?

Was a Home Care Agency involved? ☐ Yes ☐ No

If yes, what agency?

How many hours per week?

What funds were used to pay for this care?

Provide medical records, such as office notes for doctors, test results, hospital discharge summaries, etc. for the above period of time to verify the applicant's medical condition.

Any transfer or assignment of assets made in the past five years or two for cash applications may result in the imposition of a penalty period. Any such transfer is presumed to be made with the intent, by the transferor or the person accepting the transfer (the transferee), to qualify for Medicaid payment of long-term care benefits or, if applying for cash, payment of benefits under that program. Such transfer creates a debt due and owing by the transferor or transferee to DSS in the amount of assistance provided to or on behalf of the transferor. DSS and the Attorney General may seek relief as permitted by law to recover such amounts.

It is a fraudulent conveyance against the State to assign, transfer or otherwise dispose of property, for less than fair market value, to someone who knows (1) that the purpose of the transfer is to qualify for public assistance; or (2) that the transfer will leave the person making it without enough means to support himself or herself in a decent way. DSS may go to court to set aside the transfer and recover the cost of any assistance that was provided to the person making the transfer or to recover.

I have disclosed all transfers or assignments made in the past five years or two years for cash applications and understand that, if any such transfers were or are made, even in part, for the purpose of qualifying for Medicaid long-term care benefits or cash, the state has the right the right to seek repayment of the debt should any benefits be paid by the state of my behalf.

X _____ Date _____

(Applicant or Representative's Signature)

X _____ Date _____

Attorney's Signature (if assisted by an attorney)

Send proof of any sales or transfers you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application.

Special Needs. Answer the following if you or your spouse are applying for cash help and are blind, disabled or age 65 or older.

Only fill this section out if you are applying for cash.

Do you or your spouse need clothing? Yes No If yes, who?

Annuities and Your Eligibility for Long-Term Care Medical Services

You or your spouse have applied for help paying for long-term care services or home care. The department needs to know if you or your spouse owns any annuities. If you do not tell us about any annuities that you or your spouse own, you will not be eligible to get help with the cost of your long-term care. The State of Connecticut will be the remainder beneficiary of any annuities that you or your spouse have.

An annuity is a financial tool that can produce income either yearly or at regular intervals based on the terms of annuity contract. You need to tell the department about any annuities that you or your spouse may have. The department looks at any annuities that you or your spouse may own to see if you are eligible to receive long-term care medical services.

The Deficit Reduction Act of 2005 made changes to the way the Department of Social Services looks at assets when we determine eligibility for our programs. When you receive help with nursing home costs or the cost of long-term medical services in the community, the Department of Social Services becomes the preferred remainder beneficiary on any annuity purchased on or after February 8, 2006. If you have a spouse or a minor or disabled child that is named as a beneficiary, the State will become the beneficiary in the second position.

We will not ask you to change the beneficiary until we grant assistance. Once you have been granted assistance, you will have thirty days from the date that your assistance is granted to send us proof that the beneficiary has been changed. If you do not change your beneficiary within thirty days, we will take action to stop payment of long-term care medical services. You will not lose these benefits if you have a good reason for not doing what we asked.

We also require the issuer of an annuity to notify us of any changes in the way that income from the annuity is distributed or any changes in the principal from the annuity. Finally, the issuer may share information regarding the Department of Social Services' position as a remainder beneficiary to others who have a remainder interest in the annuity.

By signing this document you are stating that you understand how the department treats annuities and that you agree to cooperate in ensuring that the Department of Social Services appears as the preferred remainder beneficiary on any appropriate annuities.

Complete the information below, sign, and date.

☐ I have at least one annuity. ☐ My spouse has at least one annuity. ☐ My spouse and I do not have any annuities.

Signature of Applicant, Authorized Representative, Conservator, or Legal Reprsentative _____ Date _____

This information is available in alternate formats. Phone (800) 842-1508 or TDD/TTY (800) 842-4524.

Work Income. Tell us about your household's income from work including all jobs worked by any household member in the past 3 months. Income from work means wages, salary, tips, and commissions. Attach another page if needed.

☐ **Yes** ☐ **No** Do you or your spouse receive any income from working? If yes, tell us below.

Job 1

Name of individual working	Employer / company name		
Company contact's name and title	Employer's phone		
Employer's address (street, city, state, zip)		Start date	
How often paid? ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Other	Gross income per pay period (before taxes and deductions) $	Hours worked per week	Rate per hour

Job 2

Name of individual working	Employer / company name		
Company contact's name and title	Employer's phone		
Employer's address (street, city, state, zip)		Start date	
How often paid? ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Other	Gross income per pay period (before taxes and deductions) $	Hours worked per week	Rate per hour

Send proof of any work income you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application. Some examples below:
· Last four paystubs

Self-Employment Income. Tell us about income from current self-employment, or self-employment that ended in the last 90 days. If you are reporting any self-employment or personal business income, you must give us copies of all schedules from your IRS 1040 form.

☐ **Yes** ☐ **No** Do you or your spouse receive any income from self-employment or your personal business?

Owner(s) list all		Business address (city, state, zip)	
Business name		Business type	
Date self-employment started	Date self- employment ended	Average gross monthly income before taxes $	Hours per week worked

Send proof of any self-employment income you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application. Some examples below:
· Quarterly tax returns · Tax returns for self-employment

Job Loss

☐ **Yes** ☐ **No** Has anyone lost a job, changed jobs, quit a job, reduced work hours within the last 120 days?

If yes, who?	Which job?	Date last paid
What happened and why?		Date job ended or hours were reduced

Other Income. Tell us about income you get from other sources, such as: disability benefits, worker's compensation payments, unemployment benefits, pensions, Social Security, retirement income, veteran's benefits, child support payments, foster care or adoption subsidies, or rental income.

☐ **Yes** ☐ **No** Do you or anyone in your household have any other sources of income?

Type of benefit or income	Receiving income or benefits?	Name of person with income	Claim #	Start date	End date	How often?	Amount
SSI	☐ Yes ☐ No						$
SSDI	☐ Yes ☐ No						$
SSA	☐ Yes ☐ No						$
Retirement Benefits	☐ Yes ☐ No						$
Pension 1	☐ Yes ☐ No						$
Pension 2	☐ Yes ☐ No						$
Pension 3	☐ Yes ☐ No						$
Retirement Account Distribution	☐ Yes ☐ No						$

Other Income. continued

Type of benefit or income	Receiving income or benefits?	Name of person with income	Claim #	Start date	End date	How often?	Amount
VA Benefit - Aid and Attendance	☐ Yes ☐ No						$
VA Benefit - Other	☐ Yes ☐ No						$
Civil Service Annuity	☐ Yes ☐ No						$
Railroad Retirement Benefits Claim Number	☐ Yes ☐ No						$
Alimony	☐ Yes ☐ No						$
Worker's Compensation	☐ Yes ☐ No						$
Disability/ Sick Benefits	☐ Yes ☐ No						$
Union Benefits	☐ Yes ☐ No						$
Unemployment Benefits	☐ Yes ☐ No						$
Lump Sum Cash Amounts	☐ Yes ☐ No						$
Rental Income	☐ Yes ☐ No						$
Legal Settlement	☐ Yes ☐ No						$
Partnership, LLC or Royalty income	☐ Yes ☐ No						$
Other (specify) _____	☐ Yes ☐ No						$
Other (specify) _____	☐ Yes ☐ No						$

Send proof of any other income you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application. Some examples below:

· Social security · Railroad retirement
· VA pensions · Private pension

Other benefit applications. Tell us about other benefits that household members have applied for, but do not currently receive. Other benefits may include: Social Security benefits (including SSI or SSDI), unemployment compensation, pensions, disability payments, VA benefits, or workers compensation.

☐ **Yes** ☐ **No** Have you or anyone in your household applied for any benefits (that they currently do not receive)? If yes, tell us below.

Complete the table below with details about any benefit you or your spouse have applied for and checked off above.

Benefit type	Applied for?	Name of person applying	Start date (if known)
Disability Benefit	☐ Yes ☐ No		
Foreign Income	☐ Yes ☐ No		
Pension	☐ Yes ☐ No		
Railroad Retirement	☐ Yes ☐ No		
SSA	☐ Yes ☐ No		
SSA Early Retirement	☐ Yes ☐ No		
SSD	☐ Yes ☐ No		
SSI	☐ Yes ☐ No		
Unemployment Compensation	☐ Yes ☐ No		
VA Benefit	☐ Yes ☐ No		
Worker's Compensation	☐ Yes ☐ No		
Alimony	☐ Yes ☐ No		
Worker's Compensation	☐ Yes ☐ No		

With the exception of SSI, the Department may require you to apply for any benefits you are potentially eligible for.

Send proof of any other benefit applications you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application. Some examples below:
· Proof you have applied for said benefit

Dependent Care Expenses. Tell us about expenses your household pays for childcare or for the care of an elderly or disabled adult.

Dependent 1

Dependent's name	Provider's name	
Provider's address (street, city, state, zip)		If state pays, how much per month? $
Who pays?	Amount you pay $	How often?

Dependent Care Expenses continued

Dependent 2

Dependent's name	Provider's name	
Provider's address (street, city, state, zip)		If state pays, how much per month? $
Who pays?	Amount you pay $	How often?

Send proof of any Dependent Care Expenses you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application.

Medical Expenses.

Tell us about any household medical expenses incurred within six months (180 days) of application. Medical expenses may include: hospital or doctor bills, dental bills, prescriptions, co-pays, health insurance premiums, medical equipment, costs for glasses and over-the-counter medications/supplements, costs related to a service animal, or costs for a health aid or attendant.

☐ **Yes** ☐ **No** Have you had any medical expenses in the last six months? If yes, tell us below.

Name of person with expense	Expense type	Date of service	Amount due	How often do you pay?	Bill paid?
	Medical / dental expenses		$		☐ Yes ☐ No ☐ Partially
	Health insurance premium 1		$		☐ Yes ☐ No ☐ Partially
	Health insurance premium 2		$		☐ Yes ☐ No ☐ Partially
	Other (specify)		$		☐ Yes ☐ No ☐ Partially

Send proof of any Medical Expenses you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application. Some examples below:
· Unpaid medical bills from last 6 months

Shelter Expenses.

Tell us about shelter costs that your household is responsible for paying such as: rent or mortgage payments, condo fees, room and board, property taxes, and homeowner's insurance. Answering these questions can help you get the most benefits possible.

	Expense 1	Expense 2	Expense 3
Name of person with expense			
Expense type			
Expense amount	$	$	$
How often do you pay?			
If renting, is this subsidized?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, what type of subsidy?			
Do you live in public housing?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Send proof of any Shelter Expenses you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application. Some examples below:
· Utility bills · Rent Bills · Mortgage bills ·Monthly homeowner's insurance premium bill

Utility Expenses. Tell us about utility costs that your household is responsible for paying, such as: heating, cooling, electric, gas, water, sewer, garbage, or phones. Answering these questions can help you get the most benefits possible.

☐ Yes ☐ No	Do you pay for heating or cooling separate from your shelter expenses?
☐ Yes ☐ No	Do you pay an extra fee to your landlord for heating or cooling?
☐ Yes ☐ No	Has the household received energy assistance payments in the last year?

Complete the following section if you answered No to all three questions listed above. Do you pay for any of the following utilities separately from your shelter expenses? (Check all that apply.) Include utility expenses that are not part of rent or mortgage.

Type	Amount	Frequency	Paid to who?
☐ Sewer / septic	$		
☐ Water	$		
☐ Butane	$		
☐ Electric	$		
☐ Gas	$		
☐ Telephone	$		
☐ Wood	$		
☐ Coal	$		
☐ Garbage	$		
☐ Other fuel	$		

Send proof of any Utility Expenses you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application. Some examples below:
· Monthly utility bills

Work Related Expenses. These can include cost of tools or materials required for work, mandatory union dues, equipment installation and maintenance, FICA, life or health insurance, mandatory retirement plans, and any expenses related to self-employment.

	Expense 1	Expense 2	Expense 3
Name of person with expense			
Expense type			
Expense amount	$	$	$
How often do you pay?			
Date expense began			

Send proof of any Work Related Expenses you listed. Check the "**Do you have your proof documents?**" section of the instructions for examples of which documents to send copies of along with your application. Some examples below:
· Receipts for tools or materials required · Mandatory union dues
· Mandatory retirement plan dues

I UNDERSTAND AND AGREE TO THE FOLLOWING:

- **I am responsible for reporting changes in my situation to DSS. I must report changes within 10 days. Examples of changes in my situation are changes in my income, assets, address, health insurance premiums, or death of a spouse.**
- **I understand that I shall not sell, assign, transfer, encumber or otherwise dispose of any property without the consent of the Commissioner of Social Services. I further understand that any sale, assignment, transfer, encumbrance or other disposal of property made without the Commissioner's consent is void and of no legal effect; may result in my ineligibility for assistance for a period of time; and, that any person or entity that receives the proceeds from any sale, assignment, transfer, encumbrance or other disposal of property made without the Commissioner's consent may be subject to a claim by the State of Connecticut for reimbursement for the amount of assistance paid to me.**
- **I may request a hearing in writing if I disagree with an action taken on my case.**
- **I am voluntarily giving information requested on this application. If I fail to give certain information, my application may be denied.**
- **All information I give on this form is subject to verification by federal, state and local officials. I will cooperate with these officials by providing any necessary documents to prove what I have said. I authorize DSS to verify any information given on this form to make sure it is true.**
- **All information I give on this form, including Social Security numbers, is confidential, except as authorized or required by state or federal law, and will be used by DSS only to administer the medical assistance program.**
- **Any information I give on this form, including Social Security numbers, will be used to verify identity and eligibility and will be cross-matched against federal, state and local government files by computer.**
- **DSS will use information available to it through the Income and Eligibility Verification System (IEVS) to process my request for assistance. This information comes from the Labor Department, the Social Security Administration and the Internal Revenue Service as well as other agencies when allowed by law. DSS may verify the information it receives by contacting other sources, such as banks and employers. Results from such checking may affect my eligibility and level of benefits.**
- **I give permission to DSS to release information about me for purposes directly connected with the administration of DSS's programs. Purposes directly connected with the administration of the department's programs include, but are not limited to, establishing eligibility, determining the amount of assistance, providing services, and the investigation, prosecution or civil proceedings related to the administration of the department's programs.**
- **I will cooperate with state and federal personnel who conduct Quality Control Reviews.**
- **I declare that I am a United States citizen or, in the event that I am not, that the information that I provided regarding my non-citizen status is true.**
- **I authorize DSS to verify any information regarding my non-citizen status with the Department of Homeland Security. I also understand that the Department of Homeland Security CANNOT use the fact that I applied for assistance with DSS as basis to deny my admission to the U.S., harm my permanent resident status or deport me.**

If signing on behalf of the applicant, I am the: ☐ Conservator, ☐ Guardian, ☐ Power of Attorney or already assigned authorized representative and have attached supporting documentation. If you would like to designate an authorized representative, see page 3.

Print your or your representative's full name	Signature	Date
Print full name of any other adult applicant	Signature	Date

Persons who are deaf or hard of hearing and have a TDD/TTY device can contact DSS at 1-800-842-4524. Persons who are blind or visually impaired can contact DSS at 1-860-424-5040.

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State of Connecticut
Department of Social Services
Rights and Responsibilities

The following statements apply to all who ask for or receive help from the Department:

For All Programs

For all programs, except SNAP, I will notify the Department of Social Services (DSS) within 10 days of any change in income, assets or living arrangements.

I may request a hearing if I disagree with an action taken on my case. Hearing requests must be in writing for all programs, except SNAP. Requests for a SNAP hearing may also be made by telephone. You may represent yourself at a hearing, or you may have a lawyer, relative, friend of someone else represent you.

All information given on forms is subject to verification by federal, state, and local officials. I will cooperate with these officials by providing authorizations, documents, and other proof to prove what I have said. I authorize DSS to verify (check) any information given on forms I submit.

All information given on forms, including Social Security numbers, is confidential, except as permitted or required by court order, state, or federal law. With certain exceptions, it will be used only to administer DSS programs. If DSS believes that there is imminent danger to a child's or family's health, safety or welfare, DSS will provide the child's address and telephone number to the Department of Children and Families. For all programs, except Medicaid, DSS will give my address to a law enforcement official to locate me if I am fleeing to avoid prosecution or custody for certain crimes or for violating a condition of probation for certain crimes or if I have information that a law enforcement official needs to do his or her job concerning certain crimes.

DSS may disclose information about me and others in my family or household who are receiving benefits for purposes directly connected with the administration of DSS programs. Purposes directly connected with the administration of DSS' programs include, but are not limited to: establishing eligibility, determining the amount of help, providing services, and for investigations, prosecutions, or civil proceedings related to the administration of DSS programs.

DSS may disclose confidential information from the Department of Labor concerning unemployment compensation benefit and quarterly wage information pertaining to any household member requesting assistance to determine and review eligibility for medical assistance, SNAP, SAGA, TFA and State Supplement to its contractors.

The State may check information it gets about child support payments, which are made to the State on behalf of my child, with the DSS Office of Child Support Services Division. If I make a false or misleading statement, I may be subject to civil or criminal penalties.

I authorize DSS to check any information regarding anyone's non-citizen status with the U.S. Citizenship and Immigration Services (USCIS). I understand that DSS will not share the information given on this form with USCIS. I also understand that USCIS cannot use this application form to deny admission to the U.S., harm permanent resident status or deport me or anyone I am applying for. Information received from the USCIS may affect my household's eligibility and level of benefits.

I will cooperate with state and federal personnel in Quality Control Reviews.

DSS may disclose information about me and members of my family or household who are receiving benefits from DSS to identify other services or benefits that I may be eligible for, or to verify my eligibility for such services or benefits. DSS may share this information with: (1) state government agencies such as the Department of Public Health to see if I may be eligible for the Women, Infants and Children (WIC) program, the Office of Early Childhood to see if I may be eligible for childcare assistance, or the Department of Revenue Services to see if I may be eligible for tax credits; (2) utility companies to see if I am eligible for hardship status or discount rates; and (3) non-profit organizations partnering with the state to offer services such as SimplifyCT for the purpose of providing free tax preparation assistance. While entities that receive information from DSS may not be covered by certain federal confidentiality laws, I understand that DSS will only disclose the minimum amount of information needed to identify services or benefits I may be eligible for or to verify my eligibility for such services or benefits, and that DSS prohibits these entities from redisclosing, selling, or using my information for any other purpose. I can tell DSS not to share my information with these entities at any time by going to https://portal.ct.gov/dssoptout, which shall be effective immediately, except to the extent that information may have previously been shared. If I tell DSS not to share my information, it will not have any effect on my eligibility for any DSS program or benefit.

Any information I give on forms, including Social Security numbers, will be used to check identity and eligibility for those people in my household who are going to receive benefits. People who live with me who are not applying for benefits do not need to give their Social Security numbers, but if they are willing to do so then it may speed up the application process. Social Security numbers will be cross matched against federal, state, and local government files by computers. DSS is allowed to request Social Security numbers based on the following statutes: for SNAP, the Food and Nutrition Act of 2008 (formerly the Food Stamp Act), 7 USC §§ 2011-2036; 7 USC § 2025(e)(1) and 42 USC §§ 1320b-7(a)(1) and (b) (4); for TFA, 42 USC §§ 1320b-7(a)(1) and (b)(1); for Medicaid, 42 USC §§1320b-7(a)(1) and (b)(2); for State Supplement to the Aged, Blind and Disabled, 42 USC §§ 1320b-7(a)(1) and (b)(5); for SAGA, the Tax Reform Act of 1976, 42 USC § 405(c)(2)(C)(i); for all programs except SAGA, Conn. Gen. Stat. § 17b-77.

DSS will use information available to it through the Income and Eligibility Verification System (IEVS) and through the National Directory of New Hires to determine my eligibility and benefits. This information will come from the Labor Department, the Social Security Administration, the Internal Revenue Service, and other agencies when allowed by law. DSS may check the information it receives from these sources directly with other sources, such as banks and employers. These results may affect my household's eligibility and level of benefits.

Giving the information asked for on forms is voluntary. If I do not give certain information, however, benefits or services may be denied. For SNAP, if I fail to report or check any of the listed expenses, DSS will treat this as a statement that I do not want to receive a deduction for the unreported expense.

Keep this page 1 for your records
Do not return to DSS

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State of Connecticut
Department of Social Services
Rights and Responsibilities

For The Supplemental Nutrition Assistance Program (SNAP)

I understand that DSS administers SNAP, and that DSS has 30 days from the date of application to process the application

I will notify the Department of Social Services (DSS) by the 10th day of the month following the month when my income increases above 130% of the federal poverty level for my family size, when Abled Bodied Adults Without Dependents (ABAWD) work/training hours go below 80 hours per month or an average of 20 hours per week, or when a household member receives lottery or gambling winnings in excess of **$4,250** from a single game.

If I break any of the rules on purpose I can be barred from SNAP from between one year and permanently, fined up to $250,000, and/ or imprisoned up to 20 years. I may also be subject to prosecution under any other applicable federal and state laws, and I may also be barred from SNAP for an additional 18 months if court ordered.

My application or renewal for and receipt of my SNAP benefits is a registration for work for myself and all members of my SNAP assistance unit, ages 16 through 59, who are not exempt.

Work registrants must accept a job offer at a wage equal to the higher of the federal or state minimum wage, unless the job is unsuitable; provide employment status or availability for work information, upon request; and report to an employer if referred by DSS, a DSS contractor, or the Connecticut Department of Labor, unless the employment is unsuitable. Work registrants must not voluntarily quit a job or reduce work hours, without good cause, if working at least 30 hours a week.

Failure to comply with work requirements without good cause may result in penalties as follows: 1st violation disqualified from receiving SNAP benefits for 3 months or until the date of compliance, 2nd, and additional violations, disqualified for 6 months or until the date of compliance.

If I break a SNAP rule on purpose or if I am found guilty of buying a product with SNAP that has a container with a return deposit with the intent of getting cash by dumping the product out and returning the container for cash I am ineligible to get SNAP. The first time I break a rule I will not be able to get SNAP for one year. The second time I will not be able to get SNAP for two years. The third time I will not be able to get SNAP ever again.

If I am found guilty of trafficking SNAP benefits of $500 or more, I cannot get SNAP ever again. Trafficking in SNAP means selling them instead of using them to buy food.

I am not allowed to use, or have in my possession, an EBT card that is not mine (unless I am an authorized SNAP shopper) and may not let others use my card (unless they are an authorized SNAP shopper).

If I am found guilty of buying or trading a controlled substance or receiving SNAP benefits as payment for a controlled substance, the first time I break this rule I cannot get SNAP for 24 months and the second time I will not be able to get SNAP ever again.

If I am found guilty of buying or trading firearms, ammunition or explosives or receiving SNAP benefits as payment for firearms, ammunition, or explosives, I will not be able to get SNAP ever again.

If I am found guilty of murder, aggravated sexual abuse, sexual exploitation and other abuse of children, sexual assault, or substantially similar offense, I will not be able to get SNAP ever again.

If I intentionally misuse an Electronic Benefit Transfer (EBT) card, I may no longer get SNAP. I may also be fined up to $250,000 or sent to jail for up to 20 years or both. Misuse of an EBT card means altering, selling, or trading a card, using someone else's card without permission, or exchanging benefits.

I am not allowed to buy nonfood items, such as alcohol or cigarettes, or to buy food on credit. I understand this is an intentional misuse of an EBT card and could result in a disqualification.

If I make a false statement about the identity or address of myself or household members to get more than one SNAP benefit for the same time period, I will not be able to get SNAP for 10 years.

If a SNAP claim arises against my household, the information on forms I submit to DSS, including all Social Security numbers, may be referred to federal and state agencies, as well as private claims collection agencies for claims collection action.

The State must process applications for SNAP in accordance with SNAP procedures, including timeliness, notice and Fair Hearing requirements. A household may not be denied SNAP benefits solely because they have been denied benefits from other programs.

Your Rights

You have a right to:

Have your signed application accepted on the same day that you submit it to DSS during working hours. If you submit an application outside of working hours, including holidays, it will be accepted on the next business day.

Have an adult who knows your situation apply for you if you cannot get to the local DSS office;

Get your SNAP benefits within 30 days after you apply if you meet eligibility requirements;

Get SNAP within 7 days if you are in immediate need and qualify for faster service;

Be told in advance if DSS is going to reduce or end your benefits during your certification period because of a change in your situation;

Look at your own case file and a copy of the SNAP rules; and

Have an administrative hearing if you don't think the rules were applied correctly in your case. At an administrative hearing you may explain to a hearing officer why you don't agree with what DSS has done.

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State of Connecticut
Department of Social Services
Rights and Responsibilities

For Jobs First / TFA Cash

I and all other members of the Jobs First / TFA household who are required to do so must participate in Employment Services unless there is an exemption for that person.

DSS may conduct an unscheduled home visit.

My legally liable relative may be billed to repay the State for cash paid to me.

If I knowingly give false (wrong) information to DSS about myself or someone I am applying for in order to get Jobs First / TFA benefits or get the wrong amount of money, I will not get the benefits for 6 months the first time this happens and 12 months the second time. If it happens a third time, I will never again be able to get Jobs First / TFA benefits.

I will not use my EBT card to conduct electronic benefit transfer transactions in a liquor store, an adult-oriented entertainment establishment, or a casino, gambling casino or gaming establishment.

For State Supplement

My legally liable relative may be billed to repay the State for cash the State paid to me.

For SAGA Cash

I must cooperate with the State in getting support from my spouse.

If a member of my household has a substance abuse problem, he or she may be required to be in treatment in order to receive SAGA cash benefits.

If I make false or misleading statements when I apply for SAGA, this is breaking the law and I may not be able to get SAGA for up to a year.

For Medical Assistance

Money from a pending or future lawsuit will go (be assigned) to the State to recover any medical expenses paid by the State related to the lawsuit.

If I knowingly give false (wrong) or misleading information to DSS about myself or someone I am applying for, I am breaking federal law and I may be fined up to $25,000 or put in prison for 5 years or both.

By applying for medical assistance, I give (assign) my right of support from third parties to DSS (section 1912 of the Social Security Act).

If I am in a nursing facility or if I am applying for home and community-based services, and I want to assign my support rights against my spouse, I must sign an additional assignment of support (section 1924 of the Social Security Act).

The State may bill my legally liable relative to repay the State for the costs of my medical care.

I will not alter (change), trade, sell or use someone else's medical services identification card.

The State recovers money from my estate if I receive long-term care services when I am at least 55 years old or am permanently institutionalized, and I do not have a living spouse or child who is under 21 years old or blind or disabled.

DSS or its representative may apply for Medicare on my behalf if DSS thinks I am eligible for Medicare. DSS or its representative may also file Medicare claims and appeals on my behalf.

DSS or any other health insurer or provider may release information about me and my family as necessary for the delivery of medical and program services, as permitted by federal and state law.

By receiving medical assistance, I allow the State to recover the cost of my medical bills that are covered by a third party, such as other insurance, directly from that third party.

Child Support Assignment and Cooperation

By applying for help from the State, I assign (give) to the State all the rights I have to current support from any person for any family member included in the application.

For as long as I am getting help from the State, I must fully cooperate with the State in order to get other responsible persons to contribute to my family's support.

The State will keep child support due to me while I am receiving cash help, which means that I will not collect it during that time.

When my TFA cash help ends, all current child support will come to me. Any unpaid child support that was due to me during the time I was receiving TFA cash help is owed to the State.

The State will continue to enforce my child support order after I stop receiving help unless I notify the State that I do not want this service.

Keep this page 3 for your records
Do not return to DSS

State of Connecticut
Department of Social Services
Rights and Responsibilities

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Non-Discrimination Statement

In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or who have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

CIVIL RIGHTS COMPLAINTS INVOLVING USDA PROGRAMS

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the AD-3027 form (found online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, and at any USDA office) or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. mail: Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334, Alexandria, VA 22314; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. phone: (833) 620-1071; or
4. email: FNSCIVILRIGHTSCOMPLAINTS@usda.gov

For any other information regarding 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 found online at: https://www.fns.usda.gov/snap/state-directory

CIVIL RIGHTS COMPLAINTS INVOLVING HHS PROGRAMS

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low-Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else.

To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form online through OCR's Complaint Portal at https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov. For faster processing, we encourage you to use the OCR online portal to file complaints rather than filing via mail. Persons who need assistance with filing a civil rights complaint can email OCR at OCRMail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services. We also provide alternative formats (such as Braille and large print), auxiliary aids and language assistance services free of charge for filing a complaint.

This institution is an equal opportunity provider.

Connecticut Non-Discrimination Statement

The Connecticut General Statutes prohibit discrimination in employment and the provision of services because of age, ancestry, color, criminal record (in state employment and licensing), gender identity or expression, genetic information, intellectual disability, learning disability, marital status (including civil union status), mental disability (past or present), national origin, physical disability (including blindness), race, religious creed, sex (including pregnancy or sexual harassment), sexual orientation, veteran status, status as a victim of domestic violence, workplace hazards to reproductive systems, or retaliation for previously opposed discrimination or coercion.

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 ADA Coordinator or any of the agencies listed:

Commissioner of Social Services
Attn: ADA Coordinator
55 Farmington Avenue
Hartford, CT 06105-5033

Ph: (860) 424-5040
Fax: (860) 424-4948
TDD: (800) 842-4524
Email: AffirmativeAction.DSS@ct.gov

Connecticut Commission on Human Rights and Opportunities
450 Columbus Boulevard, Suite 2
Hartford, CT 06103

Ph: (860) 541-3400 Toll free: (800) 477-5737
Fax: (860) 246-5265
TDD: (860) 541-3459
Web: https://portal.ct.gov/CHRO

U.S. Dept. of Health and Human Services, Office for Civil Rights
JFK Federal Building, Room 1875
Boston, MA 02203

Ph: (617) 565-1340 Toll free: (800) 368-1019
Fax: (617) 565-3809
TTY: (800) 537-7697
Web: https://www.hhs.gov/ocr/complaints/index.html

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Do not return to DSS

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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. Answer the questions below and print and sign your name in the space given.

- Are you registered to vote? ☐ Yes I am already registered ☐ No I am not registered
- 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, or if you need another form, 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