

STATE OF CONNECTICUT - DEPARTMENT OF SOCIAL SERVICES  
Instructions for Special Eligibility Determination Document

The purpose of this form is to collect information we need to determine if you are eligible to receive help from the Department of Social Services.

This form may be used only by single individual households or married couples applying for the State Supplement, Medicaid, Food Stamp, State-Administered General Assistance (SAGA), or Home Care for Elders programs. Households greater than two persons or which include dependent children must use form W-1E "Eligibility Determination Document" to apply for assistance. If you are applying only for Food Stamps, it will be easier for you to use form W-1FOOD "Application for Food Stamp Benefits Only".

If you are not a citizen and are applying only for Emergency Medicaid, you do not have to provide your Social Security number or citizenship status.

Unless otherwise instructed, be sure to answer all the questions on the form. Answer each question to the best of your ability. If the answer to a question is no, write or check "NO" on the form. If the answer to a question is yes, write or check "YES" and give the details in the space provided. Your answers must be complete and correct so that we may process your Special Eligibility Determination Document properly.

If you cannot do something we ask you to do because you have a disability, you may request an accommodation or special help. We can use different methods to complete your application. For example, we may be able to complete your application over the telephone if you cannot come into the office, we may be able to help you get certain proofs, or give you extra time to provide information. If we do not agree to provide an accommodation or special help, you can complain to the department's Americans with Disabilities Act (ADA) coordinator. See the bottom of page 14 for how to make a complaint.

You can also have another person apply for Food Stamps for you or get an EBT card to buy your food. You may have someone else help you complete the form. If someone else does help you, be sure that the helper signs and dates the last page of the form. Be sure that you sign and date the form as well.

The program(s) for which you are applying require that you have a face-to-face interview. Your interview is scheduled for \_\_\_\_\_ at \_\_\_\_\_. Complete this form and bring it with you to the interview.

Mail or bring in your completed application form to this office no later than \_\_\_\_\_. If you bring this form in, be sure to call your worker for an appointment first.

Please try to bring in or mail the required proofs with the application form. However, if you do not have all the proofs, please keep your appointment or mail the form in before the deadline with whatever information you do have. If you do not appear for your interview the department will not automatically schedule a second appointment. You will have to contact the department to reschedule an appointment.

IF YOU HAVE ANY QUESTIONS, PLEASE CALL YOUR ELIGIBILITY WORKER, \_\_\_\_\_,  
AT \_\_\_\_\_.

To Home Care applicants: You must call our Alternate Care Unit at 1-800-445-5394 to be screened for Home Care Services before completing this application. If you appear to be eligible, we will also process this form as an application for Medicaid.

THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE (800) 842-1508 OR TDD/TTY (800) 842-4524.

OFFICE ADDRESS

(See Reverse Side for Information about Required Proofs and Processing Time Limits)

Certain information that you have given in your Special Eligibility Determination Document must be verified before the department can grant assistance. The following list will give you an idea of the documents that may be used to prove your statements.

**Household Members** - You may use copies of birth certificates, baptismal records or other records documenting birthdates and relationships, marriage and divorce papers, or school attendance verification for children over age 18.

**Income** - You may provide copies of pay stubs, tax returns or bookkeeping records for self-employed household members, copies of checks from the source of income, an award letter or a signed statement from the person or source of any income.

**Assets** - You may use bankbooks, bank statements, trust fund agreements, copies of stocks/bonds/U.S. Savings bonds, life insurance policies, a letter from a financial institution, a copy of a car registration, deeds or legal agreements as proof.

**Shelter and Utility Costs** - These may be proved by giving your worker your latest rent receipt, a copy of your lease, a copy of your utility bill, a letter from your landlord, a copy of your mortgage bill, a copy of your property tax bill or a copy of your homeowner's insurance.

**Medical Insurance and Expenses** - Medical insurance policies, medical cards and copies of medical bills may be used to prove these expenses.

**Child Support Costs** - You may provide a copy of the court order to prove the legal obligation to pay child support and the obligated amount. Acceptable forms of proof of your actual payments include such documents as cancelled checks, wage withholding statements, or a statement from the custodial parent as to the amount you pay in child support or the child support expected to be paid within the certification period.

**Students** - Acceptable proofs are items such as a signed School Verification Letter (W-1446), a copy of a recent (less than 30 days old) report card or a statement from a school official.

**Other** - \_\_\_\_\_

#### EXPEDITED SERVICE, EMERGENCY BENEFITS AND PROCESSING TIME LIMITS

We are required to make a determination of eligibility within certain time limits. If you are applying for a money payment or for medical assistance under a Public Assistance program, we must decide if you qualify and, if you are eligible, issue benefits within 45 days unless you are applying for a disability benefit. In that case we must decide and, if you are eligible, issue benefits within 90 days.

For Food Stamp applications, we must decide if you qualify and, if you are eligible, provide you with benefits within 30 days. If your situation is such that you have no, or almost no, income or assets, we are required to decide if you qualify and provide you with expedited service Food Stamp Benefits within seven days. You may also qualify for EXPEDITED SERVICE Food Stamp benefits if your monthly shelter expenses are more than your gross income and assets, or you are a destitute migrant or seasonal farm worker.

For State-Administered General Assistance (SAGA) applications, we must decide if you qualify and, if you are eligible, issue cash benefits within 10 days and medical benefits within 45 days. If you qualify for emergency food or medical assistance, we must issue benefits within 4 days.

If you need food or medical assistance before we decide if you qualify for benefits, or if your circumstances are such that you are in an EMERGENCY SITUATION and your needs are not being met by another source, contact your eligibility worker. Examples of these emergency situations include those in which there is an immediate need for medical treatment and you don't have a medical card, or you have no money and there is a threat of serious harm as a result.

If we know about your emergency, we can give your application a priority in deciding if you qualify. Each office has a client representative who will work with your eligibility worker in emergency situations to help make sure you get benefits quickly if it is possible. We cannot provide benefits to you, however, until we have all the information we need to make the decision that you do, in fact, qualify.

If you need legal help with your application contact your Statewide Legal Services office at 1-800-453-3320.

STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES

APPLICATION PART 2: SPECIAL ELIGIBILITY DETERMINATION DOCUMENT

| For Worker's Use Only  | Worker ID | Programs Applied For/Receiving | Assistance Unit Number(s) | Application Date                        |  |  |          |
|--|-----------|--------------------------------|---------------------------|---|--|--|----------|
| <p><b>Answer the following questions honestly and completely. Failure to give truthful and complete information may result in denial of assistance and criminal prosecution. Please print all answers.</b></p>   |           |                                |                           |   |  |  |          |
| <p>What help do you need? <input type="checkbox"/> Money Assistance <input type="checkbox"/> Help with Medical Costs <input type="checkbox"/> Other (explain) _____<br/>           (Check all that apply) <input type="checkbox"/> Food Stamp Assistance <input type="checkbox"/> Help with Cost of Nursing Home, Rest Home or Home Care _____</p> |           |                                |                           |   |  |  |          |
| <p>Do you or any other household member receive assistance now? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, from which program(s)? List ID numbers.</p>   |           |                                |                           |   |  |  |          |
| <p>Do you have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, do you need an accommodation or special help in applying for assistance because of your disability? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>           What type of special help do you need? _____</p>                         |           |                                |                           | <p>What language do you speak best?</p> |  |  |          |
| <b>NAME AND ADDRESS</b>  |           |                                |                           |   |  |  |          |
| First Name   | M.I.      | Last Name                      | Maiden Name               | Telephone Number<br>Your #<br>Message # |  |  |          |
| Where do you live?   | Number    | Street                         | Apt. Number               | Floor Number                            | City                                       | State  | Zip Code |
| Where is your mail sent if different from above?   | Number    | Street                         | Apt. Number               | Floor Number                            | City                                       | State  | Zip Code |
| <b>Previous Addresses</b>  |           |                                |                           |   |  |  |          |
| If you have lived here less than 36 months, list your previous addresses in that time.   |           |                                |                           |   |  |  |          |
| Address (Street, City, State, Zip Code)  |           |                                | Dates                     |   | Was this home owned by a household member? |  |          |
|  |           |                                | From                      | To                                      |  |  |          |
| 1  |           |                                |                           |   |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |          |
| 2  |           |                                |                           |   |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |          |
| <b>AUTHORIZED REPRESENTATIVE</b>   |           |                                |                           |   |  |  |          |
| <p>Do you wish to appoint an Authorized Representative to act on your behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you making this application as a representative for someone else? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered Yes to either question, complete the section below.</p>      |           |                                |                           |   |  |  |          |
| <p>Type of Representative: <input type="checkbox"/> Hospital/Medical Substance Abuse Treatment Facility<br/> <input type="checkbox"/> Authorized Representative <input type="checkbox"/> Conservator <input type="checkbox"/> Guardian <input type="checkbox"/> Power of Attorney</p>  |           |                                | Representative's Name     |   |  |  |          |
| Address (Street, City, State, Zip Code)  |           |                                |                           | Telephone Number                        |  |  |          |

**Before you fill out the rest of this form, please read the following instructions.**

*If you are applying for State Supplement, Medicaid, State-Administered General Assistance (SAGA), Food Stamps or Home Care Programs, list yourself as the first household member and then list your spouse if he/she lives with you.*

*If you are applying for FOOD STAMP BENEFITS ONLY, you may want to use form "W-1FOOD" instead because it is easier to complete.*

*Finally, if you are not a citizen, you must include your sponsor and your sponsor's spouse as though they are household members, even if they do not live with you.*

*If you are not sure whom you should list, call your worker.*

| HOUSEHOLD MEMBERS   |  |  |                                    |  |     | -FOR WORKER'S USE ONLY-   |
|---|--|--|------------------------------------|--|-----|---|
| <p><b>You are not required to provide race or ethnic origin information, however, your cooperation will help determine compliance with the federal civil rights law. If you do not wish to give this information, it will in no way affect consideration of your application. We are authorized to ask for this information under Title VI of the Civil Rights Act of 1964.</b></p> |  |  |                                    |  |     |   |
| <b>1</b>  | Name   | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F   | Relationship to you<br><b>SELF</b> | Date of Birth  | Age | Place of Birth (optional if you are not applying for yourself)    |
|   | Name and Address of School or Training Program |  |                                    | Social Security Number(s) (optional if you are not applying for yourself)    |     |   |
| <p>Are you any of the following? (check all that apply)</p> <input type="checkbox"/> Disabled <input type="checkbox"/> On Strike <input type="checkbox"/> Attending Day Care<br><input type="checkbox"/> Blind/Visually Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Pregnant: Expected Due Date _____   |  |  |                                    |  |     |   |
| <p>Marital Status (check one): <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed</p>  |  |  |                                    |  |     |   |
| <p>Are you Hispanic/Latino?<br/><input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |  | <p>Racial Origin: (check all that apply)</p> <input type="checkbox"/> Asian <input type="checkbox"/> Black/African descent <input type="checkbox"/> Pacific Islander<br><input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Alaskan Native/Eskimo |                                    |  |     |   |
| <p>If you are between 16 and 65 years old, are you able to work now? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain.</p>  |  |  |                                    |  |     |   |
| <b>2</b>  | Name   | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F   | Relationship to you                | Date of Birth  | Age | Place of Birth (optional if you are not applying for this person) |
|   | Name and Address of School or Training Program |  |                                    | Social Security Number(s) (optional if you are not applying for this person) |     |   |
| <p>Is this person any of the following? (check all that apply)</p> <input type="checkbox"/> Disabled <input type="checkbox"/> On Strike <input type="checkbox"/> Attending Day Care<br><input type="checkbox"/> Blind/Visually Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Pregnant: Expected Due Date _____  |  |  |                                    |  |     |   |
| <p>Marital Status (check one): <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed</p>  |  |  |                                    |  |     |   |
| <p>Are you Hispanic/Latino?<br/><input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |  | <p>Racial Origin: (check all that apply)</p> <input type="checkbox"/> Asian <input type="checkbox"/> Black/African descent <input type="checkbox"/> Pacific Islander<br><input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Alaskan Native/Eskimo |                                    |  |     |   |
| <p>If this person is between 16 and 65 years old, are they able to work now? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain.</p>  |  |  |                                    |  |     |   |

**HOUSEHOLD MEMBERS (CONTINUED)**

-FOR WORKER'S USE ONLY-

If you are applying for State Administered General Assistance (SAGA), State Supplement or Food Stamps, have you or your spouse ever been convicted of a felony?  Yes  No If Yes, please answer the following questions about that household member. Is there a current felony charge against you or your spouse?  Yes  No

Name \_\_\_\_\_ Are you fleeing from the authorities?  Yes  No If Yes, please explain.

Are you on parole?  Yes  No If Yes, are you in violation of your parole?  Yes  No If Yes, please explain.

Have you been convicted of a drug related felony since 8/22/96?  Yes  No

If Yes, have you completed the sentence imposed by the court?  Yes  No

Are you complying with your probation requirements?  Yes  No

Are you in the process of completing or have you completed participation in a substance abuse treatment or monitoring program?  
 Yes  No If Yes, please explain.

Does anyone else, other than your spouse, live with you?  Yes  No If Yes, complete below:

| Name | Relationship to you | Does this person:   | Amount person pays |
|------|---------------------|---|--------------------|
|      |                     | <input type="checkbox"/> Share expenses <input type="checkbox"/> Pay for room and meals<br><input type="checkbox"/> Buy and cook food with you <input type="checkbox"/> Pay for room only | \$ _____ per _____ |
|      |                     | <input type="checkbox"/> Share expenses <input type="checkbox"/> Pay for room and meals<br><input type="checkbox"/> Buy and cook food with you <input type="checkbox"/> Pay for room only | \$ _____ per _____ |

If you (or your spouse) are applying for benefits and are not a citizen, please give the following information. You do not need to complete this section if you are applying only for Emergency Medical assistance:

| Household Member's Name | Country of Origin | Date of Entry into: |     | Status (Permanent Resident, Refugee, etc.) and Registration Number | Name, Address, Relationship of Sponsor, and Date Affidavit Was Signed |
|-------------------------|-------------------|---------------------|-----|--|---|
|                         |                   | U.S.                | CT. |  |   |
|                         |                   |                     |     |  |   |
|                         |                   |                     |     |  |   |

If you (or your spouse) are a veteran or a spouse, widow(er) or child of a veteran, please give the following information:

| Household Member's Name | Veteran's Name | Relationship To Veteran | Military Service Number | Veteran Claim Number |
|-------------------------|----------------|-------------------------|-------------------------|----------------------|
|                         |                |                         |                         |                      |
|                         |                |                         |                         |                      |

**HOUSEHOLD MEMBERS (CONTINUED)**

-FOR WORKER'S USE ONLY-

Do you (or your spouse) expect to receive an inheritance?  Yes  No If Yes, list amount \$ \_\_\_\_\_

Who expects to receive this inheritance? \_\_\_\_\_

From whose estate will this inheritance be coming? \_\_\_\_\_

Are you (or your spouse) suing anyone? [Include suit(s) due to an accident.]  Yes  No If Yes, provide the following information: person involved, reason for suit, amount of expected settlement, name and address of your attorney.

During the last 12 months were you (or your spouse) involved in a work related, automobile, or other type of accident which required medical attention?  Yes  No If you were, when did the accident occur? Please describe what happened.

**MEDICAL INSURANCE**

Indicate whether you (or your spouse) are covered by any of the following insurances.

| Insurance Type   | You  | Spouse   | Policy/Claim Number | Effective Date | Insurance Company Name(s) | Premium Amount |
|--|--|--|---------------------|----------------|---------------------------|----------------|
| Medicare Part A – hospital?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                     |                |                           |                |
| Medicare Part B – medical?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                     |                |                           |                |
| Other medical/hospital insurance such as Blue Cross/Blue Shield, Health Maintenance Organization (HMO) or union coverage?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                     |                |                           |                |
| Long-Term Care Insurance (coverage that will pay specifically for nursing home care, adult day care, assisted living care or home care and is separate insurance from medical/hospital insurance)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |                     |                |                           |                |

If Yes, is your Long-Term Care policy approved under the Connecticut Partnership for Long-Term Care program (the face page of the policy will indicate whether the policy is approved under the Connecticut Partnership and provides Medicaid Asset Protection)?  Yes  No

If you checked Yes for any insurance other than Medicare, you must complete form W-1685 which asks more specific medical insurance questions.

Have you (or your spouse) received any hospital, doctor, or other medical services in the previous three months which have not been paid?  Yes  No

Do you have any other medical bills for which you are making payment?  Yes  No

**LEGALLY LIABLE RELATIVE INFORMATION**

-FOR WORKER'S USE ONLY-

List your parents if you are not living with them and you are under age 18.

| Absent Parent's Name | Child(ren)'s Name(s) | Parent's Address | Date parent left home | Do you receive money from this person?                   |
|----------------------|----------------------|------------------|-----------------------|--|
|                      |                      |                  |                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                      |                      |                  |                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you are married and your spouse is not living with you, complete the following items:

| Spouse Name | Address | Date of Separation |
|-------------|---------|--------------------|
|             |         |                    |

**ASSETS**

Tell us about the assets owned by you (or your spouse). Also, tell us about any asset with your name (or the name of your spouse) even if the asset is not yours. Answer each numbered section. Complete any section where you answered Yes.

1. CASH ON HAND (Money that is not in an account)  Yes  No

| Name | Amount | Name | Amount |
|------|--------|------|--------|
|      | \$     |      | \$     |

2. BANK/CREDIT UNION ACCOUNTS  Yes  No List savings, checking, C.D., I.R.A., vacation, Christmas club, burial accounts or any other type of account. Include joint and trustee accounts listed under your name (or the name of your spouse), even if the money is not yours or theirs. Also, include accounts, such as those for children, held in trust for you (or your spouse).

| Name | Bank/Credit Union Name and Address | Account Number | Balance |
|------|------------------------------------|----------------|---------|
|      |                                    |                | \$      |
|      |                                    |                | \$      |
|      |                                    |                | \$      |
|      |                                    |                | \$      |

3. LIFE INSURANCE POLICIES/DEATH BENEFITS (Include group policies)  Yes  No

| Name | Company Name and Address | Policy Number | Face Value |
|------|--------------------------|---------------|------------|
|      |                          |               | \$         |
|      |                          |               | \$         |

**ASSETS (CONTINUED)**

-FOR WORKER'S USE ONLY-

4. ANNUITIES/TRUST FUNDS/LIMITED PARTNERSHIPS  Yes  No

| Name | Company Name and Address | Account Number | Amount |
|------|--------------------------|----------------|--------|
|      |                          |                | \$     |

5. STOCKS/MUTUAL FUNDS/BONDS/U.S. SAVINGS BONDS  Yes  No For stocks and mutual funds, identify owner, name of company, number of shares and value. For bonds, identify owner, type of bond, serial number, date of purchase and denomination.6. PREPAID FUNERAL CONTRACT  Yes  No

| Name | Funeral Home Name and Address | Amount |
|------|-------------------------------|--------|
|      |                               | \$     |

**Motor Vehicles**Do you (or your spouse) own, have registered or have listed in your/their name a car, truck, boat, camper, recreational vehicle, trailer, motorcycle or other vehicle (include unregistered vehicles)?  Yes  No If Yes, complete the following section:

| Owner Name | Vehicle Type | Year | Make | Model | Mileage | License Plate Number | Amount Owed |
|------------|--------------|------|------|-------|---------|----------------------|-------------|
|            |              |      |      |       |         |                      | \$          |
|            |              |      |      |       |         |                      | \$          |

**Real Estate**Do you (or your spouse) own any real estate (include home, land, and non-home property)?  Yes  No If you are applying for SAGA or State Supplement does your spouse own any real estate (include home, land and non-home property)?  Yes  No If Yes to either question, please give the following information:

1 Owner(s) Location (Street, Town, State)

Is this:  land only  single family dwelling  two-family dwelling  other (specify \_\_\_\_\_)

2 Owner(s) Location (Street, Town, State)

Is this:  land only  single family dwelling  two-family dwelling  other (specify \_\_\_\_\_)Do you (or your spouse) have life-use of any real estate?  Yes  No**Other Assets**Do you (or your spouse) own any other assets not listed above (for example, contents of safe deposit box, mortgage payable to you, jewelry, furs, paintings, etc.)?  Yes  No If Yes, identify owner, asset and value.



**Transfer of Assets**

-FOR WORKER'S USE ONLY-

Have you (or your spouse) sold, traded, given away, or transferred ownership of any motor vehicles, bank accounts, property of any kind, stocks, bonds, mutual funds or cash during the last thirty-six months?  Yes  No  
 Have you had assets transferred through the probate court/surrogate courts in state or out of state in the last 36 months?  Yes  No  
 If Yes to either question, what was transferred, sold or given away, to whom, when, and how much money or what was received in return?  
 (Attach an additional page if needed.)

Have you (or your spouse) established a trust or funded a trust with income or property of any kind within the past 60 months?  
 Yes  No If Yes, provide additional details. (Attach an additional page if needed.)

Have you (or your spouse) closed any type of account during the last thirty-six months?  Yes  No If Yes, explain below. Include the bank name, address, account number and date closed.

Have you (or your spouse) sold or junked a motor vehicle in the last thirty-six months?  Yes  No

**INCOME**

How have you paid your bills during the last six months? If you have no income or your expenses are greater than your income, how do you pay your bills?

**Current and Previous Employment Income**

Are you (or your spouse) employed full-time, part-time or temporarily?  Yes  No  
 Is anyone self-employed? For example, does anyone own a business, baby-sit, give home demonstrations, work on construction, sell homemade crafts, clean house, etc.?  Yes  No  
 If you answered Yes to either of the above two questions, complete the following section. If a person has more than one job, list each job separately. Include anyone who receives income from a job training program.  
 If No, list the last job held by each person within the last year. Attach an additional page if needed.

|                           |      |                       |  |                       |              |            |
|---------------------------|------|-----------------------|--|-----------------------|--------------|------------|
| <b>1</b>                  | Name | Pay before deductions | Tips? <input type="checkbox"/> Yes <input type="checkbox"/> No | Hours worked per week | Date Started | Date Ended |
|                           |      | \$ per                | Weekly amount \$   |                       |              |            |
| Employer Name and Address |      |                       |  | Reason For Leaving    |              |            |
| <b>2</b>                  | Name | Pay before deductions | Tips? <input type="checkbox"/> Yes <input type="checkbox"/> No | Hours worked per week | Date Started | Date Ended |
|                           |      | \$ per                | Weekly amount \$   |                       |              |            |
| Employer Name and Address |      |                       |  | Reason For Leaving    |              |            |

**Current and Previous Employment Income (continued)**

-FOR WORKER'S USE ONLY-

Have you (or your spouse) quit or been fired from a job in the last ninety days?  Yes  No If Yes, list name(s) and reason(s) for quitting or being fired.

| Name | Name of Former Employer | Reason for Quit or Fire |
|------|-------------------------|-------------------------|
|      |                         |                         |
|      |                         |                         |

**Dependent Care**

Do you (or your spouse) pay someone for day care for a child or disabled adult so that you, he or she can work, attend training or look for a job?  Yes  No If Yes, complete below:

| Name (Who day care is for) | Amount Per Week | Name and Address of Day Care Provider | Telephone Number |
|----------------------------|-----------------|---------------------------------------|------------------|
|                            | \$              |                                       |                  |
|                            | \$              |                                       |                  |

Does the State or anyone else pay your day care?  Yes  No If Yes, how much? Amount \$ \_\_\_\_\_

**Students**

Are there any students (full-time or part-time) in your household over 18 years of age?  Yes  No  
If Yes, complete the following section.

| Name of Student             | School or Program |                          |
|-----------------------------|-------------------|--------------------------|
|                             |                   |                          |
| Expected Date of Graduation | Semester Hours    | Tuition & Mandatory Fees |
|                             |                   | \$                       |

Is this student on a meal plan?  Yes  No

Does this student have a job?  Yes  No If Yes, how many hours per week? \_\_\_\_\_

Does this student receive federally funded work-study?  Yes  No If Yes, how many hours each week? \_\_\_\_\_

Does this student receive any educational grants, loans, and scholarships, including work-study?  Yes  No  
If Yes, form W-1471, which asks more specific school information must be completed.

**Other Income**

-FOR WORKER'S USE ONLY-

Check Yes or No to indicate if you (or your spouse) receive or have applied for money from any of the following sources:

- 1) Child Support and/or Alimony  Yes  No
- 2) Social Security [Types are: Retirement (OA), Disability, Survivor's Disability Insurance (SDI)]  Yes  No
- 3) SSI (Supplemental Security Income)  Yes  No
- 4) Unemployment Compensation  Yes  No
- 5) Other Government Benefits (Types are: Railroad Retirement, Educational Loans and Grants, Veterans Benefits, VA Aid and Attendance, Military Allotment and HUD Subsidy)  Yes  No
- 6) Other Private Benefits: Maternity/Sick Pay, Pensions, Worker's Compensation, Union Benefits  Yes  No
- 7) Other Income: from Stocks, Bonds, Annuities, Rental Property, Roomers, Boarders, Money from Friends or Relatives, Any Other Source  Yes  No

If you (or your spouse) are receiving income from any of the sources listed above, complete the following:

| Name | Type of Income | Amount Receiving/<br>How Often? | ID/Claim Number(s) (Optional<br>if not applying for assistance) |
|------|----------------|---------------------------------|---|
|      |                | \$ _____ per _____              |   |
|      |                | \$ _____ per _____              |   |
|      |                | \$ _____ per _____              |   |
|      |                | \$ _____ per _____              |   |

If you (or your spouse) have applied for income from any of the sources listed above, complete the following:

| Name | Type of Income | Date of Application or Claim |
|------|----------------|------------------------------|
|      |                |                              |
|      |                |                              |
|      |                |                              |

Have you (or your spouse) received cash assistance for your family from any state or U.S. territory other than Connecticut since 10/1/96?

Yes  No If Yes, from which state or U.S. territory? \_\_\_\_\_ When? From \_\_\_\_\_ To \_\_\_\_\_

Have you (or your spouse) received any other assistance from another state within the last 90 days?  Yes  No If Yes,

which type of assistance?  Food Stamps  Medical From which State? \_\_\_\_\_

**LIVING ARRANGEMENT AND SHELTER EXPENSES**

-FOR WORKER'S USE ONLY-

Check one of the following boxes which most clearly describes your type of living arrangement:

- Own Home     Share Rent     Homeless     Rent a room (meals included)     Other Medical Facility  
 Rent     Living with another and not paying rent     Rent a room (meals not included)     Nursing Home  
 Other (specify) \_\_\_\_\_     Licensed Boarding Facility

If you checked "Licensed Boarding Facility" or "Other Medical Facility", do not answer the remaining questions A-I in this section. If you checked "Nursing Home", do you have a spouse in the community?  Yes  No If Yes, answer questions A, B, C, D, H and I in this section about your spouse's living arrangement and shelter expenses. If No, do not answer the remaining questions in this section.

A. Write in the amounts you are expected to pay each month for the following costs:

Rent \$ \_\_\_\_\_ Mortgage \$ \_\_\_\_\_ Condominium Fees \$ \_\_\_\_\_  
 Taxes \$ \_\_\_\_\_ Insurance \$ \_\_\_\_\_

B. Do you receive any type of rental or housing assistance, such as Section 8, HUD, or State Rental Assistance?

Yes  No If Yes, enter amount **you pay** to the landlord \$ \_\_\_\_\_.

C. Do you pay for heat?  Yes  NoD. Do you have an air conditioner and pay for electricity?  Yes  NoE. Does your landlord charge you extra for heat or cooling?  Yes  NoF. Did you receive a check from the Energy Assistance Program during the last year at this address?  Yes  No

G. Do you pay for any of the following utilities: electricity, gas for cooking, trash removal, water, sewer, septic maintenance?

Yes  No

H. Do you pay a monthly phone bill (residential or cellular)?  Yes  No

I. If you rent, please provide the following information about your landlord.

Landlord Name

Landlord Address

Telephone Number

**SPECIAL CLOTHING NEED FOR STATE SUPPLEMENT APPLICANTS**

The department may be able to help you (or your spouse) if you do not have the proper type or amount of clothing.

Do you (or your spouse) have a need for clothing?  Yes  No**SPECIAL EATING ARRANGEMENT**

Complete this section ONLY if you (or your spouse) are blind, disabled, or over age 65, and are applying for State Supplement or medical assistance.

Do you (or your spouse) eat at least one meal a day at a restaurant?  Yes  NoDo you (or your spouse) have a special diet?  Yes  No If Yes, why?

**CHILD SUPPORT DEDUCTION – FOOD STAMP PROGRAM**

FOR WORKER'S USE ONLY-

Do you (or your spouse) pay court ordered child support to someone for a child(ren) who is not a member of your household?

Yes  No If Yes, complete one of the following sections for each person to whom you pay child support.

Name and address of the person you send the child support payments to: *(If you make payments to a state, list the state and file number)*

1

Name and date of birth of the child(ren) for whom you pay this child support:

Name

DOB

Name

DOB

What is the amount of child support that has been ordered by the court? \$ \_\_\_\_\_ How often is support due? \_\_\_\_\_

How much child support do you **actually** pay each month? \$ \_\_\_\_\_ Do you pay by wage withholding?  Yes  No

Have you been paying child support for three or more months within the last six-month period?  Yes  No

Are your support payments up to date?  Yes  No

Are you making payments to reduce an arrearage (back support)?  Yes  No

If yes, how much do you pay on the arrearage? \$ \_\_\_\_\_ How often do you pay? \_\_\_\_\_

Name and address of the person you send the child support payments to: *(If you make payments to a state, list the state and file number.)*

2

Name and date of birth of the child(ren) for whom you pay this child support:

Name

DOB

Name

DOB

What is the amount of child support that has been ordered by the court? \$ \_\_\_\_\_ How often is support due? \_\_\_\_\_

How much child support do you **actually** pay each month? \$ \_\_\_\_\_ Do you pay by wage withholding?  Yes  No

Have you been paying child support for three or more months within the last six-month period?  Yes  No

Are your support payments up to date?  Yes  No

Are you making payments to reduce an arrearage (back support)?  Yes  No

If yes, how much do you pay on the arrearage? \$ \_\_\_\_\_ How often do you pay? \_\_\_\_\_

## READ CAREFULLY AND SIGN

### FOR ALL PROGRAMS

I understand and agree to the following:

- I will notify the Department of Social Services within 10 days of any change in income, assets or living arrangements.
- I may request a hearing in writing if I disagree with an action taken on my case. I may request a hearing orally if applying for Food Stamps.
- All information given on this form 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 the Department of Social Services to verify any information given on this form.
- All information given on this form, including Social Security numbers, is confidential, except as authorized or required by state or federal law, and will be used only to administer all programs except for certain exceptions for the Food Stamp and SAGA programs indicated below. Information I give on this form may be shared with law enforcement officials in order to locate and arrest persons fleeing to avoid the law.
- I give my permission to the department to release information about me and others in my family who are receiving benefits for purposes directly connected with the administration of the department'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 declare that I and the other people for whom I am requesting benefits are either United States citizens or, in the event any of us are not, that the information I have provided regarding anyone's non-citizen status is true.
- I authorize the Department of Social Services to verify any information regarding anyone's non-citizen status with the Bureau of Citizenship and Immigration Services (BCIS). I understand that the department will not share the information given on this form with BCIS. I also understand that BCIS CANNOT use this application to deny admission to the U.S., harm permanent resident status or deport me.
- 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.
- Information available to the State through the Income and Eligibility Verification System (IEVS) will be requested and used to process my request for assistance. This information will come from the Labor Department, the Social Security Administration and the Internal Revenue Service as well as other agencies when allowed by law. Information received may be verified directly with other sources such as banks and employers. Results from such verification may affect my household's eligibility and level of benefits.
- Information regarding child support payments, which are made to the State on behalf of my child, may be verified with the Bureau of Child Support Enforcement (BCSE).
- Giving the information requested on the application is voluntary. If I fail to give certain information, my application will be denied.
- I will cooperate with state and federal personnel in Quality Control Reviews.

### FOR FOOD STAMPS

I understand and agree to the following:

- People who quit jobs or cut back on their hours without a reason cannot get Food Stamps. The first time it is for three months. It is six months the second time. It is forever the third time they quit a job.
- People who lie about who they are or where they live cannot get Food Stamps for ten years.
- People who do not follow the Food Stamp Employment and Training rules cannot get Food Stamps. The first time it is for three months. It is six months the second time. It is forever the third time they do not follow the rules.
- When people who receive Food Stamps break a program rule on purpose, they cannot get Food Stamps. The first time it is for one year. It is two years the second time. It is forever the third time they break a rule.
- People found guilty of trafficking in Food Stamps of more than \$500 cannot get Food Stamps. Trafficking in Food Stamps means selling them instead of using them to buy food for their family.
- People who are found guilty of buying illegal drugs with Food Stamps cannot get Food Stamps for two years.
- Law enforcement officers can get, from the Department of Social Services, the address, Social Security number and photograph of a person who gets Food Stamps when the person is a fleeing felon or violating parole or probation. They can also get this information about a person who may know something about a felony.
- Failure to report or verify actual expenses incurred by your household will be seen as a statement that you do not want to receive an allowable deduction for that expense.
- The money in my EBT Food Stamp account will be taken back by the department if I do not make any withdrawals from that account for 9 months (270 days). The amount taken back by the department may be used to reduce any Food Stamp overpayments that exist on my case.

### FOR FOOD STAMPS (continued)

- My application for and receipt of my Food Stamp benefits is a registration for work for myself and all members of my Food Stamp assistance unit who are required to register. I further understand that I and all other members of the Food Stamp assistance unit who are required to do so must participate in Employment Services unless there is good cause not to participate.
- People who live with me but who are not going to receive Food Stamps do not have to give their Social Security numbers. However, if they wish to do so it may be easier to verify their income and speed up the application process.
- People who misuse an Electronic Benefit Transfer (EBT) card may no longer get Food Stamps. They 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 for cash.
- Information on my application form can be given to federal and state agencies as well as private collection agencies if a Food Stamp claim is made against my household.

### FOR STATE SUPPLEMENT

I understand and agree to the following:

- Inheritance money or money from a pending lawsuit will be assigned to the State.
- The State will place a lien against my home and the property of my spouse.
- I will be required to grant the department a security mortgage on the non-home property that I own.
- The State recovers monies from the estates of individuals who received cash assistance.
- My legally liable relative may be billed to repay the State for cash assistance paid to me.
- The State may recover an amount up to the total amount of benefits paid if I or anyone for whom I receive assistance receives money at a future date from sources including but not limited to lottery winnings, an inheritance, settlement of a law suit or the sale of property.

### FOR SAGA CASH AND SAGA MEDICAL ASSISTANCE

I understand and agree to the following:

- Inheritance money or money from a pending lawsuit will be assigned to the State.
- The State will place a lien against my home. The State will also place a lien against the property of the spouse or parent of any member of the household. I understand that I will be required to grant the department a security mortgage on the non-home property that I own.
- The State may recover an amount up to the total amount of benefits paid if I, my spouse, or anyone for whom I receive assistance receives money at a future date from sources including, but not limited to, lottery winnings, an inheritance, settlement of a lawsuit or the sale of property.
- I must cooperate with the State in securing support from spouses and/or parents of all household members.
- 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 cash benefits.
- False or misleading statements made when applying for SAGA violate State law and may cause me to be disqualified for up to one year.

### FOR ALL MEDICAL, MONEY AND HOME CARE PROGRAMS

I understand and agree to the following:

- False or misleading statements made when applying for Medical Assistance violate federal law and may be punishable by a fine up to \$25,000 or imprisonment for 5 years, or both.
- By receiving medical assistance, I allow the State to recover the cost of my medical bills which may have been covered by other insurance directly from the insuring company.
- The State recovers monies from the estates of individuals who received long term care services, Home Care Services or who were age 55 or older at the time that community medical assistance benefits were paid and who do not have a living spouse or a surviving child who is under age 21 or blind or disabled.
- I give the Department of Social Services permission to apply for Medicare on my behalf. I understand that an application will be filed only if the department thinks I am eligible. I also agree to let the Department of Social Services file Medicare claims and pursue appeals. These actions may be taken by the department or its representative.
- I give permission to DSS or any health insurer, provider, or any other entity providing services to me or my family under the Medicaid program to release information about me or my family as necessary for the delivery of Medicaid program services and the administration of the Medicaid program, as permissible by federal or State law.
- I will not alter, trade, sell, or use someone else's medical services identification card.
- The State can place a lien, under certain conditions, on my home if I permanently enter a nursing facility.
- My legally liable relative may be billed to repay the State to repay the cost of my medical care.

## SIGNATURES

I have read this form or have had it read to me in a language that I understand. I certify that the information given on this form is true and complete to the best of my knowledge. If I have knowingly given incorrect information, I may be subject to penalties for false statement as specified in the Connecticut General Statutes Section 53a-157b and 17b-97 and to penalties for larceny as specified in Section 53a-122 and 53a-123. I also may be subject to penalties for perjury under Federal Law. I authorize the Department of Social Services to verify any information given on this form.

X \_\_\_\_\_  
 Applicant's Signature Date

If someone helped the applicant complete this form, this person must sign also.

\_\_\_\_\_  
 Spouse's Signature Date

\_\_\_\_\_  
 Helper's Signature Relationship (if any) Date

\_\_\_\_\_  
 Witness' Signature (if signed with an X) Date

If someone completed this form on the recipient's behalf, this representative must sign also.

\_\_\_\_\_  
 Interpreter's Signature Date

\_\_\_\_\_  
 Representative's Signature Date

\_\_\_\_\_  
 Printed Name of Interpreter/Representative Date

\_\_\_\_\_  
 Reviewed by Date

## AUTHORIZATION TO DISCLOSE APPLICATION STATUS

I, \_\_\_\_\_, hereby authorize the Department of Social Services to share information regarding the status of this application for assistance with the following individuals, agencies or institutions:

| Name | Address | Telephone Number |
|------|---------|------------------|
|      |         |                  |

Applicant's or Authorized Representative's Signature \_\_\_\_\_ Date \_\_\_\_\_

## FOR HOSPITAL AND SUBSTANCE ABUSE TREATMENT FACILITY REPRESENTATIVES

I certify that the applicant was informed of his/her responsibility to complete this application; and that his/her signature could not be obtained for the following reason(s):

**Your Right to Make a Complaint:** Under federal and state law you have the right to make a complaint if you think we have taken actions against you because of your race, color, religion, creed, sex, age, national origin, ancestry, marital status, criminal record, past or present mental disorder, mental retardation, sexual orientation, physical disability or learning disability, including denying your request for a reasonable accommodation because of your disability. You or someone representing you may write to or call one or more of these agencies to make a complaint: **Commissioner of the Department of Social Services, Attention Affirmative Action Director/ADA Coordinator, 25 Sigourney Street, Hartford, CT 06106-5033**, or call 1-860-424-5040 (TDD: 1-800-842-4524); **Connecticut Commission on Human Rights and Opportunities, 21 Grand Street, Hartford, CT 06106**, or call 1-860-541-3400 (TDD: 1-860-541-3459); **US Department of Health and Human Services, Director, Office of Civil Rights, 200 Independence Avenue SW, Room 506-F, Washington, D.C. 20201**, or call 1-202-619-0403 (TDD: 1-202-619-3257); for Food Stamps write **US Department of Agriculture, Director, Office of Civil Rights, Whitten Building, Room 326-W, 1400 Independence Avenue SW, Washington, D.C. 20250-9410**, or call 1-202-720-5964 (voice and TDD).