W-1TB
(New 10/11)

State of Connecticut
Department of Social Services

Tuberculosis (TB) Medicaid Program
Application/Redetermination Form

The Tuberculosis Program provides Medicaid coverage for individuals infected or sick with tuberculosis. This coverage will be limited to tuberculosis-related services relating to the treatment of individuals infected or sick with tuberculosis. These services include prescribed drugs, physician services, laboratory and X-ray services, clinic and Federally-qualified health center services, case management services and services designed to encourage completion of prescribed drugs by outpatients. Diagnosis of tuberculosis must be provided from physician.

Section A. Applicant Information

Name_____ Daytime Phone (___)_____ Evening Phone (___)_____
(Last) (First) (M.I.)

Address_____
(Street) (City) (State) (Zip Code)

Mailing Address_____

Date of Birth_____ Place of Birth_____ SSN_____

Aliases_____ Race/Ethnicity_____ Primary Language_____

Section B. Medical Insurance

Do you have medical insurance of any kind? ☐ Yes ☐ No

If Yes, check one: ☐ Medicare ☐ Medicaid ☐ Group Health ☐ Veteran's ☐ Other

Company Name:_____

Address:_____

Policy Number:_____ Group Number:_____

Policy Start Date:_____ Stop Date:_____

Section C. Immigration Status

Are you a U.S. Citizen? ☐ Yes ☐ No

If No, please give date of entry into the U.S._____ Country of origin_____

Alien Registration Number_____ Non-Citizen Status_____

Important: If you are not a U.S. citizen, you must provide proof of your non-citizen status.

Section D. Please read carefully and sign below.

- This application is a request for help from the Tuberculosis (TB) Medicaid program only;
- All the information given on this form is confidential and will only be used to administer DSS programs;
- The Social Security number given on this form will be used to verify identity and eligibility. The Social Security number will also be matched against federal, state and local government files by computer. The department is allowed to request Social Security numbers based on the following statutes: for Medicaid, 42 USC sections 1320b-7(a)(1), (b)(2) and Connecticut General Statutes section 17b-77.

I authorize the Department of Social Services to verify any information about non-citizen status with the United States Citizenship and Immigration Services (USCIS). I understand that the department will not share the information I give on this form with USCIS. I also understand that USCIS cannot use this application to deny admission to the U.S., harm permanent resident status or deport me.

I give permission to the Department of Social Services, the Connecticut Medicaid Agency, or any health insurer, provider, or any other entity providing services to me under the Medicaid program to release information about me as necessary for the delivery of Medicaid program services and the administration of the Medicaid program, as permissible by federal or state law.

I certify that all statements made on this form are 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 Statute Section 53a-157b and 17b-97 and to penalties for larceny as specified in Sections 53a-122 and 53a-123 as well as penalties for perjury under Federal Law.

In accordance with Federal law and U.S. Department of Health and Human Services (HHS) policy, the Department of Social Services is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write HHS, Director, Office for Civil Rights, 200 Independence Avenue, S.W., Room 509-F, HHH Building, Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY).

Under state law you have the right to make a discrimination complaint if you think we have taken actions against you because of your race, color, religious creed, sex, marital status, age, national origin, ancestry, criminal record, political beliefs, sexual orientation, mental retardation, mental disability, learning disability or physical disability, including but not limited to blindness. You or someone representing you may write to or call one or more of these agencies to make a discrimination complaint: **Commissioner of the Department of Social Services, Attention Affirmative Action Division 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).

Signature Date	Interpreter's Signature *(if any)* Date
Witness' Signature Date *(if application signed with an "x")*	Helper's Signature Date *(if you helped the applicant fill out this form)*
Authorized Representative Name *(if any)*	Authorized Representative Signature Date

Please mail application to Adult Services – 10th floor, Department of Social Services, State of Connecticut, 25 Sigourney St, Hartford, CT 06106-5033 or fax to (860) 424-4957.