CONNECTICUT
Developmental Services

DDS Medicaid Waiver Overview

DDS.Waiver@ct.gov

Topics Covered

- MyAccount
- DSS forms
- How to get individuals back on Medicaid
- Coverage Groups
- Best Practices
- Resources
- Questions

MyAccount

- You can complete:
  - New applications
  - Renewals
- You can upload:
  - Status changes (new address, new arep, etc.)
  - Verifications requested
- Keep record of the submission ID#’s

W-1LINST
(New. 07/22)

State of Connecticut
Department of Social Services

Apply Faster Online!

ConneCT

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

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

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：如果您使用繁體中文，您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 (हिंदी):
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं 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):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-626-6632
(رقم هاتف الصم والبكم: 1-800-842-4524)

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

W-1LTSS

- Submit new application online, if possible.
- Providers can use the W-1LTSS to apply for state supp
- New applications can be sent to DDS.Waiver@ct.gov only for individuals ready to be waivered or already on the waiver.
- Ensure it is sign and benefits marked
- If benefits have been terminated for over 30 days, please reach out to the inbox for further assistance.

W-1ER (Rev. 6/14)

State Of Connecticut
Department Of Social Services
Renewal Of Eligibility

Head Of Household
Client ID Number
_____

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

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

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

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

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

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

_____

Section 1: Head Of Household (you)

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

Home Street Address	City	State	Zip Code

Mailing Address (If Different)	City	State	Zip Code

Section 2: Household Members

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

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

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

W-1ER

- Complete renewals online, if possible
- Submit or upload verifications with renewal
- Send 40 days prior to the due date
- Separate renewal needed for every benefit if renewal is due at a different date. If on same date, one renewal is sufficient
- Paper renewals go to the scanning center.
- Ensure to include the DSS cover sheet
- Send renewal even if you do not receive a renewal form in the mail

Welcome to ConneCT!

Page Help | ¿Habla español? | Access Health CT

Mail Documents to DSS

Get Applications and Forms

DSS forms are available to print here.

Frequently Asked Questions

Find answers to the most commonly asked questions about ConneCT and Access Health CT.

Watch Videos about ConneCT and MyAccount.

Renewing your HUSKY Coverage?

If you are a HUSKY A, B or D member and it's time to renew your coverage, please click here to submit an application. Due to changes in federal law, you will be asked to provide new information. You will be considered for HUSKY Health and other insurance affordability programs offered through Access Health CT.

Am I Eligible?

See if you may qualify to receive medical benefits, help buying food, and/or cash assistance.

CHECK NOW

Apply For Benefits

For a fast and easy way to apply for benefits.

APPLY NOW

MyAccount

Securely access your account and view information about your DSS benefits.

ACCESS NOW

New to ConneCT?
Create an Account

Register Online to Vote

Mail Documents to DSS

To send documents to DSS, you will need a document cover sheet. Include one cover sheet for each envelope of documents you send to DSS. Please note: If you are making an application, a cover sheet is not necessary. You can mail only your application.

My Personal Information

Please complete the below information, and then click Continue.

First Name :	
Middle Initial :	
Last Name :	
Client ID :	
Case Number :	

Print Cover Sheet

W-71GFL
(Rev. 11/13)

State of Connecticut
Department of Social Services
FastLink

(General Cover Sheet)

Case Number :987654321

Client ID :123456789

This address must display in window of return envelope.

DSS ConneCT SCANNING CENTER
PO BOX 1320
Manchester CT, 06045-9968

IMPORTANT: YOU MUST FILL OUT AND SEND THIS COVER SHEET WITH ALL DOCUMENTS RETURNED TO DSS. FAILURE TO SEND COVER SHEET MAY RESULT IN SERVICE DELAY.

Instructions:

1. **Fill out the information below.**

   First Name: John

   Last Name: Doe

   Date: __ / __ / ____

   Number of Pages I am returning (including this cover sheet) : __

2. **Fold this cover sheet so that the return address (above) shows through the return envelope window.**

Note: Please send photocopies of your documents. DO NOT send original documents.

Specific to the indivdiual noted in the cover sheet

123456789 NNN

Benefits Summary

For more information about your benefits, click the icon.

Medical Benefits	EDG Head of Household	Details
Medicaid for Adults	[redacted]	

Recently Received Documents

Below are the documents we have recently received from you. Please note: Documents that have been reviewed may not impact your case status right away.

Document Type	Document Category	Document Status	Document Received Date
W-1348FL	Miscellaneous	Reviewed	12/08/2023
5262	Miscellaneous	Reviewed	12/08/2023
ONAP	Applications and Renewals	Reviewed	02/27/2021
ONAP	Applications and Renewals	Reviewed	02/07/2017
RPO	Miscellaneous	Reviewed	02/07/2017

View Additional Documents

Document Upload

Click here to upload your documents.

Your Notices

You currently do not have any available notices to view.

You are currently enrolled to recieve paperless notices. To disenroll, click here.

Request A Hearing

To request a hearing for this case, click here.

DSS Data Sharing Consent

Data Sharing allows DSS clients to obtain the full range of help for which they are eligible.
If you do not want your data to be shared, you can opt-out by clicking here

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

W-265
(Rev. 6/17)

REPORT OF ADMISSION OR DISCHARGE
RATED HOUSING FACILITY/RESIDENTIAL CARE HOME

Client Name: _____ Client ID#: _____

Facility Name: _____ Vendor ID#: _____

Facility Address: _____ Facility ph#: _____

☐ **ADMISSION** Date of Admission: _____

Admitted From: ☐Home ☐Hospital ☐Skilled Nursing Facility/Chronic Disease Hospital
☐Other Rated Housing Facility ☐ICF/IDD ☐Other Setting/Institution

Please provide the name and address of the home, institution or facility from which the individual was admitted: _____

☐ **DISCHARGE**

☐Notice of Permanent Discharge Date of Discharge: _____

☐Notice of Temporary Discharge Date of Discharge: _____

If a temporary discharge, is the individual expected to return by the last day of the month following the month of discharge? ☐Yes ☐No *

If no, when is the individual expected to return _____

Are you holding the bed for this individual? ☐Yes ☐No *

Discharged to: ☐Home ☐Hospital ☐Skilled Nursing Facility/Chronic Disease Hospital
☐Other Rated Housing Facility ☐ICF/IDD ☐Other Setting/Institution

Please provide the name and address of the home, institution or facility to which the individual was discharged: _____

Completed by: _____ Date: _____
Print Name

_____
Signature

This form is not a request for assistance. Please notify the Department of Social Services (DSS) **within 10 days** of any changes in living arrangements for DSS clients.

To order additional forms, send request on your agency letterhead to:
DSS, Document Center, 55 Farmington Ave., Hartford, CT 06105 FAX: (860) 424-4954
Please include a complete mailing address, form number and the quantity needed.
Please note forms cannot be mailed to P.O. Boxes.

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.

W-265

- CLA's only
- W-265 is needed when there is a new admission, transfer or discharge.
- One form for admission and one for discharge
- Ensure to put Vendor ID#, admission or discharge date and it is signed by authorized rep

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

W-265
(Rev. 6/17)

REPORT OF ADMISSION OR DISCHARGE
RATED HOUSING FACILITY/RESIDENTIAL CARE HOME

Always complete

Client Name: _____ Client ID#: _____

Facility Name: _____ Vendor ID#: _____

Facility Address: _____ Facility ph#: _____

☐ **ADMISSION** Date of Admission: _____

Admitted From: ☐Home ☐Hospital ☐Skilled Nursing Facility/Chronic Disease Ho
☐Other Rated Housing Facility ☐ICF/IDD ☐Other Setting/Institution

Please provide the name and address of the home, institution or facility from which the individual was admitted: _____

Admission info only

☐ **DISCHARGE**

☐Notice of Permanent Discharge Date of Discharge: _____

☐Notice of Temporary Discharge Date of Discharge: _____

If a temporary discharge, is the individual expected to return by the last day of the month following the month of discharge? ☐Yes ☐No

If no, when is the individual expected to return _____

Are you holding the bed for this individual? ☐Yes ☐No

Discharged to: ☐Home ☐Hospital ☐Skilled Nursing Facility/Chronic Disease Hospital
☐Other Rated Housing Facility ☐ICF/IDD ☐Other Setting/Institution

Please provide the name and address of the home, institution or facility to which the individual was discharged: _____

Discharge info only

Completed by: _____ Date: _____
Print Name

Signature _____

This form is not a request for assistance. Please notify the Department of Social Services (DSS) **within 10 days** of any changes in living arrangements for DSS clients.

Always complete

To order additional forms, send request on your agency letterhead to:
DSS, Document Center, 55 Farmington Ave., Hartford, CT 06105 FAX: (860) 424-4954
Please include a complete mailing address, form number and the quantity needed.
Please note forms cannot be mailed to P.O. Boxes.

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.

STATE OF CONNECTICUT – DEPARTMENT OF SOCIAL SERVICES

W-298
(Rev. 11/14)

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Name of DSS Client _____ **Client ID or S.S. #** _____

I authorize DSS to disclose the information indicated below to: (name and address of person to receive information)

Agency name only!

_____

for the following purpose(s):

_____

(If you do not wish to state a purpose, you may write "at my request."

Type of Information DSS is Authorized to Disclose (check all that apply):

☐ PHI (other than mental health, substance abuse and HIV-related records) ☐ mental health records*

☐ substance abuse treatment records** ☐ HIV related information***

☐ DSS application and documentation relating to benefits applied for, received or receiving

☐ other _____
(Please specify)

- I understand that my refusal to sign will not affect my ability to obtain services or benefits from DSS.
- I understand that I may revoke this authorization at any time by notifying DSS, in writing, except if a disclosure has already been made in reliance on it.
- I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by privacy regulations.

This authorization expires on _____ (Date) or upon _____ (Event). (If use or disclosure of PHI is for research, including the creation and maintenance of a database, write "end of research study" or "none.")

X _____ Date: _____

Signature of DSS Client or Person with Legal Authority to Sign for Client
(Attach copy of designation as Conservator/ Power of Attorney/ Guardian)

Printed Name of Person Who Signed _____

Note to Recipient of Information:

* The confidentiality of psychiatric records is required under chapter 899 of the Connecticut general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.

** **Alcohol and/or Drug Treatment Records:** This information has been disclosed to you from records protected by Federal confidentiality rule (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise, permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

*** **HIV Related Information:** This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.

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.

W-298

- Signed by individual or guardian with current date
- Ensure that guardianship paperwork is submitted to DSS.
- Form should have agency name only
- Only needed when there is a new guardian or AREP

W-1685
(Rev. 3/05)

STATE OF CONNECTICUT - DEPARTMENT OF SOCIAL SERVICES

MEDICAL INSURANCE INFORMATION

For Worker's Use Only:
☐ New Insurance ☐ Change in Insurance
HOH Name_____ Client ID #_____
☐ Attached is a copy of the Medical Insurance Card (front and back)

Client Approved for Coverage Group S05 Medicaid For Working Disabled ☐ Yes ☐ No
Premium purchase requested? ☐ Yes ☐ No
Premium currently being paid by DSS? ☐ Yes ☐ No If Yes, to whom?_____

This form asks questions about medical insurance coverage for you and your family. This information is required for our computer file. We also need this information to determine whether we can pay for medical insurance premiums on your behalf.

Fill out a separate form for each policy. Please provide as much information as you can and return it to the local Department of Social Services office no later than _____.

Client Name_____ Customer Service Phone_____

Insurance Company Name_____

Insurance Company Address_____

What medical services are covered by this policy? Check all that apply:
☐ Hospital ☐ Doctor/Medical/Surgical ☐ Prescription ☐ Vision/Optical ☐ Dental ☐ Long Term Care

Policy Number_____ Group Number_____

Is this a Long-Term Care Partnership Policy? ☐ Yes ☐ No

Policy Effective Dates: Start_____ Stop_____

Premium Amount $_____ per _____ Premium Effective Date_____

IF THE INSURANCE IS HELD BY SOMEONE OTHER THAN YOURSELF, PLEASE FILL IN THE FOLLOWING:

Policy Holder's Name_____ Social Security Number_____

Policy Holder's Date of Birth_____

Policy Holder's Address_____

IF THE INSURANCE IS THROUGH EMPLOYMENT, COMPLETE BELOW:

Employer_____ Phone #_____

Employer's Address_____

LIST ALL PERSONS COVERED BY THIS MEDICAL INSURANCE POLICY BELOW:

Name	Date of Birth	Sex	List any major illness/ injury within last year	Worker's Use Only: Client ID #
1.				
2.				
3.				
4.				
5.				
6.				

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 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.

Client Signature_____ Date_____

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

W-1685

- Only if the individual has private insurance, other than Medicare
- Submit copy of insurance card front and back

W-849
(Rev. 4/04)

State of Connecticut- Department of Social Services

Legally Liable Relative (LLR) Form for Institutionalized Children Receiving Medicaid Long Term Care Services or Medicaid Home and Community Based Waiver Services

Applicant/Recipient Name_____

Parent(s) Name(s)._____ Phone#:_____

Parent(s) Address_____

If your child is receiving Medicaid long term care services or Medicaid Home and Community Based Waiver Services, we may require you to contribute to your child's cost of care. This amount cannot exceed the amount of assistance paid to or on behalf of the child by the Department of Social Services.

In order for us to determine your share of the cost of your child's care, we need the following information:

1. The father's net adjusted taxable income for the last calendar year; if applicable: *(Attach a copy of your 1040 tax form to verify your net adjusted taxable income.)* $_____
2. The mother's net adjusted taxable income for the last calendar year; if applicable: *(Attach a copy of your 1040 tax form to verify your net adjusted taxable income.)* $_____
3. The joint net adjusted taxable income of the father and mother for the last calendar year; if applicable: *(Attach a copy of your1040 tax form to verify your net adjusted taxable income.)* $_____
4. If you are divorced or legally separated and are under a court order to pay support please indicate your monthly court ordered support payment: *(Attach a copy of your court order verifying the payment amount.)* $_____
5. Any in-kind support provided by the parent(s) during the last calendar year while living with the child, along with verification of such support, which is over and above that provided to a healthy child. Examples of in-kind support include, but are not limited to, the following:

   cost of medical supplies which are not covered by insurance or Medicaid; $_____

   cost of special diet; $_____

   cost of special transportation; $_____

   cost of adaptations to a home to accommodate the special need of the child; $_____

   other *(please indicate specific service)* $

List below the people living in your household. Place a check mark (4) next to the names of those dependent on you for support

4	Name of Household Members	Age	Relationship

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

W-849

- Only for children, up to age 21.
- Submit with parents or guardians most recent tax returns
- Bank statement showing the child's SSI or SS deposit
- Statement showing how the child's income is spent

State of Connecticut
Department of Social Services

W-300T19
(New 1/16)

Medical Report
(For Title XIX Disability Determination)

Dear Medical Provider:

The patient named on page 2 has applied for assistance with the Department of Social Services (DSS) and has acknowledged physical and/or mental health problems. Please complete the questions on this form in the space provided so we can decide whether he or she is eligible for this assistance. To qualify, the patient must have a severe mental or physical impairment, or a combination of impairments, that precludes substantially gainful employment and is terminal or expected to last for at least 12 months.

In addition to completing these questions, please provide objective medical evidence, including copies of any diagnostic test results, that pertain to the diagnosed condition(s). **We cannot grant benefits without this objective medical evidence.** If you recently submitted this information to the Social Security Administration, or if your progress notes provide this information, you may substitute copies of those materials. A form W-303A, "Permission to Share Medical Information," was provided to the patient to sign so that you may release his or her medical information, but feel free to use your own authorization form if you prefer.

Please return the completed form to:

Colonial Cooperative Care
PO Box 2040
Manchester, CT 06045

Phone: 860-885-0630
Fax: 860-885-0631

To bill DSS for your services, refer to the instructions on form W-513, "Request for Medical Payment," which was also provided to your patient.

Thank you for taking the time to provide information on behalf of your patient.

State of Connecticut
Department of Social Services

W-300MED
(New 1/16)

Medical Report
(For Medicaid for the Employed Disabled)

Dear Medical Provider:

The patient named on page 2 has applied for assistance with the Department of Social Services (DSS). He or she has acknowledged physical and/or mental health problems and is requesting Medicaid benefits. Please complete the questions on this form in the space provided so we can decide whether he or she is eligible for these benefits. To qualify, the patient must have a severe mental or physical impairment, or a combination of impairments, that precludes substantially gainful employment and is terminal or expected to last for at least 12 months.

In addition to completing these questions, please provide objective medical evidence, including copies of any diagnostic test results, pertaining to the diagnosed condition(s). **We cannot grant benefits without this objective medical evidence.** If you recently submitted this information to the Social Security Administration, or if your progress notes provide this information, you may substitute copies of those materials. A form W-303A, "Permission to Share Medical Information," was provided to the patient to sign so that you may release his or her medical information, but feel free to use your own authorization form if you prefer.

Please return the completed form to: Colonial Cooperative Care
PO Box 2040
Manchester, CT 06045

Phone: 860-885-0630
Fax: 860-885-0631

To bill DSS for your services, refer to the instructions on form W-513, "Request for Medical Payment," which was also provided to your patient.

Thank you for taking the time to provide information on behalf of your patient.

Medical Packet

- This is needed only when an individual has not been determined disabled by Social Security.
- This is a temporary disability determination.
- The W-300T19 form is for individuals who are not working.
- The W-300MED is for individuals who are working.
- Either form must be submitted with the W-303 and W-303a forms.
- The medical packet is completed and sent to the address noted on the main form.
- The main form is completed by the physician and/or disability specialist (if the individual has several doctors, multiple copies can be sent).

MEDICAID COVERAGE GROUPS AND ACTIONS

Medicaid Coverage Groups	Description of Medicaid Groups	Action Needed for Waiver Enrollment for Case Manager	Action Needed for Waiver Enrollment for Providers
B01	Husky B - CHIP Program. Not Husky.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov
B02	Husky B - CHIP Program. Not Husky.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
B03	Husky B - CHIP Program. Not Husky.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
D01	Husky A. DCF group under age 18, eligible for adoption assistance or foster care payments.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
D02	Husky A. DCF medical coverage group.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
D03	Husky A. DCF coverage group under 21, for subsidized adoption.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
D04	Husky A. DCF coverage group, between 18 and 21 years and leaving foster care.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
D05	Husky A. DCF coverage group. State funded Medicaid coverage. Limited to selected community based Behavioral Health Services.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
D10	Husky A. Children Receiving Title IV-E Subsidized Guardianship	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
D11	Husky A. Children Receiving Title IV-E Foster Care.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov
X03	Husky A extended medical assistance for 12 mos. After exceeding income limits.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
F04	Husky A extended medical assistance for 12 mos. After exceeding income limits due to child support.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
F06	Husky A presumptive eligibility for kids while pursuing other eligibility.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.
X07	Husky A for Parents and Caretakers/ families.	W-1E application to DDS.Waiver@ct.gov. Waiver packet to PRAT	W-1E application to DDS.Waiver@ct.gov.
X10	Husky A for newborns	Applies to newborns/infants only.	Applies to newborns/infants only.
F10/F11	Husky A for newborns for first 12 mos.	Applies to newborns/infants only.	Applies to newborns/infants only.
F12	Husky A for children 19 & 20 who do not receive SSI or SSDI. AFDC income & asset requirements.	Seek SSA and/or complete Medical packet with T19 app to DDS.Waiver@ct.gov.	Seek SSA and/or complete Medical packet with T19 app to DDS.Waiver@ct.gov.
X25/D25	Husky A. Children Receiving Non-Title IV-E Foster Care/Subsidized Guardianship	W-1E application to DDS.Waiver@ct.gov. Waiver packet to PRAT	W-1E application to DDS.Waiver@ct.gov.
F95	Husky A for medically needy children under 21 years of age.	Initial T19 appl to DDS.Waiver@ct.gov. Waiver packet to PRAT	Initial T19 appl to DDS.Waiver@ct.gov.

T19 Coverage Groups

- Coverage groups
- W01 – Waiver medical. Renewed yearly. Income limit $2,901 (3x's the amount of SSI). Asset $1,600.
- S05 – Med-ConneCT. Income limit $85,000. Asset $20,000 ($30k for married couples). Verifications every 6 months.
- S01 – Cash. Renewed yearly. Income limit is computed on an individual basis, using the standards of basic needs. Asset $1,600.
- H01 (Husky A) – Waiver medical for children (up to age 21). Renewed yearly. Asset limit $1,000. Income determination based on parents' income.
- Husky D/A switches- email DDS.Waiver@ct.gov

Med-Connect & Spend Downs

MED-Connect

Medicaid for Employees with Disabilities, (S05)

- Premium invoices are sent monthly
- Spouse's income counted when determining premium amounts. Household size affect premiums.
- If countable income is below 200% of the Federal Poverty Level (FPL) there is no premium cost.
- If countable income is over 200% FPL, the premium cost is based on 10% of income above the limit.
- Certain assets are exempted under the S05 coverage group.

Spend down

Spend down (S99) is when an individual's income exceeds the Husky C limit.

- Individual's can use certain medical expenses to reduce their income.
- Submit medical expenses that you want to be applied to your spend-down with a DSS spend down cover sheet.
- Spend down must be met for Medicaid to remain active.
- 6-month review period.
- May need to establish a pooled trust to qualify for Medicaid.

Please email DDS.Waiver@ct.gov with any questions.

Over Income vs Over Asset

Over Income

This means that the individual's **income** exceeds the Husky C limit (this is how much an individual receives each month, work, pension, rental income, etc.).

- DSS may place them on a spend down (S99) with a high deductible.

What you can do:

- Check to ensure the income amount listed is correct.
- There aren't many options for individuals over income. Communicate with us to assist with next steps.

Over Asset

This means the individual's **assets** exceed the program limit. (This is how much money the individual has stored overall, bonds, cash, bank accts, life insurance, etc.)

- DSS will discontinue benefits.

What you can do:

- If the individual is employed, ensure that they are on the right coverage group (W01 vs S05)
- Check to ensure the asset amount(s) listed is/are correct.
- There are several options available to reduce assets or maintain assets without impacting the individual's benefits.

DDS

STATE OF CONNECTICUT
DEPARTMENT OF DEVELOPMENTAL SERVICES

460 Capitol Avenue, Hartford, Connecticut 06106 ◆ Phone: 860/418-6000 ◆ Fax: 860/418-6001 ◆

DDS Maintaining Medicaid Eligibility equals Waiver Eligibility

Updated December 2019

Maintaining Medicaid Benefits is really Important!

You must complete your DSS redetermination of eligibility on time!

Your DDS Waiver services are at risk of being discontinued if Medicaid Eligibility is not maintained.

Medicaid requires an annual redetermination application. **You must complete it as soon as you get it.** It is called "State Of Connecticut Department Of Social Services Renewal Of Eligibility W-1ER". It is due **40 days before** your Medicaid expires, if you do not do this before the 40 days you will be discontinued from benefits and forced to reapply for Medicaid. If you are receiving any services from DDS such as; a day program, case management, etc. These services are paid through Medicaid and it is really important to maintain that benefit.

Link to redetermination form: https://portal.ct.gov/DSS/Search-Results?SearchKeyword=W-1E **in English & Spanish**

Medicare Savings Program

If you have applied for the Medicare Savings benefit /waiver (aka QMB or Q01)you also have to do a redetermination application separately each year. If you do not do the application the benefit will be taken out of your monthly Social Security check.

Medicare Savings program English & Spanish - https://portal.ct.gov/DSS/Search-Results?SearchKeyword=MSP

Fact Sheet

- Various information
  - Where to send premium payments
  - Asset reduction information
  - Spend down
  - DSS Cover sheet information
  - Scanning Center address
  - DDS Waiver Unit Contacts

MyAccount Guide

CONNECTICUT
Social Services

How to setup a MyAccount

Create a MyAccount

Creating a MyAccount is quick and easy. Your account lets you log in safely, save your progress, and manage your information anytime.

Just follow these steps to set up your account and get started!

Getting Started: Setting Up MyAccount

Step 1.

Go to https://www.connect.ct.gov

Step 2.

In the "MyAccount" box on the right side of the page, click "Create an Account." This will take you to the "Setting Up MyAccount" page.

Important
Once you create your account, keep your account details safe to avoid being locked out of your account.
If you do get locked out, call MyAccount IT at 1-877-874-1612.

MyAccount Renewal Guide

CONNECTICUT
Social Services

How to renew benefits on MyAccount

Submitting a Renewal

Renewals are important because they help individuals and families continue receiving the benefits they need while verifying that they still meet eligibility requirements.

Follow these steps to complete a renewal online!

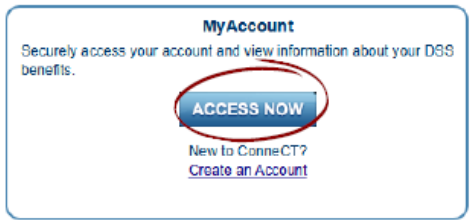
Info
If your MyAccount is linked to your client ID and your renewal is due in 40 days, you will see a link on your MyAccount homepage to renew online.

Step 1.

Go to https://www.connect.ct.gov

Step 2.

In the "MyAccount" box on the right side of the webpage, click "Access Now" and log in to go to your MyAccount homepage.



Resources

- DDS.Waiver@ct.gov (DDS/DSS assistance for providers and CMs)
- DDS-DSS.Issues-Provider@ct.gov (for providers)
- DDS-DSS.Issues@ct.gov (for CMs)
  - Status updates on new apps and renewals
  - Questions/case errors
- DSS Benefit Center at 1-855-626-6632 (after 1st and 2nd option is listed press#2 for an LTSS representative)
  - questions, report changes, status, etc.
- DSS ConneCT Helpdesk 1-877-874-1612
  - Forgot User ID/Password resets
  - Issues associating cases
  - Report website issues
- DSS MED-ConneCT Premium and Payment Address
  - 1-800-656-6684
  - DSS Premium Payment Processing Center
PO Box 150445
Hartford, CT 06115-0445
Checks payable to: Commissioner of Social Services
- DSS Video Guides
  - Videos that guide individuals on how to create a MyAccount, associate cases, complete a PRF form (SNAP), do an online renewal, report changes, etc.
  - https://portal.ct.gov/DSS/Common-Elements/How-to-Apply-for-Services/Video-Guides-for-DSS-Clients

Resources

- Med-Connect Information
  - https://portal.ct.gov/DSS/Health-And-Home-Care/Disability-Services/Med-Connect-Medicaid-for-Employees-with-Disabilities/Med-Connect-Medicaid-for-Employees-with-Disabilities/Eligibility
- Spend down Information
  - https://portal.ct.gov/DSS/Common-Elements/Medicaid-Spend-Down-Information-and-Forms
  - https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Brochures/Medical-Medicaid-Medicare/spndown.pdf
- Medicare
  - What is Medicare?
    - https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare
  - What Medicare covers
    - https://www.medicare.gov/what-medicare-covers
- Direct Express (SSI/SSA) statements
  - 1-888-741-1115
  - https://www.usdirectexpress.com/
- http://MyPlaceCT.org
  - All resources available in the community

Questions

- You can find these forms and the training online at

Medicaid Provider Training (ct.gov)

DDS.Waiver@ct.gov