State of Connecticut
Department of Social Services

W-1EINST
(Rev. 3/17)

Apply Faster Online!

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

W-1E Application for Benefits

Use this form to apply for Food, Cash or Medical help.

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

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.

Apply Faster Online

Apply faster online at **connect.ct.gov.** We will get your application sooner and you do not need to use this form.

What can I apply for using this application form?

- Help buying food (also called SNAP, the **S**upplemental **N**utrition **A**ssistance **P**rogram)
- Cash help
- Some types of medical help (health care coverage / HUSKY / Medicaid) - read next section for details.

Who can use this application form?

- Anyone can apply for **food** (SNAP) or **cash** help using this application form.
- For **medical** help, use this application form **only** if the person who needs help:
  - is 65 or older, **or**
  - has Medicare, **or**
  - is blind or disabled.
- To apply for **long term care** (nursing home) or **home based care**, apply online at connect.ct.gov**,** or in person at a DSS office, or using form W-1LTC. Call 855-626-6632 to ask for a W-1LTC form, or get form W-1LTC at a DSS office.
- To apply for **all other types of medical help**, apply online at AccessHealthCT.com or apply by phone at 855-805-4325, or use application form AH3. Call 855-805-4325 for the AH3 form, or get the AH3 form at a DSS office.

How do I fill out this form?

Use the icons (pictures) as a guide. Fill out the sections that match the icons for each program. The exclamation point means that all programs need the information.

- To apply for food help (SNAP) fill out all sections marked 
- To apply for cash assistance fill out all sections marked 
- To apply for medical help fill out all sections marked 
- **Complete all sections with an exclamation mark**
- You can apply for SNAP just by writing your name and address and signing on the first page. This will get your application started but we need answers to all SNAP questions to determine if you are eligible.
- If you need help filling out this application form because of a disability or impairment, or if you need a translator, call 1-855-626-6632.

What happens next?

- Bring the application form to any DSS office or mail it to:
  DSS Scanning Center,
  PO Box 1320, Manchester, CT 06045-1320
- We will review your application form and contact you if we need more information. If you apply for SNAP, you must complete an interview. We will try calling you for an interview. You may also call the Benefit Center to complete the interview after you submit your application form. The Benefit Center phone number is 855-626-6632.
- Temporary Family Assistance (TFA) applicants are required to have an in person office interview as a condition of eligibility unless waived by the Department.
- Depending on what help you apply for, we may need you to prove things that you tell us. See the next page for more information about proofs.

When will I know if I am eligible?

- If you apply for SNAP, we may be able to give you emergency assistance within 7 days of when you apply. To get emergency assistance, you must prove your identity and meet the following:
  - your household's total income is less than $150 a month **and** your household's cash and bank accounts total less than $100; **or**
  - the total of your household's income, cash, and bank accounts are less than your total housing and utility cost for a month; **or**
  - there is a migrant or seasonal farm worker in your household.
- For SNAP applicants who are not eligible for emergency 7-day processing we will tell you within 30 days if you are eligible. If the SNAP applicant is in an institution and applying for SNAP and Supplemental Security Income (SSI) at the same time, the filing date is the date of release from the institution. All SNAP applications are processed in accordance with SNAP procedures, even if you apply for SNAP and other programs. You will not be denied SNAP solely because you are denied benefits from other programs. If we decide you are eligible for SNAP, your benefits usually start from the date we receive your application form.
- If you apply for medical help, we will tell you our decision within 45 days, except in unusual circumstances. If your eligibility is based on disability, we will make our decision within 90 days from when you apply.
- If you apply for cash help, we will tell you if you are eligible within 45 days from when you applied.

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Do you have your proof documents?

You may have to provide us with copies of certain proofs (sometimes we call these verifications). Proof of identity, address, social security numbers, citizenship status, income, assets, expenses, and more for each individual listed in the application form may be necessary. The proofs we are looking for can include:

Household Members
- Birth certificates
- Baptismal records
- Marriage papers
- Divorce Papers
- Non-Citizen status resident card (I-551)
- Arrival / Departure Form (I-94)

Income
- Pay stubs (proof of the last 4 weeks of wages)
- IRS form 1040 including all schedules
- Bookkeeping records for self-employment
- Award Letter (for SSA or VA benefits, etc.)

Medical Insurance and Expenses
- Medical cards
- Medical bills

Child Support Costs
- Court order to pay child support
- Cancelled checks
- Wage withholding statements
- Statement from custodial parent of amount you pay

Shelter and Utility Costs
- Lease
- Latest rent receipt
- Utility bill
- Letter from your landlord
- Mortgage bill
- Property tax bill
- Homeowner's insurance policy

Assets
- Bank statements
- Trust fund agreements
- Stocks/bonds/U.S. savings bonds
- Life insurance policies
- Letter from a financial institution
- Car registration
- Deeds
- Legal agreements

Students
- Signed school verification letter (W-1446 - this is a DSS form)
- Report card or a statement from a school official (less than 30 days old)

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

People 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.

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

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W-1E
(Rev. 12/19)

State of Connecticut
Department of Social Services
W-1E Application for Benefits

Apply Faster Online!

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

Who are you applying for? Check one box.	**What kind of help are you applying for?** Check all that apply.
Complete all sections with this exclamation icon (picture).	**Complete all sections that match the icons (pictures) for each program you select.**
☐ Only myself	☐ Food (SNAP - Supplemental Nutrition Assistance Program)
☐ Myself and my spouse	☐ Cash
☐ Myself and my family	☐ Medical (HUSKY/ Medicaid/ health insurance)
☐ Only children under 19 in my care	☐ Special medical help to pay for unpaid medical bills from the past 3 months

Is anyone in the household pregnant?	☐ Yes	☐ No
Does anyone applying live in a licensed residential care facility (boarding home)?	☐ Yes	☐ No

Answer the following questions if you are applying for SNAP:

Complete sections with the apple icon (picture) if applying for food help.

Is your household's total income less than $150 a month (before taxes)?	☐ Yes	☐ No
Do your household's cash and bank accounts total less than $100?	☐ Yes	☐ No
Is the total of your household's monthly income, cash, and bank accounts less than the total of your housing and utility costs for the month?	☐ Yes	☐ No
Is anyone in your household a migrant or seasonal farm worker?	☐ Yes	☐ No

Do you need a reasonable accommodation or extra help getting benefits because of a disability or impairment?

☐ Yes ☐ No If yes, describe your condition and the help you need.

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

My name (first, middle, last, suffix)	Legal or other name (if different)

Client ID (if known)	Social security number

Gender	Preferred spoken language	Do you need an interpreter? ☐ Yes ☐ No
Date of birth	Best phone number	Phone type ☐ Home ☐ Work ☐ Cell

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

By signing, I agree that:

- **I have read this form including the section about rights and responsibilities listed at the end of this application, or have had it read to me in a language that I understand, and that I must comply with these rules;**
- **The information I am giving is true and complete to the best of my knowledge, including all information about citizenship, alien and felon status;**
- **I could go to prison or be required to pay fines if I knowingly give wrong or incomplete information; and**
- **DSS and other federal, state, and local officials may verify (check) any information I give.**

If signing on behalf of the applicant, I am the: ☐ Conservator, ☐ Guardian, ☐ Power of Attorney or already assigned authorized representative and have attached supporting documentation. If you would like to designate an authorized representative, see page 2.

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

Person 1 Continued

Marital Status	☐ Never married ☐ Married living with spouse ☐ Married living apart ☐ Legally separated ☐ Divorced ☐ Widowed

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

Ethnicity (optional)	☐ Not of Hispanic origin ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Cuban ☐ Puerto Rican ☐ Other Hispanic, Latino/a or Spanish
Race (optional)	☐ White ☐ Black or African American ☐ Hispanic or Latino/a ☐ Vietnamese ☐ Chinese ☐ Asian Indian ☐ Japanese ☐ Korean ☐ Filipino ☐ Pacific Islander ☐ Guamanian or Chamorro ☐ Other Asian ☐ American Indian or Alaska Native ☐ Samoan ☐ Native Hawaiian

Are you a student?	☐ Not a student ☐ Full Time ☐ Less than full time	Last grade or education level completed	Complete if student	Name of School / Do you have work study? ☐ Yes ☐ No
Citizenship Status	☐ US Citizen ☐ Permanent Resident ☐ Other Non-Citizen	City/State/Country of Birth		
	If you are not a US citizen, fill out the following	When did you enter the United States?	I-94 or Alien Registration #	Immigration Status

Do you plan to remain in CT? ☐ Yes ☐ No	Do you have a disability or impairment? ☐ Yes ☐ No If yes, explain.
Date moved to CT	

Authorized Representative.

You may appoint other people to help you with your application form and to help you get, use, or keep your benefits. If you want to appoint a person to help you, complete this section. If a conservator, guardian, or power of attorney is helping you, you do not need to appoint an AREP.

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

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

Name	Phone number	Address (street, city, state, zip)

☐ **SNAP Shopper** (A person to shop for you - only if you are applying for SNAP food assistance)

Name	Phone number	Address (street, city, state, zip)

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

Name	Phone number	Address (street, city, state, zip)

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

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

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

Print full name	Signature	Date

Person 2

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

Marital Status: ☐ Never married ☐ Married living with spouse ☐ Married living apart ☐ Divorced ☐ Legally separated ☐ Widowed

Relationship to you?

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

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

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

Is this person a student? ☐ Less than full time ☐ Full time ☐ Not a student

Last grade or education level completed

Complete if student — Name of school

Does this person have work study? ☐ Yes ☐ No

Citizenship Status: ☐ US citizen ☐ Permanent resident ☐ Other non-citizen

City/state/country of birth

If this person is not a US citizen, fill out the following — When did this person enter the United States? | I-94 or Alien registration # | Immigration status

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

Do you buy, prepare and eat food together with this person? ☐ Yes ☐ No

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

Date moved to CT

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

Person 3

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

Marital Status: ☐ Never married ☐ Married living with spouse ☐ Married living apart ☐ Divorced ☐ Legally separated ☐ Widowed

Relationship to you?

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

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

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

Is this person a student? ☐ Less than full time ☐ Full time ☐ Not a student

Last grade or education level completed

Complete if student — Name of school

Does this person have work study? ☐ Yes ☐ No

Citizenship Status: ☐ US citizen ☐ Permanent resident ☐ Other non-citizen

City/state/country of birth

If this person is not a US citizen, fill out the following — When did this person enter the United States? | I-94 or Alien registration # | Immigration status

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

Do you buy, prepare and eat food together with this person? ☐ Yes ☐ No

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

Date moved to CT

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

Person 4

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

Marital Status: ☐ Never married ☐ Married living with spouse ☐ Married living apart ☐ Divorced ☐ Legally separated ☐ Widowed

Relationship to you?

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

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

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

Is this person a student? ☐ Less than full time ☐ Full time ☐ Not a student

Last grade or education level completed

Complete if student

Name of school

Does this person have work study? ☐ Yes ☐ No

Citizenship Status: ☐ US citizen ☐ Permanent resident ☐ Other non-citizen

City/state/country of birth

If this person is not a US citizen, fill out the following

When did this person enter the United States?

I-94 or Alien registration #

Immigration status

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

Do you buy, prepare and eat food together with this person? ☐ Yes ☐ No

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

Date moved to CT

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

Person 5

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

Marital Status: ☐ Never married ☐ Married living with spouse ☐ Married living apart ☐ Divorced ☐ Legally separated ☐ Widowed

Relationship to you?

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

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

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

Is this person a student? ☐ Less than full time ☐ Full time ☐ Not a student

Last grade or education level completed

Complete if student

Name of school

Does this person have work study? ☐ Yes ☐ No

Citizenship Status: ☐ US citizen ☐ Permanent resident ☐ Other non-citizen

City/state/country of birth

If this person is not a US citizen, fill out the following

When did this person enter the United States?

I-94 or Alien registration #

Immigration status

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

Do you buy, prepare and eat food together with this person? ☐ Yes ☐ No

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

Date moved to CT

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

If you need to add additional people that live in your household to your application, please attach a separate piece of paper with their information along with this form.

Other questions about people in your household.

Does anyone in your household have a medical condition that prevents them from working?	☐ Yes	☐ No	If yes, who?
Is anyone in your household unable to work because he or she is caring for a disabled person?	☐ Yes	☐ No	If yes, who?
Is there a joint custody agreement for any child listed in the household?	☐ Yes	☐ No	If yes, which child?
Is there a court ordered supervision for any child listed in the household?	☐ Yes	☐ No	If yes, who?

Meals. Answer these questions if you are applying for food help (SNAP).

Does anyone in your household receive more than 1/2 their meals from an organization?	☐ Yes	☐ No	If yes, who?
Does anyone in your household receive at least one meal as part of rent?	☐ Yes	☐ No	If yes, who?

Military Service. Tell us about anyone in your household that has a relationship with the U.S. military, or is the widow, spouse or child of someone that does.

Is anyone in your household in the U.S. military, or has anyone been in the U.S. military?	☐ Yes	☐ No	If yes, who?
Please explain his or her military status. (active, retired, honorably discharged, etc.)			
Is anyone in your household a widow, spouse, or child (under age 18) of anyone in the U.S. military, or anyone who has been in the U.S. military?	☐ Yes	☐ No	If yes, who?
Please explain his or her relation to the member of the U.S. military.			

Criminal History. Tell us about the criminal history of people in your household.

Complete this section if you are applying for food or cash help.

Have you or anyone in your household been convicted of a drug felony after August 22, 1996?	☐ Yes	☐ No	If yes, who?
Are you or any members of your household a fleeing felon?	☐ Yes	☐ No	If yes, who?
Do you or any member of your household have a probation or parole violation?	☐ Yes	☐ No	If yes, who?
Have you or anyone in your household been convicted of trading SNAP benefits for drugs after August 22, 1996?	☐ Yes	☐ No	If yes, who?
Have you or anyone in your household been convicted of buying or selling SNAP benefits over $500 in any state after September 22, 1996?	☐ Yes	☐ No	If yes, who?
Have you or anyone in your household been convicted of fraudulently receiving duplicate SNAP benefits in any state after September 22, 1996?	☐ Yes	☐ No	If yes, who?
Have you or anyone in your household been convicted of trading SNAP benefits for guns, ammunitions or explosives after September 22, 1996?	☐ Yes	☐ No	If yes, who?
Have you or anyone in your household been convicted of aggravated sexual abuse, sexual exploitation and other abuse of children, sexual assault, or a substantially similar offense after February 7, 2014?	☐ Yes	☐ No	If yes, who?
Have you or anyone in your household been convicted of murder after February 7, 2014?	☐ Yes	☐ No	If yes, who?

Legally Liable Relatives. Tell us about legally liable relatives, including spouses who do not live with you or parents of your children who do not live with you. Give as much information as you know.

Name of relative	Gender	Social security number	Date of birth

Address (street, city, state, zip)	Relationship to household members

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

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

Name(s) of non-citizen(s)

Name(s) of sponsor(s)

Sponsor's relationship to you

Do you buy, prepare and eat food together with the sponsor(s)? ☐ Yes ☐ No

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

If you are a refugee, please provide the name of your refugee agency.

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

☐ Cash help	Amount $	State	☐ Medical help	State	☐ Food help	State

Has anyone in your household received cash assistance for families since 1996? ☐ Yes ☐ No

If yes, who?

Which state(s)?

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

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

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

Person on Medicare	Claim #	Type (A, B, D)	Start date
Person on Medicare	Claim #	Type (A, B, D)	Start date

If you or anyone in your household has other medical insurance fill out the table below.

Policy holder	Policy #	Insurance company	Type of coverage	Policy start date	Policy end date

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

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

Do you or your spouse have a special diet?	☐ Yes ☐ No	If yes, who?
Do you or your spouse need clothing?	☐ Yes ☐ No	If yes, who?
Do you or your spouse eat at least one meal at a restaurant each day?	☐ Yes ☐ No	If yes, who?

Cash, bank accounts and other assets. Tell us about your household's cash, savings accounts, checking accounts and other assets. Other assets can include: stocks, trusts, annuities, certificates of deposit, investment accounts, medical savings accounts or Achieving a Better Life Experience (ABLE) accounts. Attach another page if needed.

	Asset 1	Asset 2	Asset 3
Owner(s) list all			
Type			
Name of bank or institution			
Current balance	$	$	$
Account #			

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

	Account 1	Account 2	Account 3
Owner(s) list all			
Type			
Name of bank or institution			
Current balance	$	$	$
Account #			

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

Property 1

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

Property 2

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

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

Insurance 1

Owner(s) list all	Policy #	Death Benefit $	Cash Surrender Value $
Insurance Company	Policy Type: (select one) ☐ Term Life Insurance ☐ Whole Life Insurance		

Insurance 2

Owner(s) list all	Policy #	Death Benefit $	Cash Surrender Value $
Insurance Company	Policy Type: (select one) ☐ Term Life Insurance ☐ Whole Life Insurance		

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

Contract 1

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

Contract 2

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

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

Vehicle 1

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

Vehicle 2

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

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

Has anyone in your household filed a lawsuit that is still pending? ☐ Yes ☐ No	If yes, who?	Attorney's name
	Attorney's address (street, city, state, zip)	

Does anyone in your household expect to receive an inheritance? ☐ Yes ☐ No	If yes, who?	Amount of inheritance $	Date Expected

Sales or transfers. Tell us if anyone in your household has sold or transferred ownership of any motor vehicles, bank accounts, real property, cash, stocks, bonds, or mutual funds. If applying for cash, tell us about any sales or transfers within the past 24 months. If applying for SNAP tell us about any sales or transfers in the past 90 days.

	What was sold, given away, etc.?	By who?	Amount / value	Date of sale, transfer or gift
Item 1			$	
Item 2			$	
Item 3			$	

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

Job 1

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

Job 2

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

Job 3

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

Job Loss and Striker Status. Tell us about recent job changes or if anyone in your household is on strike.

Has anyone lost a job, changed jobs, quit a job, reduced work hours within the last 120 days? ☐ Yes ☐ No	If yes, who?		
Which job?	Date job ended or hours were reduced	Date Last Paid	
What happened and why?			
Is anyone in the household currently on strike? ☐ Yes ☐ No	If yes, who?	Date strike began	

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

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

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

Name of person with income	Type / source	Claim #	How often?	Amount	Start date	End date
				$		
				$		
				$		
				$		

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

Has anyone in your household applied for any of the following benefits? Check all that apply.

☐ SSD ☐ SSA ☐ SSI ☐ Disability ☐ Pension ☐ SSA Early Retirement ☐ VA Benefit ☐ Foreign Income ☐ Workers Compensation
☐ Unemployment Compensation ☐ Railroad Retirement ☐ Other _____

Complete the table below with details about any benefit that you've applied for and checked off above.

	Benefit 1	Benefit 2	Benefit 3
Name of person applying			
Type / source			
Start date (if known)			

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

Dependent 1	Dependent's name	Provider's name	
	Provider's address (street, city, state, zip)		If state pays, how much per month? $
	Who pays?	Amount you pay $	How often?
Dependent 2	Dependent's name	Provider's name	
	Provider's address (street, city, state, zip)		If state pays, how much per month? $
	Who pays?	Amount you pay $	How often?

Medical Expenses. Tell us about any household medical expenses. Medical expenses may include: hospital or doctor bills, dental bills, prescriptions, co-pays, health insurance premiums, medical equipment, costs for glasses and over-the-counter medications/supplements, costs related to a service animal, or costs for a health aid or attendant.

	Expense 1	Expense 2	Expense 3
Name of person with expense			
Expense type			
Date of service			
Amount due	$	$	$
How often do you pay?			
Bill paid?	☐ Yes ☐ No ☐ Partially	☐ Yes ☐ No ☐ Partially	☐ Yes ☐ No ☐ Partially

Court-Ordered Child Support. Tell us about child support that a court has ordered you to pay for children who do not live with you.

	Child 1	Child 2	Child 3
Child's name			
Who pays?			
Amount paid	$	$	$
How often do you pay?			
Type	☐ Current child support ☐ Arrearage ☐ Health insurance premium	☐ Current child support ☐ Arrearage ☐ Health insurance premium	☐ Current child support ☐ Arrearage ☐ Health insurance premium

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

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

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

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

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

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

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

☐ Sewer / septic ☐ Water ☐ Butane ☐ Electric ☐ Gas
☐ Telephone ☐ Wood ☐ Coal ☐ Garbage ☐ Other fuel

People 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.

ED-682
(Rev. 9/15)

Do You Want To Register To Vote?

Federal and State laws require the Department of Social Services (DSS) to give you the chance to register to vote. Answer the questions below and print and sign your name in the space given.

- Are you registered to vote? ☐ Yes I am already registered ☐ No I am not registered
- If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

You can register online at https://voterregistration.ct.gov/OLVR, or you can complete a paper voter registration application form and leave it at DSS or mail it in. The form is included with DSS applications and renewals that we mail to you, and you can also get one at all DSS offices. You can mail your completed form to DSS in the enclosed envelope or send it directly to your Town Hall. If you need help, or if you need another form, call **1-855-626-6632**.

Print Your Name	Sign Here	Date

Your Address (#, Street, Apt #)	City	State	Zip Code

For DSS Worker's Use Only

Date _____ ☐ No boxes checked ☐ Voter Registration Card Sent

Worker Name _____ Worker Number _____

(Tear here and keep)

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preferences, you may file a complaint with: State Elections Enforcement Commission, 20 Trinity Street, Hartford, CT 06106; 860-256-2940, toll-free 866-733-2463, TDD: 1-800-842-9710; or online at SEEC@ct.gov

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(Rev. 1/23)

State of Connecticut
Department of Social Services
Rights and Responsibilities

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

For All Programs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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State of Connecticut
Department of Social Services
Rights and Responsibilities

For The Supplemental Nutrition Assistance Program (SNAP)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights

You have a right to:

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

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

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

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

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

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

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

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State of Connecticut
Department of Social Services
Rights and Responsibilities

For Jobs First / TFA Cash

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

DSS may conduct an unscheduled home visit.

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

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

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

For State Supplement

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

For SAGA Cash

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

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

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

For Medical Assistance

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

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

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

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

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

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

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

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

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

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

Child Support Assignment and Cooperation

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

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

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

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

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

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

State of Connecticut
Department of Social Services
Rights and Responsibilities

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Non-Discrimination Statement

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

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

CIVIL RIGHTS COMPLAINTS INVOLVING USDA PROGRAMS

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

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

For any other information regarding SNAP issues, persons should either contact the USDA SNAP hotline number at (800) 221-5689, which is also in Spanish, or call the state information/hotline numbers found online at: https://www.fns.usda.gov/snap/state-directory

CIVIL RIGHTS COMPLAINTS INVOLVING HHS PROGRAMS

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

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

This institution is an equal opportunity provider.

Connecticut Non-Discrimination Statement

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

An individual with a disability may request and receive a reasonable accommodation or special help from the Department of Social Services when it is necessary to allow the individual to have an equal and meaningful opportunity to participate in programs administered by the Department.

If you asked for an accommodation or special help and we refused to provide it, you may make a complaint to the Department's ADA Coordinator or any of the agencies listed:

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

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

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

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

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

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

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Do not return to DSS