W-1130
(Rev. 2/07)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

ACQUIRED BRAIN INJURY (ABI) WAIVER REQUEST FORM

1. Personal Data

Name_____ Social Security #_____

Address_____
No. Street Apt. No.

_____
City State Zip Code

Telephone (_____)_____ Age_____ Date of Birth_____/_____/_____
(month) (day) (year)

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Contact person if other than yourself:

Name_____ Telephone ____(_____)_____

Address_____
No. Street Apt. No.

_____
City State Zip Code

Relationship (check all that apply)
☐ Conservator of Person ☐ Conservator of Estate
☐ Other (*specify)*_____

---

2. ABI Information

Do you have an acquired brain injury? ☐ Yes ☐ No

If Yes, please indicate date of injury____/_____/_____ and diagnosis_____

---

3. Freedom of Choice - Please read the following and check the box that indicates your choice

☐ If possible, I would prefer to live in the community rather than a nursing home or other institutional setting.

☐ I would prefer to live in a nursing home or other similar setting.

---

4. Medicaid (Title 19) and Medicare Information

Please check the blocks that apply to you:

☐ I am receiving Medicare benefits (enter claim number)_____
☐ I am receiving Medicaid/Title 19 benefits (enter case number)_____
☐ I have a Medicaid "Spenddown" (enter case number, if known)_____
☐ I have applied for Medicaid benefits but have not received a decision
☐ I have not applied for Medicaid benefits

(800) 842-4524.

5. Financial Data

My total monthly income (for example, Social Security, SSI, disability benefits, pension benefits, Workers Compensation, wages, contributions, income from interest or dividends, etc.) is:

Amount	**Source**
_____	_____
_____	_____
_____	_____

My total assets (for example, cash, bank accounts, IRAs, life insurance, annuities, stocks, bonds, motor vehicles, property, etc.)

Amount	**Source**
_____	_____
_____	_____
_____	_____

_____ _____
Signature of Applicant Date

_____ _____
Signature of Conservator or Other Representative Date

_____ _____
Typed or Printed Name of Conservator or Other Representative Date

Return This Form To:

Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033
Attention: Social Work Services
10th Floor