Items Needed for Your Long-Term Medical Care / Home Care Application

KEEP PAGES 1 and 2 FOR YOUR RECORDS

If you do not already get Long-Term Care Medical Assistance or Home Care Assistance from the Department of Social Services, we need the items listed below to process your application. Send copies, **do not send originals.** In some cases, we may request more documents than those listed below. If we do, we will give you time to send us them. If you do not have, or if you need help getting the needed documents, contact DSS for help.

DO NOT WAIT TO APPLY

If you do not have copies of all the documents listed, send us what you have when you apply. It is important that you apply as soon as possible. We will give you more time to send the other documents we need.

Each month you will need to pay a portion of your income to the nursing home; this is called applied income. A married applicant may be able to give a part of their income to their spouse in the community. The following is needed to make this determination:

- ☐ Spouse's monthly gross income
- ☐ Condo fees
- ☐ Mortgage payment
- ☐ Lot rental amount
- ☐ Property tax bill
- ☐ Rent/Lease
- ☐ Electric bill
- ☐ Homeowner's insurance

The following documents are needed from you and your spouse to determine if you are eligible for Long-Term Care Medical Assistance or Home Care Assistance from DSS:

☐ Federal law requires DSS to review 5 years of bank and financial statements on all accounts owned and co-owned by you and your spouse. DSS does this by reviewing 2 full years of statements from the date of application including the current month and statements for December of the remaining 3 years showing the year to date interest. If you cannot provide the statements for the 3 remaining years you can provide your federal tax returns. You must also explain any deposits or withdrawals of $5,000.00 or more.

- ☐ Stocks
- ☐ Bonds
- ☐ Money Market Funds
- ☐ Certificates of Deposit
- ☐ Mutual Funds, Treasury and other notes
- ☐ Retirement Accounts
- ☐ IRA and Keogh Accounts
- ☐ Annuities (a copy of the original annuity contract in addition to the statements)
- ☐ Trusts

☐ Current gross monthly income from all sources including:

- ☐ Social Security
- ☐ Railroad Retirement
- ☐ VA Pensions
- ☐ Private pensions
- ☐ Annuities (a copy of the original annuity contract in addition to the statements)

- ☐ Face and cash value of Life Insurance Policies (current annual statement)
- ☐ Burial Contracts (Irrevocable and Revocable)
- ☐ Burial Plot Deeds
- ☐ Life Use documents
- ☐ Privately held Promissory Notes
- ☐ Reverse Mortgage Documents - monthly/quarterly statements are required for the 60 month look back
- ☐ Real Estate Purchase/Warranty Deeds
- ☐ Quit Claim Documents
- ☐ Trusts and Annuities (including appendices, schedules, annual accountings, and amendments for the past 5 years)
- ☐ Private Health Insurance Cards including Medicare (copy of both sides)
- ☐ Health Insurance Premium Amounts
- ☐ A copy of your spouse's death certificate, Will and Probate Inventory Document if your spouse died in the past 5 years.
- ☐ A copy of your divorce decree if you were divorced in the past 5 years.
- ☐ Power of Attorney or Conservator Documents (if any)

The asset limit for Long-Term Care and Home Care Medicaid is $1600.00. You will not qualify for assistance in any month in which your assets exceed $1600.00.

If you are in a nursing facility you should be paying the nursing facility during the application process. Contact the business office of your facility to find out what is due to the facility during this time frame.

Continue by completely answering every question on the attached application.
Attach additional sheets if you need more space to complete the application. Please be sure to include your name, DSS client ID number or your social security number on each additional sheet.

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Client ID:

FOR WORKER USE ONLY This part is for our staff. Continue to Section A.	Worker's Name: _____ Application Date: _____ Office: _____ Programs Applied for or receiving: _____ Assistance Unit IDs and Client IDs: _____

SECTION A – APPLICANT INFORMATION: Tell us about yourself.

I am applying for: ☐ Care in a facility ☐ Home Care

Last Name _____ First Name _____ Middle Initial _____ Suffix _____ (Jr., Sr., etc.)

Maiden Name or Other Name
_____

Social Security Number:
If you have a Social Security Number, enter it here.
_____ - _____ - _____

Date of Birth: _____/_____/_____
Place of Birth: _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated
(Check one) ☐ Widowed, date of death for your spouse: _____

If married please provide your spouse's name:

Last Name	First Name	Middle Name	Suffix	Maiden Name or Other Name
_____	_____	_____	_____ (Jr., Sr., etc.)	_____

Are you a resident of Connecticut?
☐ Yes ☐ No

Are you a U.S. Citizen? ☐ Yes ☐ No If No, complete SECTION E – IMMIGRATION STATUS, below.

What is your primary language? _____
Do you need an interpreter? ☐ Yes ☐ No

Do you have a disability? ☐ Yes ☐ No
If Yes, do you need an accommodation or special help applying because of your disability? ☐ Yes ☐ No
What type of accommodation or special help do you need?
_____

Ethnicity: Optional
Are you Hispanic or Latino? ☐ Yes ☐ No

Race: ☐ Native American ☐ Asian ☐ Alaskan Native/Eskimo ☐ Black/African descent ☐ White

You are not required to provide race or ethnic origin; however, your cooperation will help determine compliance with the federal civil rights law. If you do not wish to give this information, it will in no way affect consideration of your application. We are authorized to ask this information under Title VI of the Civil Rights Act of 1964.

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SECTION B – CURRENT ADDRESS of Your HOME or INSTITUTION/LONG-TERM CARE FACILITY:
Tell us about your home or Long-term Care Facility, if you live in one.

What is the address of your home?
Street _____
City _____ State _____ Zip _____

Telephone # _____ Cell # _____

Is this your mailing address? ☐ Yes ☐ No If No, provide your mailing address.
_____

Do you or your spouse own your home? ☐ Yes ☐ No
If No, do you have life use of the property? ☐ Yes ☐ No

If you live in a facility, what is the name of the facility? _____
What is the address of the facility?
Street _____
City _____ State _____ Zip _____

On what date did you enter the facility? ____/ ____/ ____

SECTION C – PREVIOUS ADDRESSES: If you have lived at your current address for less than five years, tell us where you lived before.

Street _____
City _____ State _____ Zip _____
Did you or your spouse own this home? ☐ Yes ☐ No

Street _____
City _____ State _____ Zip _____
Did you or your spouse own this home? ☐ Yes ☐ No

SECTION D – AUTHORIZED REPRESENTATIVE(S): Do you authorize someone to represent you in this application? ☐Yes ☐No Are you making this application as a representative for someone else? ☐Yes ☐No
If you answered Yes to either question, complete the section below. This individual(s) will receive correspondence from the department regarding your application and they will be able to contact the department regarding your application.

First Name _____ Last Name _____ Suffix _____ (Jr., Sr., etc.)

Address _____

City_____ State _____ Zip _____

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SECTION D – AUTHORIZED REPRESENTATIVE(S): (continued)

☐ Home Telephone # _____
☐ Cell # _____
☐ Work Telephone # _____
☐ Email: _____

Type of Representative: **Send Proof**
☐ Conservator
☐ Power of Attorney
☐ Guardian

First Name _____ Last Name _____ Suffix _____ (Jr., Sr., etc.)

Address _____

City_____ State _____ Zip _____

☐ Home Telephone # _____
☐ Cell # _____
☐ Work Telephone # _____
☐ Email: _____

Type of Representative: **Send Proof**
☐ Conservator
☐ Power of Attorney
☐ Guardian

SECTION E – IMMIGRATION STATUS (FOR NON-CITIZENS ONLY)

SEND PROOF Send a copy of the front and back of your immigration card or other immigration document.
What is your current USCIS status? _____
On what date did you receive your status? _____/ _____/ _____

Do you have a sponsor? ☐ Yes ☐ No
Sponsor's name and address: _____

What is your Country of Origin? _____
When did you enter the United States? ____/ ____/ ____
What is your USCIS number? _____

If you are a refugee, list your Refugee Resettlement Agency:
_____

SECTION F – MILITARY SERVICE / VETERAN INFORMATION:
Have you or your spouse ever served in the U.S. Military? ☐ Yes ☐ No
Have you been rated with a service related disability? ☐ Yes ☐ No

Veteran's Name	Relationship to Veteran	Veteran's Status	Military Service #

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SECTION G – MEDICAL INSURANCE: If you have insurance, complete this section. If Yes, for any insurance other than Medicare, DSS will send you a form W-1685 to complete, which asks more specific questions about your medical insurance.

SEND PROOF Send a copy of the front and back of your insurance card(s) and proof of the premium amounts you pay.

		Premium Amount	Effective Date
Do you receive Medicare Part A?	☐ Yes ☐ No	$_____	_____
Do you receive Medicare Part B?	☐ Yes ☐ No	$_____	_____
Do you receive Medicare Part D?	☐ Yes ☐ No	$_____	_____
Do you have a Medicare Advantage Plan?	☐ Yes ☐ No	$ _____	_____

If yes, provide your Medicare Claim Number: _____

Do you have other medical/hospital insurance such as Blue Cross/Blue Shield, Health Maintenance Organization (HMO) or union coverage? ☐ Yes ☐ No

Insurance Company Name: _____
Address: _____

Union Name: _____
Union Local Number: _____

Policy/Claim Number	Group Number	Effective Dates	Premium Amount
_____	_____	From: _____ To: _____	$_____

Do you have Long-Term Care Insurance (coverage that pays for nursing home care, adult day care, assisted living or home care) that is separate insurance from your medical/hospital insurance? ☐ Yes ☐ No

Insurance Company Name: _____
Address: _____

Policy/Claim Number	Group Number	Effective Dates	Premium Amount
_____	_____	From: _____ To: _____	$_____

If yes, is your Long-Term Care policy approved under the Connecticut Partnership for Long-Term Care program (the face page of the policy will indicate whether the policy is approved under the Connecticut Partnership and provides Medicaid Asset Protection)? ☐ Yes ☐ No If Yes, give a copy of the contract, asset protection report or the service summary report.

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SECTION H – YOUR BENEFITS AND OTHER INCOME: Tell us about any income or benefits that you are receiving, have applied for, or have been denied.

SEND PROOF Submit current copies of statements that show the gross amount of the income you receive, other than Social Security.

Type of Benefit or Income	Receiving Income or Benefits?	Amount	Application Status	Application Date or Denial Date
Social Security Claim number:	☐ Yes ☐ No			
SSI (Supplemental Security Income) Claim number:	☐ Yes ☐ No			
Black Lung Benefits	☐ Yes ☐ No			
Veteran's Pension/Benefits	☐ Yes ☐ No			
Pension or Retirement	☐ Yes ☐ No			
Civil Service Annuity	☐ Yes ☐ No			
Railroad Retirement Benefits Claim number:	☐ Yes ☐ No			
Alimony	☐ Yes ☐ No			
Worker's Compensation	☐ Yes ☐ No			
Disability/Sick Benefits	☐ Yes ☐ No			
Union Benefits	☐ Yes ☐ No			
Unemployment Benefits	☐ Yes ☐ No			
Lump Sum Cash Amounts	☐ Yes ☐ No			
Rental Income	☐ Yes ☐ No			
Compensation from a legal settlement	☐ Yes ☐ No			
Other	☐ Yes ☐ No			

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SECTION I – ASSETS: Tell us about your assets. Check YES or NO for each ASSET TYPE. If you check Yes, fill in the other boxes. List all assets owned by you or your spouse individually, jointly, or with other persons. If you have more than one asset of the same type, please attach an additional page.

SEND PROOF Send copies of statements that verify the value of the assets.

Asset Type	Check One	Owner	Amount	Account Number	Institution Name
Cash on Hand	☐ Yes ☐ No		$		
Checking Account	☐ Yes ☐ No		$		
Savings Account	☐ Yes ☐ No		$		
Certificate of Deposit	☐ Yes ☐ No		$		
Credit Union Account	☐ Yes ☐ No		$		
Resident Fund Account	☐ Yes ☐ No		$		
Money Market Fund	☐ Yes ☐ No		$		
Mutual Funds, Treasury and other notes	☐ Yes ☐ No		$		
IRA or Keogh Account	☐ Yes ☐ No		$		
Stocks and/or Bonds	☐ Yes ☐ No		$		
Annuity	☐ Yes ☐ No		$		
Trust Fund	☐ Yes ☐ No		$		
Ownership in a Company	☐ Yes ☐ No		$		
Promissory/ Mortgage Notes or Installment Contracts	☐ Yes ☐ No		$		

Have you paid an entrance fee to a Continuing Care Retirement Community (CCRC)? ☐ Yes ☐ No
If yes, can the fees be used to pay for your care? ☐ Yes ☐ No
Can a refund be issued upon death or on leaving the CCRC? ☐ Yes ☐ No

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SECTION I – ASSETS: (continued)		Owner	Value	Make	Amount owed
Automobile	☐ Yes ☐ No		$		$
Recreational Vehicle	☐ Yes ☐ No		$		$

SECTION J – OTHER ASSETS: Tell us about any other assets you own and assets jointly owned with other individuals. This could include collections of antiques, coins, jewelry or stamps, contents of a safe deposit box, paintings, etc.? ☐ Yes ☐ No

SEND PROOF Send copies of current statements or documents that establish the fair market value of the asset(s).

Asset Type	Current Fair Market Value	Owner
	$	
	$	

SECTION K – EXPECTED ASSETS OR INCOME: Tell us about any accident settlement, trust fund, inheritance, or any other money, real property, you expect to receive.

SEND PROOF Send copies of current statements or documents that describe the nature, amount, and payment schedule of the expected asset or income.

Income or Asset Type	Lawyer Name & Telephone Number
_____	_____

Anticipated Date of Receipt: _____

SECTION L – LIFE INSURANCE AND FUNERAL PLANS: Tell us about any life insurance or pre-paid burial plans or funds that you own. List all policies and funds, no matter who pays for them.

SEND PROOF Send a copy of the declaration page of each policy and copies of current statements to show the cash value of each policy or the funeral trust contract, if applicable.

Original Face Value or Value of Policy or Plan	Cash Value	Type of Plan	Policy Number or Account Number	Policy Owner	Company, Funeral Home or Bank Name
		☐ Life Insurance ☐ Funeral Contract			
		☐ Life Insurance ☐ Funeral Contract			

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SECTION M – REAL PROPERTY: Tell us about any real property that you own in or out of the state.

SEND PROOF Send a copy of the deed to each property.

Do you and/or your spouse own or have legal interest/life use in any other real property?
☐ Yes ☐ No If Yes, answer the following questions and provide a copy of the life use documents.

Address of Property	Type of Ownership	Current Fair Market Value	Current Amount Owed
	☐ Primary Residence ☐ Life Estate/Use ☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights ☐ Burial Plot		
	☐ Primary Residence ☐ Life Estate/Use ☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights ☐ Burial Plot		
	☐ Primary Residence ☐ Life Estate/Use ☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights ☐ Burial Plot		

Do you have a reverse mortgage, home equity line of credit or other home equity conversion plan on any of the above? ☐ Yes ☐ No
If Yes, please provide a copy of the note and/or repayment agreement.

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SECTION N – TRANSFER OF ASSETS: Have you (or your spouse) sold, traded, gifted or transferred ownership of any real property, motor vehicles, stocks, bonds, cash, or other assets in the past 5 years. ☐ Yes ☐ No
Have you (or your spouse) had assets transferred through probate court/surrogate courts in or out of state in the past 5 years? ☐ Yes ☐ No

SEND PROOF Send copies of the current statements or documents that show the date the asset was transferred, the value of the asset at the time of the transfer, and the amount you received for the transferred asset. (Attach additional page if needed)

Transfer Date	Type of Asset Transferred	Value of the Asset at the Time of the Transfer	Who Received the Asset and the Reason for the Transfer?	Amount Received
		$		$
		$		$
		$		$
		$		$

Have you (or your spouse) closed any type of account during the past 5 years? ☐ Yes ☐ No If Yes, explain below. Include the bank or financial institution's name, address, account number and date closed.

_____

_____

Have you or someone else closed a jointly held account of any type during the past 5 years? ☐ Yes ☐ No
If Yes, explain below. Include the bank or financial institution's name, address, account number and date closed.

_____

_____

Have you (or your spouse) established a trust or funded a trust with income or property of any kind in the past 5 years? ☐ Yes ☐ No
Are you the beneficiary of a trust? ☐ Yes ☐ No

If Yes to either question, provide the details. (Attach additional page if needed)
Include a copy of the trust.

_____

_____

SECTION N – TRANSFER OF ASSETS: (continued)

If you transferred assets in the past 5 years for something other than cash, answer the following questions:

1. Did you live with the person to whom you transferred the asset(s) without interruption for at least two years prior your admission to the nursing facility? ☐ Yes ☐ No

2. What Activities of Daily Living were you capable of doing on your own during this time?

   ☐ Bathing ☐ Toileting
   ☐ Dressing ☐ Grooming
   ☐ Walking ☐ Maintaining continence
   ☐ Feeding ☐ Transferring

3. If you were unable to do any of the above, who helped you do them?
   _____

4. During these two years, did the individual you transferred the asset(s) to work? ☐ Yes ☐ No
   If yes, how many hours/days per week? _____
   If yes, who was home with you while he/she was working?
   _____

5. Was a Home Care Agency involved? ☐ Yes ☐ No
   If yes: What agency? _____
   How many hours/days per week? _____
   What funds were used to pay for this care? _____

6. Provide medical records such as, office notes for doctors, test results, hospital discharge summaries, etc. for the above period of time to verify the applicant's medical condition.

Any transfer or assignment of assets made in the past five years may result in the imposition of a penalty period. Any such transfer is presumed to be made with the intent, by the transferor or the person accepting the transfer (the transferee), to qualify for Medicaid payment of long-term care benefits. Such transfer creates a debt due and owing by the transferor or transferee to DSS in the amount of assistance provided to or on behalf of the transferor. DSS and the Attorney General may seek relief as permitted by law to recover such amounts.

It is a fraudulent conveyance against the state to assign, transfer or otherwise dispose of property, for less than fair market value, to someone who knows (1) that the purpose of the transfer is to qualify for public assistance; or (2) that the transfer will leave the person making it without enough means to support himself or healthy in a decent way. DSS may go to court to set aside the transfer and recover the cost of any assistance that was provided to the person making the transfer or to recover.

I have disclosed all transfers or assignments made in the past five years and understand that, if any such transfers were or are made, even in part, for the purpose of qualifying for Medicaid long-term care benefits, the state has the right to seek repayment of the debt should any benefits be paid by the state on my behalf.

X_____ _____ X _____ _____
Applicant or Representative's Signature Date Attorney's Signature (if assisted by an attorney) Date

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SECTION O – SPOUSE BENEFITS AND OTHER INCOME: Tell us about any income or benefits that your spouse is receiving, has applied for, or has been denied.

SEND PROOF Send current copies of statements that verify the gross amount of income your spouse receives.

Type of Benefit or Income	Receiving Income or Benefits?	Amount	Application Status	Application Date or Denial Date
Social Security Claim number:	☐ Yes ☐ No			
SSI (Supplemental Security Income) claim number:	☐ Yes ☐ No			
Black Lung Benefits	☐ Yes ☐ No			
Veteran's Pension/Benefits	☐ Yes ☐ No			
Pension or Retirement	☐ Yes ☐ No			
Civil Service Annuity	☐ Yes ☐ No			
Railroad Retirement Benefits Claim number:	☐ Yes ☐ No			
Alimony	☐ Yes ☐ No			
Worker's Compensation	☐ Yes ☐ No			
Disability/Sick Benefits	☐ Yes ☐ No			
Union Benefits	☐ Yes ☐ No			
Unemployment Benefits	☐ Yes ☐ No			
Lump Sum Cash Amounts	☐ Yes ☐ No			
Rental Income	☐ Yes ☐ No			
Compensation from a legal settlement	☐ Yes ☐ No			
Other	☐ Yes ☐ No			

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SECTION P – INCOME FROM WORKING: Tell us about any income you or your spouse currently receives from work, including sick leave payments.

SEND PROOF Send copies of any proof of pay, your last four current pay stubs or a letter from your employer.

Employer Name: _____

Employer Address: _____

Telephone #: _____

How often are you paid? ☐ Weekly ☐ Bi-weekly ☐ Monthly

Gross wages per pay period, including tips and commissions. $_____ per _____

Date Employment Began ____/____/____ Date Employment Ended ____/____/____

SECTION Q – ALLOWANCES and DIVERSIONS

Do you have a spouse, child under 21, or any other dependent relatives living in your home in the community? ☐ Yes ☐ No If yes, fill in the section below.

Name	Relationship	Age

If you are in a long-term care facility; do you intend to return home within 6 months? ☐ Yes ☐ No

SEND PROOF If you answered yes to either of the above questions, fill in the section below and show proof of how much you pay each month.

Rent/Mortgage	Utilities	Heat	Property Taxes	Homeowners insurance	Condo Fees
$_____	$_____	$_____	$_____	$_____	$_____

MEDICAL BILLS: Do you have any unpaid medical bills? ☐ Yes ☐ No
If you have any of these, you may be able to use some of your income to help you pay for these bills.

SEND PROOF If you answered Yes, provide a copy of the unpaid medical bill(s). The bill must include a service date, charge, and a detail description of the service(s) provided. Attach copies of the bill(s) to your Long-Term Care Medical Assistance Application when you send it in. If you do not have the bills at the time you send the application, the bills may be sent at a later date during this application process.

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SECTION R – SPOUSAL NEEDS: Complete this section if you have a spouse living in the community. Your spouse may be able to keep some of your assets. List all assets owned in the month you were admitted to a hospital or long-term care facility and had a continuous stay of 30 days or more. Include all assets you owned individually and jointly or those assets owned individually and jointly by your spouse. If you have more than one asset of the same type, please attach an additional page.

Have you or your spouse been in an institution/Long-term Care Facility in the past?
☐ Yes ☐ No Date entered: _____ Name of facility: _____

SEND PROOF Send copies of statements that show the value of the assets as of the first day that you were in a facility for 30 days or more. (Attach additional pages if needed)

Asset Type	Check One	Owner	Amount	Account Number	Institution Name
Cash on Hand	☐ Yes ☐ No		$		
Checking Account	☐ Yes ☐ No		$		
Savings Account	☐ Yes ☐ No		$		
Certificate of Deposit	☐ Yes ☐ No		$		
Credit Union Account	☐ Yes ☐ No		$		
Money Market Fund	☐ Yes ☐ No		$		
Mutual Funds, Treasury or other notes	☐ Yes ☐ No		$		
Life Insurance	☐ Yes ☐ No		$		
IRA or Keogh Account	☐ Yes ☐ No		$		
Stocks and/or Bonds	☐ Yes ☐ No		$		
Annuity/Trust Fund	☐ Yes ☐ No		$		
Vehicles	☐ Yes ☐ No		$		
Real Estate	☐ Yes ☐ No		$		
Mortgage Note or Installment Contract	☐ Yes ☐ No		$		
Ownership in a Company	☐ Yes ☐ No		$		

Notification of Annuity Requirements

You or your spouse have applied for help paying for long-term care services or home care. The department needs to know if you or your spouse owns any annuities. If you do not tell us about any annuities that you or your spouse own, you will not be eligible to get help with the cost of your long-term care. The State of Connecticut will be the remainder beneficiary of any annuities that you or your spouse have.

Complete the information below, sign, and date.

☐ I have at least one annuity.

☐ My spouse has at least one annuity.

☐ My spouse and I do not have any annuities.

_____ _____

Signature of Applicant, Authorized Representative or Conservator Date

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READ CAREFULLY AND SIGN

I UNDERSTAND AND AGREE TO THE FOLLOWING:

- I am responsible for reporting changes in my situation to DSS. I must report changes within 10 days. Examples of changes in my situation are changes in my income, assets, address, health insurance premiums, or death of a spouse.
- I may request a hearing in writing if I disagree with an action taken on my case.
- I am voluntarily giving information requested on this application. If I fail to give certain information, my application may be denied.
- All information I give on this form is subject to verification by federal, state and local officials. I will cooperate with these officials by providing any necessary documents to prove what I have said. I authorize DSS to verify any information given on this form to make sure it is true.
- All information I give on this form, including Social Security numbers, is confidential, except as authorized or required by state or federal law, and will be used by DSS only to administer the medical assistance program.
- Any information I give on this form, including Social Security numbers, will be used to verify identity and eligibility and will be cross-matched against federal, state and local government files by computer.
- DSS will use information available to it through the Income and Eligibility Verification System (IEVS) to process my request for assistance. This information comes from the Labor Department, the Social Security Administration and the Internal Revenue Service as well as other agencies when allowed by law. DSS may verify the information it receives by contacting other sources, such as banks and employers. Results from such checking may affect my eligibility and level of benefits.
- I give permission to DSS to release information about me for purposes directly connected with the administration of DSS's programs. Purposes directly connected with the administration of the department's programs include, but are not limited to, establishing eligibility, determining the amount of assistance, providing services, and the investigation, prosecution or civil proceedings related to the administration of the department's programs.
- I will cooperate with state and federal personnel who conduct Quality Control Reviews.
- I declare that I am a United States citizen or, in the event that I am not, that the information that I provided regarding my non-citizen status is true.
- I authorize DSS to verify any information regarding my non-citizen status with the Department of Homeland Security. I also understand that the Department of Homeland Security CANNOT use the fact that I applied for assistance with DSS as a basis to deny my admission to the U.S., harm my permanent resident status or deport me.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

- Money from a pending lawsuit will be assigned to the State to recover any medical expenses paid by the State related to the lawsuit.
- False or misleading statements made when applying for medical assistance violate federal law and may be punishable by a fine up to $25,000 or imprisonment for 5 years or both.
- By applying for medical assistance, I assign my right of support from legally liable third parties to the department (section 1912 of the Social Security Act). I also understand that, 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, I must sign an additional assignment of support (section 1924 of the Social Security Act).
- By receiving medical assistance, I allow the State to recover the cost of my medical bills, which may have been covered by other insurance or legally liable third parties, directly from it.
- The State recovers monies from the estates of individuals who received long-term care services, Home Care Services or who were age 55 or older at the time that community medical assistance benefits were paid and who do not have a living spouse or a surviving child who is under the age of 21, blind or disabled.
- DSS has my permission to apply for Medicare on my behalf. I understand that an application will be filed only if the department thinks I am eligible. I agree to let the DSS file Medicare claims and pursue appeals on my behalf. These actions may be taken by the department or its representative.
- DSS or any health insurer, provider or any other entity providing services to me or my family under the Medicaid program may release information about me or my family as necessary for the delivery of the Medicaid program services and the administration of the Medicaid program, as permissible by federal or state law.
- I will not alter, trade, sell or use someone else's medical services identification card.
- The State may place a lien, under certain conditions, on my home if I permanently enter a nursing facility.
- DSS may, under certain circumstances, bill a spouse or the parents of a child under the age of 18 and institutionalized to repay the state's cost of my medical care.

State of Connecticut
Department of Social Services
Long-term Care/Waiver Application

Client ID:

SIGNATURES

I have read this form or have had it read to me in a language that I understand. I certify that the information given on this form is true and complete to the best of my knowledge. If I have knowingly given incorrect information, I may be subject to penalties for false statement as specified in the Connecticut General Statutes sections 53a-157b and 17b-97 and to penalties for larceny as specified in sections 56a-122 and 53a-123. I also may be subject to penalties for perjury under federal law. I authorize the Department of Social Services to verify any information given on this form.

X_____ _____
Applicant Signature Date Witness' Signature (if signed with an X) Date

_____ _____
Interpreter's Signature Date Helper's Signature Date

If someone completed this form on the recipient's behalf, this person must sign

_____ _____
Representative's Signature Date Printed Name of Interpreter/Representative

_____
Reviewed by Date

YOU HAVE THE RIGHT TO MAKE A DISCRIMINATION COMPLAINT

You have the right to make a discrimination complaint if you think the Department of Social Services has taken action against you because of your race, color religion, sex, gender identity or expression, marital status, age, national origin, ancestry, political beliefs, sexual orientation, intellectual ability, mental disability, learning disability or physical disability, including by not limited to, blindness.
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 Affirmative Action Division Director or any of the agencies listed below.

Commissioner of Social Services, Attention Affirmative Action Director/ADA Coordinator, 25 Sigourney Street, Hartford, CT 06106-5033 or call 1-860-424-5040, toll free: 1-800-842-1508, TDD: 1-800-842-4524 or fax: 1-860-424-4948

Connecticut Commission on Human Rights and Opportunities, 25 Sigourney Street, Hartford, CT 06106**,** or call 1-560-541-3400, toll free: 1-800-477-5737, TDD: 1-860-541-3459 or fax: 1-860-246-5265
Web: http://www.ct.gov/chro/site/default.asp

US Department of Health and Human Services, Office of Civil Rights, JFK Federal Building, Room 1875, Boston, MA 02203 or call 1-617-565-1340, toll free: 1-800-368-1019, TDD: 1-800-537-7697 or fax 1-617-565-3809
Web: http://www.hhs.gov/oct/office/file/index.html

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AUTHORIZATION TO DISCLOSE INFORMATION

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

1. Name: _____
   Address: _____
   Telephone Number: _____

2. Name: _____
   Address: _____
   Telephone Number: _____

3. Name: _____
   Address: _____
   Telephone Number: _____

_____ _____
Applicant's or Authorized Representative's Signature Date

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. Please answer the questions below and print and sign your name in the space provided.

Are you registered to vote? ☐ Yes, I am already registered ☐ No

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

To register, complete a voter registration application form and leave it at DSS or mail it in. The form is included with DSS applications 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, please call 1-855-626-6632.

_____ _____ _____
Print Your Name Your Signature Date

_____
Street

_____ _____ _____
City State Zip Code

For Worker's Use Only

Date_____ ☐ No check boxes checked ☐ Voter Registration Card Sent

Worker Name_____ Worker DMC 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; SEEC@ct.gov.