State of Connecticut
Department of Social Services

W-1487 (Rev. 1/12)

This box to be completed only if the person is in a hospital or nursing home. (Not needed if a health screen is attached.)

Applicant's name_____

Name of facility_____

Address_____

_____

Telephone Number_____

Staff member_____

Date_____

Projected NH Admission Date_____

Hospital Discharge Date_____

CONNECTICUT HOME CARE PROGRAM FOR ELDERS
HOME CARE REQUEST FORM

The State of Connecticut wants to give you an opportunity to stay home instead of going to a nursing home. That is the purpose of a home care program called the Connecticut Home Care Program for Elders. You can find out whether you may qualify for any of the services from this program by completing this Request Form.

- We want to make sure that all Elderly persons 65 years and over are informed about the program. We are asking that you complete, sign and return this form whether or not you qualify for services. Please refer to the back of this form for specific information regarding the income and asset level to determine if you may qualify for home care services.

- You will be expected to apply for Medicaid if you meet the financial criteria. If you do not meet the financial criteria for Medicaid, you may still be eligible for State Funded Home Care Services. Refer to the back of the form.

- If your income is below the program limit, but your counted assets currently exceed the applicable asset limit, you still may qualify to be screened for Home Care Program services when you reduce your assets to the limit. You are not required to spend your excess assets on health care. You may spend them on any goods or services for yourself or your spouse. However, you must receive fair market value in exchange for your excess assets and keep all of your receipts. When you have reduced your assets to the limit, you can submit another form like this one, which can be obtained by calling the toll-free number below.

- **Notice to Married Couples –** Under state and federal law, a married couple is allowed to protect assets for the person who is living in the community while his or her spouse is institutionalized or living at home and needing the kind of care that would otherwise be provided in a long term care institution. To obtain additional information or to request an Assessment of Spousal Assets, if you have not had one done already, and you are applying for home care, please call toll-free 1-800-445-5394 or 1-860-424-4904. If applying for home care services, please check appropriate box on the back of this form.

- Be advised that you are expected to provide any change of income, assets or living arrangements within 10 days of the change.

- Be advised that the Department may pursue legally liable relative contributions from spouses or recipients receiving services under the Connecticut Home Care Program for Elders.

- Be advised that the State has the right to recover monies from the sale of real estate and from the estates of individuals who received services under the Connecticut Home Care Program for Elders including private insurance premiums paid on behalf of the individual.

QUESTIONS – PROBLEMS – CALL OUR TOLL FREE NUMBER

1-800-445-5394

1-800-445-5394

This information is available in alternate formats. Phone (800) 842-1508 or TDD/TTY (800) 842-4524.

ESTA FORMA ESTA DISPONIBLE EN ESPAÑOL. LLAME AL 1-800-445-5394.

APPLICANT PERSONAL INFORMATION

Name_____ Social Security Number_____

Address_____

Marital Status *(check one)* ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Phone_____ If not yours, whose number is it?_____ Date of Birth_____

Sex *(optional)* ☐ Male ☐ Female Doctor's Name_____ Phone_____

Name of your Home Health/Adult Day Care Agency_____Phone_____

Medicaid Number_____ Medicare Number_____

Medicaid Application Pending? ☐ Yes ☐ No

INCOME AND ASSET INFORMATION

WHAT IS COUNTED FOR YOUR GROSS MONTHLY INCOME?

Your total income before any deductions including any deductions for Medicare premiums.

Count only your income and no one else's. (If married, do not count your spouse's income.)
Count all income you get on a regular basis like your wages, pension, Social Security, Veterans benefits, and Supplemental Security Income.

WHAT ARE YOUR COUNTABLE ASSETS?

DO NOT COUNT your house, furnishings, personal belongings (clothes, jewelry) or the motor vehicle that is your essential means of transportation. Also, do not count:

- **Burial Funds** - Irrevocable up to $5,400.00 for each person OR Revocable up to $1,800.00.
- **Burial Plots** - For single individuals, one plot. For married individuals, one plot for each spouse and certain other family members under certain conditions. A plot may include a casket, outer container and opening and closing of the grave.
- **Life Insurance Policies** - If the total face value of all policies does not exceed $1,500.00. (Otherwise count total cash surrender value of all policies.)

COUNT ASSETS OWNED BY YOU OR YOUR SPOUSE. All jointly held assets must be counted in full as yours unless you can show they are owned by someone else (not your spouse). This includes things like: real estate not used as your home, non-essential motor vehicles, campers, boats, bank/credit union accounts (savings, checking, CD, IRA, Vacation or Christmas Club), stocks, revocable trust funds, bonds, U.S. Savings Bonds, total cash surrender value of life insurance with a total face value that exceeds $1,500.00.

MEDICAID WAIVER INCOME LIMIT - *$2,094.00 per month or less* **STATE FUNDED INCOME LIMIT - *No Limit***

ASSET LIMITS – MEDICAID WAIVER*		**STATE FUNDED****
Individual -- $1,600.00		Individual -- $34,092.00
Couple -- $3,200.00	(both receiving services)	Couple Combined Assets -- $45,456.00
Couple -- $24,328.00*	(one receiving services)	(one or both receiving services)

* **A higher amount may be allowed if you have a spousal assessment done *(see Notice to Married Couples).***

** **Participation in program is based on availability of funds. State Funded clients are required to pay 7% of the cost of their services.**

If your income and assets are within these amounts you may qualify for services.

Please Check All Appropriate Boxes Below:

☐ I may be financially eligible for Home Care Services and would like to be screened. My income is $_____.
My assets are $_____. Combined assets with spouse or someone else total $_____.
If married: I am asking for a Spousal Assessment and wish to have a determination of whether I need the kind of services that would otherwise be provided in an institution. ☐ Yes ☐ No *(See front for more information).*

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

_____ _____
Authorized person completing form on applicant's behalf Relationship to applicant. Address/Phone Number

NOTE: If you are in the hospital, return the Request Form to the hospital staff. If you are not in the hospital, send it to Department of Social Services, Alternate Care Unit 11th floor, 25 Sigourney Street, Hartford, CT 06106-5033. For further assistance or questions you may call our toll-free number 1-800-445-5394.