

Connecticut Home Care Program for Disabled Adults (CHCPD) Pilot Program Application Form



**Phone Numbers: Toll free 1-800-445-5394
Local/out of State: 860-424-4904**

Please complete the following sections.

Are you currently receiving Medicaid (T-19)? YES NO

If you are eligible for Medicaid (T-19) you are not eligible for the program.

Personal information and Identification

1. Last Name _____ First Name _____ M.I. _____

Street Address _____ P.O. Box or APT# _____

City _____, Connecticut Zip Code _____

Telephone number _____

2. SEX: Female Male

3. Date of Birth (ddmmyyyy) _____/_____/_____

4. Social Security Number _____ - _____ - _____

5. Race (optional) Caucasian Native American
 Black Hispanic
 Asian Pacific Alaska Native

6. Marital Status (check one): Never Married Married Divorced
 Separated Widowed

Income information

7. Please list all gross monthly income received by you and your spouse. There is no income limit for this program. However, you may have to contribute toward the cost of your care if your income exceeds 200% of the (FPL) Federal Poverty limit. Effective 7/1/07= \$1702.00.

If joint information place amount in "applicant" column.

	Applicant	Spouse
✓ Unemployment	\$ _____	\$ _____
✓ Social security, SSI, Railroad retirement	\$ _____	\$ _____
✓ Child support and/or alimony	\$ _____	\$ _____
✓ Income (wages, annuities, dividends, etc.)	\$ _____	\$ _____

Medical Insurance

8. Do you have medical insurance?

YES NO

If YES, please provide the information below:

Name of Insurance company _____ Policy number _____

Policy Start Date: ____/____/____ Policy Stop Date: ____/____/____

Are you enrolled in Medicare Part A? YES NO

Medicare Part B? YES NO

Is the State paying your Medicare B premiums? YES NO

9. Do you have any paid or unpaid medical expenses?

YES NO

If so, please list them below.

Asset Information

10. Please list all assets owned by you and/or your spouse. The asset limit for this program (effective 1/1/09) is **\$20,880** for single applicants and **\$31,320** for married applicants.

	Account Name	Number	Balance
Bank accounts/checking, savings, credit union	_____	_____	\$ _____
Life Insurance policies, cash values	_____	_____	\$ _____
Annuities/Trust Funds	_____	_____	\$ _____
Stocks/bonds	_____	_____	\$ _____
Real Estate(home, out of state property)	_____	_____	\$ _____
Any other asset not listed	_____	_____	\$ _____

Contact Person

11. If you are making this application as a representative for someone else, complete the section below.

Name _____ Phone (____) _____

Street Address _____

City _____, Connecticut Zip code _____

Certification and Authorization:

I certify that the information on this form is true, accurate, and complete. I understand that if I provide false, fraudulent, or misleading information, I face fines under State Law.

Your signature or mark _____ Date _____

Authorized Representative signature _____ Date _____