

# Connecticut Home Care Program for Disabled Adults (CHCPDA) 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

## Income information

6. 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

7. 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

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

YES  NO

If so, please list them below.


## Asset Information

9. Please list all assets owned by you and/or your spouse. The asset limit for this program (effective 7/1/07) is **\$20,328** for single applicants and **\$30,492** for married applicants.

	Account 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

10. 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 \_\_\_\_\_