



STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

W-1514
(Rev. 10/13)

CLIENT APPLIED INCOME CONTRIBUTION AGREEMENT FOR MEDICAID

I, _____, understand that I am eligible to receive home care services
Client Name
and that I am required to help pay for the cost of those services. I will make a monthly payment of
\$_____ effective date _____ to: Allied Community Resources, Inc.
P.O Box 479
East Windsor, CT 06088-0479

I understand that the amount of my monthly applied income payment could change when my case
is reviewed. If there is a change I understand that I will be notified.

I understand that if I have an emergency that makes me unable to pay my applied income, I must
contact _____ at _____ as soon as possible.

I understand that I will not be allowed to receive services if I do not make my payment. I will be
contacted by my care manager, provider and/or facility before services stop.

Before I am discontinued from the program, I will be given written notice. I will also be given an
opportunity for a hearing.

My care manager, provider and/or facility has discussed the applied income with me. I
understand that if I have questions I can call the Alternate Care toll-free number 1-800-445-5394.

Date Client

Date Family/Care Giver

Date Care Manager/Provider/Facility

If a family member or another individual has assumed liability for paying this client's mandatory
contribution, that must be indicated by separate signature.

I, _____ hereby agree to pay the client contribution
Name or Liable Party/Organization
for _____
Name of Client

Signature (Liable Party/Organization) Telephone (Liable Party/Organization)

Address Date

The Department has a TDD/TTY hotline number for persons who are deaf or hearing impaired. If you have a
TDD/TTY, you can call 1-800-842-4524. The Department also has auxiliary aids for the blind or visually impaired.
Please call your local Department of Social Services for more information.