Instructions: Please follow carefully - Incomplete applications will be returned

1. **Complete all areas**. If an item does not apply to you, mark "N/A" on that line.
2. **We need copies of Social Security Cards** The government **requires** that all applicants over the age of 65 submit a copy of their social security card with the attached housing application. If you do not have a social security card, we can accept one of the following, as long as your social security number appears on the document.

   Social Security Administration (SSA) printout, W-2, or SSA-1099

   Note: Copies of Metal Social Security Cards <u>are not</u> acceptable.

   If you cannot provide us with any of the above documents, it will be necessary that you certify to us that you have made application to the Social Security Office for a new card before we will accept your housing application.
3. **Proof of US Citizenship** The US Department of Housing & Urban Development **requires** that all applicants be US Citizens, nationals or certain categories of eligible noncitizens. To do this, you **must** have the attached Citizenship Declarartion forms completed by **EACH** family member (including yourself). Please make sure you follow the instructions on the Declaration Form.
4. **Signatures are required by all adult applicants**
5. **Return your application to:**

   Lutheran Assisted Living at Middletown
628 Congdon Street West
Middletown, CT 06457

Your application is being returned because:

- o **You did not complete all areas or you did not sign the application.**
- o **You did not provide the required social security cards for all household members over the age of 5.**
- o **You did not complete/sign the Citizenship Declaration.**
- o **You did not complete/sign the Authorization for Verification of Credit and Criminal History.**
- o **You did not sign the Authorization to Release Information form.**

Please return your application along with the information that was missing if you want to be considered for Assisted Living.

Lutheran Assisted Living at Middletown**USE ONLY:** **DATE RECEIVED:** ____________ **TIME RECEIVED:** __________
INITIALS: __________

APPLICATION FOR ASSISTED HOUSING – (ASSISTED LIVING)

- If the information provided by or about any applicant from any source at any time during the screening process reveals negative information relating to the applicant's ability to meet the obligations of tenancy, the information will be researched as part of the tenant selection screening process and that applicant will be asked to explain this information as part of a uniformly applied policy applicable to all applicants.
- All applicants must be able to meet essential obligations of tenancy -- they must be able to pay rent, to care for their apartment, to report required information to Lutheran Assisted Living at Middletown, to avoid disturbing their neighbors, etc., but there is no requirement that they be able to do these things without assistance.

Lutheran Assisted Living at Middletown is a management company that provides low rent housing to eligible households, elderly households and single people. Lutheran Assisted Living at Middletown is not permitted to discriminate against applicants on the basis of their race, color, religion, sex, national origin, disability handicap or familial status. In addition Lutheran Assisted Living at Middletown has a legal obligation to provide "reasonable accommodations" to applicants if they, or any household member, have a disability or handicap.

- A reasonable accommodation is some modification or change Lutheran Assisted Living at Middletown can make to its apartments or procedures that will assist an otherwise eligible applicant with a disability to take advantage of government programs.

- The Fair Housing Act/Federal law prohibits discrimination in the sale, rental or financing of housing on the basis of race, color, national original, sex, religion, age, disability, marital or familial status. USDA, Rural Development applicants may file any complaints of discrimination to USDA Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC, 20250-9410 or call (202) 720-5964 (voice or TDD). Section 8 applicants may file any complaints of discrimination to the U.S. Dept. of Housing & Urban Development, Assistant Secretary for Fair Housing & Equal Opportunity, Washington DC 20410.

A. **FAMILY SUMMARY** -List all persons, including yourself, who will be living in the apartment. List head of household first.

Name – including MIDDLE NAME	Relationship	Gender	Soc Sec #	Birth Date	Place of Birth
1	**Head**				
2					

Mailing Address: City: State: Zip:

Physical Address:
(if different than mailing address) City: State: Zip:

Telephone No. (which you can be reached at): ________________ E-Mail Address ______________________

Applying to Property(s): ______________ Requested Unit Size: ______ **Bedrooms**

How did you hear about the apartment for which you are applying? ________________________________

If you require any modifications to an apartment, check here and explain in a note to us ☐

Are you currently enrolled in the Connecticut Homecare Program for Elders? ________
Are you currently on Title XIX (Title 19)? _________
If no, have you filed an application for Title XIX? _________

Are you a Veteran? ___________ **If yes, please list branch of military**________________

B. **INCOME - All sources of regularly received monies must be listed regardless of recipient's age.**

Family Member Name	Sources of Income	Amount
	Social Security Gross Monthly Amount	$
	Social Security Gross Monthly Amount	$
	Pension Gross Monthly Amount	$
	Source:	
	Address:	
	Claim No.	
	Pension Gross Monthly Amount	$
	Source:	
	Address:	
	Claim No.	
	VA Benefits (Claim #)	$
	SSI Benefits Gross Monthly Amount	$
	Unemployment Compensation Gross Monthly Amount	$
	Address:	
	Wages Gross Monthly Amount	$
	Employer:	
	Address:	
	Wages Gross Monthly Amount	$
	Employer:	
	Address:	
	Alimony Gross Monthly Amount Other Income Gross Monthly Amount (for example, rental income, etc.)	$
		$
		$

C. **ASSETS**:

Have you sold or disposed of any asset(s) valued over $1,000 in the last two years? Yes_____ No_____

If yes, type of asset (e.g., money/land/house) ________________________________

Market value when sold/disposed $______ Amount sold/disposed for $______ Date of transaction _______

C. **ASSETS** (continued)

Provide the following information for all members of the household (use another sheet of paper if necessary).

Checking Accounts

Bank		Bank	
Address		Address	
Account No.		Account No.	
Int. Rate	Balance $	Int. Rate	Balance $

Savings Accounts

Bank		Bank	
Address		Address	
Account No.		Account No.	
Int. Rate	Balance $	Int. Rate	Balance $

Certificates of Deposit

Bank			Bank		
Address			Address		
Acct.#	Int Rate	Amt. $	Acct.#	Int Rate	Amt. $
Penalty for Early Withdrawal	Maturity Date		Penalty for Early Withdrawal	Maturity Date	

Stocks / **IRA's/401-K's**

Name		Bank	
Address		Address	
Value $	Div. Rate	Value $	Div. Rate

Bonds / **Trust Accounts**

Bank	Bank	
Address	Address	
Present Value $	Account No.	
Maturity Date	Int. Rate	Balance $

C. **ASSETS** (continued):

Real Estate

Do you own any property? Yes_____ No_____

If yes, type & location of property ____

____

Appraised market value $____________________ Mortgage or outstanding loan due $____________________

Name & address of broker/realtor who would provide verification of market value:

____

Broker/Realtor	**Address**	**City**	**State**	**Zip**

D. **MEDICAL AND CHILD CARE EXPENSES**

FOR ELDERLY, DISABLED, HANDICAPPED APPLICANTS ONLY

Medical Costs - **Complete only if head or spouse is 65 or older, handicapped, or disabled AND ONLY if these medical expenses are paid for out of your own pocket and not reimbursed by medical insurance.**

Medicare

Monthly Amount $	Monthly Amount $

Medical Insurance

Name	Name
Address	Address
Claim No. Monthly Amt. $	Claim No. Monthly Amt. $

Pharmacy

Name	Name
Address	Address
Anticipated prescription costs **not covered by insurance** - Monthly Amount $	Anticipated prescription costs **not covered by insurance** - Monthly Amount $

Physician

Are you seeing a physician **REGULARLY**? Yes_____ No_____	
Name	Name
Address	Address
Anticipated costs **not covered by insurance** - Monthly Amount $	Anticipated costs **not covered by insurance** - Monthly Amount $

Outstanding Medical Bills for which You are Making Monthly Payments

Name	Name
Address	Address
Anticipated costs **not covered by insurance** - Balance Due $ Monthly Amount $	Anticipated costs **not covered by insurance** - Balance Due $ Monthly Amount $

E. **PROGRAM INFORMATION**

Are you currently living in subsidized housing? Yes_____ No_____

F. **APPLICANT INFORMATION-Please place a checkmark in the box if any of the following statements apply to you.**

1. You have been served a Notice to Quit or been asked to leave by a previous landlord ☐
2. You have been served with lease violations from a previous landlord ☐
3. You have been evicted ☐
4. You or any household member have been evicted from federally assisted housing for drug-related criminal activity? ☐

If you checked any of the above boxes, please explain the circumstances on an attached sheet of paper and identify property & landlord.

5. You or a household member have been convicted of a sex related crime or are subject to a lifetime registration in a State sex offender registration program? ☐

   List all states, other than the one that you reside in now, in which you have lived in during the last seven years? ____

G. **REFERENCE INFORMATION**

Current Landlord (Name, Address,& Phone No.)

____

How long have you lived there? ________________ Is this landlord related to you? Yes____ No____

List all Previous Landlords for ALL Adults in Household (Attach a sheet of paper if more space is needed.) (Name, Address & Phone No.)

1.	2.
Address of Apt.	Address of Apt.
How long did you live there?	How long did you live there?
Is this landlord related to you? Yes____ No____	Is this landlord related to you? Yes____ No____

List two Professional Personal References for ALL Adults in Household (Attach a sheet of paper if more space is needed.) (Name, Address, Phone No. & Relationship)

(Example: teachers, principals, past/present employers, physicians, etc.) Please do not list relatives or friends.

1.	2.
Phone No. Relationship	Phone No. Relationship

All information received by Lutheran Assisted Living at Middletown during the application process regarding the applicant or applicant's household will be taken into consideration as part of the application.

Other Information

Please provide us with the name, address, & phone number of an emergency contact:

____

Vehicles - List any vehicle owned

Type ______________________ Year/Make ______________________

Color ______________________ License Plate No. ______________________

Do you own a pet? Yes____ No____ If yes, describe ______________________

(Please note that pets are allowed in independent housing and in congregate housing. Pets are not allowed in the assisted living facility. A separate pet application must be completed.)

CERTIFICATION

I/we hereby certify that I/we do not and will not maintain a separate, subsidized rental unit in another location. I/we understand I/we must pay a security deposit for this apartment prior to occupancy. I/we certify that the housing I/we will occupy is/will be my/our permanent residence.

I/we understand that eligibility for housing will be based on either the USDA, Rural Development or the Department of Housing and Urban Development's eligibility criteria and Lutheran Assisted Living at Middletown's resident selection criteria. I/we understand that this application in no way ensures occupancy and that my/our application can be rejected based on, but not limited to (1) a history of unjustified and/or chronic nonpayment of rent and/or financial obligations; (2) a history of living or housekeeping habits that would pose a direct threat to the health and safety of other individuals or whose tenancy would result in substantial physical damage to the property of others; (3) a history of disturbance of neighbors; (4) a history of violations of the terms of previous rental agreements, especially those resulting in eviction from housing or termination from residential programs; (5) police records indicating any type of criminal activity or convictions; and (6) any records which show the applicant's behavior to be unacceptable, even if it is a manifestation of an applicant's disability.

I/we certify that the information given in this application is true to the best of my/our knowledge. I/we understand that any false information or any omission of any significant information is punishable by law, and could be grounds for cancellation of this application or termination of residency after occupancy.

Head ______________________ Spouse/Co-Tenant ______________________

Date ______________________ Date ______________________

____
For Lutheran Assisted Living at Middletown

The information regarding race, national origin, and sex designation solicited on this application is requested in order to assure the Federal Government, acting through the USDA, Rural Development/HUD, that Federal Laws prohibiting discrimination against tenant applicants on the basis of race, color, national origin, religion, sex, familial status, age, and handicap are complied with. You are not required to furnish this information, but are encouraged to do so. This information will not be used in evaluating your application or to discriminate against you in any way. However, we would like to make you aware that, if you do not provide this information, the owner/rental agent is required to note race/national origin and sex based on visual observation or surname.

( ) American Indian or Alaskan Native ( ) Black ( ) Hispanic ( ) Asian or Pacific Islander ( ) White ( ) Other
( ) Male ( ) Female

(To be completed by Owner/Agent)

Member #	Last Name of Family Member	First Name	Relationship to Head of Household	Sex	Date of Birth	Declaration 1	2	3	Date Verified	4
Head										
2										
3										

Authorization for Verification of Credit and Criminal History

This document authorizes the verification of an applicant's credit and criminal history in accordance with HUD, CHFA, and DOH guidelines.

Applicant Information

- **Full Name:** ______________________________
- **Date of Birth:** ______________________________
- **Social Security Number:** ______________________________
- **Current Address:** ______________________________

  ____
- **Phone Number:** ______________________________
- **Email Address:** ______________________________

Authorization Statement

I hereby authorize the property owner, property management company, housing authority, or any designated agent acting on their behalf to obtain and review my credit report, criminal background report, and any other consumer report necessary to determine my eligibility for housing assistance or tenancy. This authorization is granted in accordance with HUD, CHFA, and DOH program requirements.

I understand and acknowledge the following:

- The information obtained will be used solely for determining my eligibility for housing or housing assistance programs.
- This authorization complies with all applicable federal and state regulations, including HUD program rules, CHFA underwriting and compliance requirements, and DOH housing program guidelines.
- I have the right to request information about the nature and scope of any report obtained.
- I may revoke this authorization in writing at any time, except where action has already been taken based on this consent.

Release of Information

I authorize any credit reporting agency, law enforcement agency, court system, financial institution, employer, or other entity in possession of relevant information to release such information to the requesting housing provider or agency.

I release all persons and organizations from any liability arising from the release of information related to this authorization, provided such release complies with applicable laws and regulations.

Applicant Certification

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that providing false or misleading information may result in denial of housing assistance or termination of tenancy.

Signatures

Applicant Signature: ____
Date: ____________________

Co-Applicant Signature (if applicable): ________________________________
Date: ____________________

For Office Use Only

- **Received By:** ________________________________
- **Date Received:** ______________________________
- **Verification Completed By:** ________________________
- **Date Completed:** _____________________________

Exhibit 3-5: Citizenship Declaration

INSTRUCTIONS: Complete this Declaration for each member of the household listed on the Family Summary Sheet

LAST NAME____

FIRST NAME____

RELATIONSHIP TO HEAD OF HOUSEHOLD ______________ SEX ______ DATE OF BIRTH ____________

SOCIAL SECURITY NO.______________________ ALIEN REGISTRATION NO.______________________

ADMISSION NUMBER_________________________if applicable (this is an 11-digit number found on DHS Form I-94, *Departure Record*)

NATIONALITY __________________________________ (Enter the foreign nation or country to which you owe legal allegiance. This is normally but not always the country of birth.)

SAVE VERIFICATION NO.____
(to be entered by owner if and when received)

INSTRUCTIONS: Complete the Declaration below by printing or by typing the person's first name, middle initial, and last name in the space provided. Then review the blocks shown below and complete either block number 1, 2, or 3:

DECLARATION

I, ____ hereby declare, under

penalty of perjury, that I am ____
(print or type first name, middle initial, last name):

______ 1. A citizen or national of the United States.

Sign and date below and return to the name and address specified in the attached notification letter. If this block is checked on behalf of a child, the adult who will reside in the assisted unit and who is responsible for the child should sign and date below.

____ __________
Signature Date

Check here if adult signed for a child: _______

_______ 2. A noncitizen with eligible immigration status as evidenced by one of the documents listed below:

NOTE: If you checked this block and you are 62 years of age or older, you need only submit a proof of age document together with this format, and sign below:

If you checked this block and you are less than 62 years of age, you should submit the following documents:

a. Verification Consent Format (**see Sample Verification Consent Form in

Exhibit 3-6**).

AND

b. One of the following documents:

(1) Form I-551, *Alien Registration Receipt Card* (for permanent resident aliens).

(2) Form I-94, *Arrival-Departure Record*, with one of the following annotations:

(a) "Admitted as Refugee Pursuant to section 207";

(b) "Section 208" or "Asylum";

(c) "Section 243(h)" or "Deportation stayed by Attorney General"; or

(d) "Paroled Pursuant to Sec. 212(d)(5) of the INA."

(3) If Form I-94, *Arrival-Departure Record*, is not annotated, it must be accompanied by one of the following documents:

(a) A final court decision granting asylum (but only if no appeal is taken);

(b) A letter from an DHS asylum officer granting asylum (if application was filed on or after October 1, 1990) or from an DHS district director granting asylum (if application was filed before October 1, 1990);

(c) A court decision granting withholding or deportation; or

(d) A letter from an DHS asylum officer granting withholding of deportation (if application was filed on or after October 1, 1990).

(4) Form I-688, *Temporary Resident Card*, which must be annotated "Section 245A" or "Section 210."

(5) Form I-688B, *Employment Authorization Card*, which must be annotated "Provision of Law 274a.12(11)" or "Provision of Law 274a.12."

(6) A receipt issued by the DHS indicating that an application for issuance of a replacement document in one of the above-listed categories has been made and that the applicant's entitlement to the document has been verified.

(7) Form I-151 Alien Registration Receipt Card.

If this block is checked, sign and date below and submit the documentation required above with this declaration and a verification consent format to the name and address specified in the attached notification. If this block is checked on behalf of a child, the adult who will reside in the assisted unit and who is responsible for the child should sign and date below.

If for any reason, the documents shown in subparagraph 2.b. above are not currently available, complete the Request for Extension block below.

____ __________
Signature Date

Check here if adult signed for a child: ______

REQUEST FOR EXTENSION

I hereby certify that I am a noncitizen with eligible immigration status, as noted in block 2 above, but the evidence needed to support my claim is temporarily unavailable. Therefore, I am requesting additional time to obtain the necessary evidence. I further certify that diligent and prompt efforts will be undertaken to obtain this evidence.

____ __________
Signature Date

Check if adult signed for a child: ______

______ 3. I am not contending eligible immigration status and I understand that I am not eligible for financial assistance.

If you checked this block, no further information is required, and the person named above is not eligible for assistance. Sign and date below and forward this format to the name and address specified in the attached notification. If this block is checked on behalf of a child, the adult who is responsible for the child should sign and date below.

____ __________
Signature Date

Check here if adult signed for a child: ______

AUTHORIZATION TO RELEASE INFORMATION

RE: Applicant/Tenant: ______________________ Unit # __________

Property Name: Lutheran Assisted Living

Address: 628 Congdon St West

Middletown, CT 06457

As managing agents for this Low Income Housing Tax Credit Project, Federal Regulations require we verify the program eligibility of all members of families applying for admission and verify this information periodically for residents. To comply with this requirement, your cooperation is needed in supplying the information requested. This information will be held in strict confidence for use in determining eligibility status and income for this family. A signed authorization for your release appears below. Please complete the attached form and return it to the address above at your earliest convenience. Thank you for your assistance.

______________________	Housing Manager
Authorized Signature	Title
Amy Rosado	______________________
Print Name	Date

Release by Applicant/Tenant

I hereby authorize the release of all requested information.

______________________	______________________
Signature	Date

Verification form is attached.

© SPECTRUM ENTERPRISES 1/2024

FAX: (860) 347-3942

Luther Ridge
at Middletown

628 Congdon Street West
Middletown, CT 06457

PHYSICIAN'S REPORT - APPENDIX 1

Patient's Name: ____ Age: ______

Address:____

City:___________________ State:___ Zip Code:__________________

Dear Doctor,

Your patient wishes to join us at the Luther Ridge Assisted Living Facility. As you know, Assisted Living is a special combination of housing, supportive services, personalized assistance and health care designed to respond to the individual needs of those who need help with activities of daily living. This facility provides individual accommodation~ with private kitchen and bath facilities; three meals a day; housekeeping services; weekly laundry services; and a staff member on site 24 hours a day. In addition, your patient will be receiving assisted living services from a licensed Assisted Living Services Agency (ALSA).

As part of the application process, we need a physician report completed. **This report must be completed by a primary care physician who intends to follow this patient and is willing to update orders every 120 days.** We ask that you complete each item on this form and return it to us with any other pertinent comments you deem appropriate. The confidential information you provide will be used by our professional staff during our assessment for eligibility and used by the ALSA provider to identify the appropriate level of assisted living services, and to initiate a care plan.

It is important that each resident be chronic and stable. These services are designed to help provide assistance to residents who need additional help, but do not need a skilled nursing facility. The resident will need to be able to maintain himself/herself in an independent manner without endangering either themselves or others in order to benefit from our facility. It is equally important that each resident be emotionally stable, suited to and capable of residential community living, since the welfare and peace of mind of many residents are involved. This information is CONFIDENTIAL. If you have any questions, please feel free to call **Bruce Graves, RN** at **(860) 347-7144**. Thank you in advance for your cooperation.

Date of Birth: _______________________ Date of Last Office Visit: ___________________

Drug or other allergies: ____

Does your patient have a history of:

Condition	No	Yes	Comments:
Alzheimer's Disease	☐ No	☐ Yes	____________
Asthma or Allergy	☐ No	☐ Yes	____________
Cancer	☐ No	☐ Yes	____________
Cerebrovascular	☐ No	☐ Yes	____________
Dementia	☐ No	☐ Yes	____________
Depression	☐ No	☐ Yes	____________
Diabetes	☐ No	☐ Yes	____________
Emphysema	☐ No	☐ Yes	____________
Epilepsy	☐ No	☐ Yes	____________
Gastrointestinal	☐ No	☐ Yes	____________
Glaucoma	☐ No	☐ Yes	____________
Heart Disease	☐ No	☐ Yes	____________
Hypertension	☐ No	☐ Yes	____________
Kidney Disease	☐ No	☐ Yes	____________
Liver Disease	☐ No	☐ Yes	____________
Osteoporosis	☐ No	☐ Yes	____________
Parkinson's Disease	☐ No	☐ Yes	____________
Respiratory Disease	☐ No	☐ Yes	____________
Thyroid Disease	☐ No	☐ Yes	____________

Current or recent (within 6 months) problems with:

Problem	No	Yes
Arthritis	☐ No	☐ Yes
Appetite, poor	☐ No	☐ Yes
Chronic back pain	☐ No	☐ Yes
Fainting	☐ No	☐ Yes
Falls	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Indigestion	☐ No	☐ Yes
Jaundice	☐ No	☐ Yes

Loss of weight	☐ No	☐ Yes
Nausea or Vomiting	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes
Psychiatric illness	☐ No	☐ Yes
Seizures	☐ No	☐ Yes
Urinary retention	☐ No	☐ Yes
Urinary Incontinence	☐ No	☐ Yes

Hospitalizations: (During the past 5 years)

Date:	Cause:
____________	____________________________________
____________	____________________________________
____________	____________________________________
____________	____________________________________
____________	____________________________________
____________	____________________________________
____________	____________________________________

Medical History:

Regarding the questions below: If "yes" or "no" provides adequate meaning, please use it If a descriptive phrase will convey more useful information, we would appreciate the phrase.

Regarding your Patient:

a. Do you detect any condition or disease that would require care from a skilled Long-term facility at this time? ____________________________________

b. Is your patient's medical condition chronic and stable and are they able to live independently?

____

Check here if exhibiting TB-like symptoms: ☐

If TB skin test is 10 mm or greater (5mm in the HIV infected) previously positive or if TB-like symptoms exist, respond to the following:

a. Date of last Chest X-Ray evaluation: ______________________________

b. Are chest x -rays suggestive of active TB? ☐ No ☐ Yes

c. Were sputum smears collected and analyzed for presence of acid fast bacilli (AFB)?
   ☐ No ☐ Yes

d. If "c" above is "Yes," were three consecutive smears negative for AFB?
   ☐ No ☐ Yes

Based on the above information, is this individual free of communicable TB? ☐ No ☐ Yes

****

I have completed the medical history section, and have determined that my patient ____________ ______________________________ may require the services of a Home Care Agency for any reimbursable service and also qualifies for ALSA services.

______________________________ ______________

Physician Signature Date

______________________________ ______________

Physician Name Printed Telephone

______________________________ ______________

Address Fax

____

City State Zip Code

Applicants, Families, and Physicians:

This report may need to be updated based on the availability of an apartment. Please include a list of current medications (see last page).

Thank you,

Bruce Graves, RN, Luther Ridge Supervisor of Assisted Living Services

Phone: (860) 347-7144 ext. 119

Fax: (860) 347-3942

Current Medications (including dose and frequency):

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

__________________________	__________________________
Physician's Signature	Physician's Name – Printed
__________________________	__________________________
Date	Telephone number

NOTE: If you are attaching a medication list, please sign and date the attached information. Thank you.

EQUAL HOUSING OPPORTUNITY

W-1487
(Rev 2025)

STATE OF CONNECTICUT
Department of Social Services

COMMUNITY OPTIONS REFERRAL FORM

Use this form to request a referral for the following programs:
- **Connecticut Homecare Program for Elders (CHCPE), for individuals age 65 or older**
- **Personal Care Assistant (PCA) Waiver Program, for individuals ages 18 to 64**

These programs provide in-home assistance to eligible individuals who would otherwise receive services in a long-term care facility or nursing home. To be eligible for these programs, a person must meet functional and financial criteria.

Functional Criteria: The applicant must physically demonstrate that they have need for hands-on assistance in performing some Activities of Daily Living (ADL) or Cognitive Impairment. ADL needs include: bathing, dressing, eating, transfers and toileting.

Financial Criteria: The individual must have income and assets at or below allowable limits. The PCA program is a Medicaid program and applicants must meet Medicaid financial criteria. CHCPE is also a Medicaid program, but applicants whose income or assets make them ineligible under Medicaid rules may qualify for state-funded services under the program. *These state-funded services are provided only if there is available funding, and individuals who receive state-funded services must pay for 3% of the cost of the services.* If you apply for CHCPE and appear to meet the Medicaid financial criteria shown below, you will be required to apply for Medicaid.

INCOME AND ASSET INFORMATION

Monthly Income Limits [1]		CHCPE and PCA WAIVER INCOME LIMIT	STATE FUNDED INCOME LIMIT
		$2,901.00 per month	**No Limit**
Asset Limits [2]		CHCPE and PCA (WAIVER)	STATE FUNDED
	Individual -	**$1,600.00**	**$47,376.00**
	Couple -	**$3,200.00 (Both receiving services)**	**$63,168.00 - Combined Assets**
	Couple -	**$1,600.00 [3] (One receiving services)**	

[1] **Income - How DSS Counts Your Monthly Income:** We count your total (gross) monthly income, *before any deductions, including any deductions for Medicare premiums*. This includes all income you get on a regular basis, like wages, pension, Social Security, Veteran's benefits and Supplemental Security Income. We count only your income, not your spouse's or anyone else's income. List only your income and no one else's.

[2] **Assets - How DSS Counts All of Your Assets:** We count all assets owned by you and your spouse. This includes, but is not limited to, 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.

[3] **Notice to Married Couples –** Under federal law, a married couple can keep some assets for the spouse who is living at home while the other spouse is either in a nursing home or receiving nursing home level-of-care at home. This is called a spousal assessment. Any assets included in the spousal assessment will not count towards the asset limit. When you apply for Medicaid, we will determine a spousal assessment and let you know how much you are allowed to keep.

Important Additional Information

► **For CHCPE:** If your income is below the program limit, but your counted assets exceed the asset limit, you will not be considered for CHCPE services until you reduce your assets below 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, as long as you receive fair market value in return for your excess assets and keep all of your receipts. When you have reduced your assets to the limit, you may reapply for CHCPE services.

► **For the PCA program**: You may be added to a waitlist regardless of whether you are within the income or asset limits when you apply. You are required to be within the program's financial limits only when you are offered services.

► **For both programs:** DSS may require your spouse to contribute to the cost of the services provided to you if your spouse is not also receiving services. DSS may also recover the cost of the services provided to you from your estate.

COMMUNITY OPTIONS REFERRAL FORM

Please check the Program you wish to apply to:

O **Connecticut Homecare Program for Elders (CHCPE)**

O **Personal Care Assistant Program Waiver (PCA)**

Section A **APPLICANT'S PERSONAL INFORMATION**

Applicant's Last Name_______________ First Name_______________

Date of Birth _______________ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Social Security Number_______________ Gender: ☐ Male ☐ Female

Address (of applicant)_______________ Town _______ State _______ Zip _______

Phone _______________ Medicaid Number (if you have one) _______________

I live: (check one) ☐ Alone ☐ With family ☐ In a group home ☐ In an assisted living facility

Section B **Financial Information**

1. My monthly income is: $_______________ **2**. My total assets are: $_______________

SECTION C **Functional Needs**

1. Medical Diagnosis or Condition: (Write in below)

____

2. Personal Needs: Tell us if you need help with these tasks. (Write the number that corresponds to your need):

0 = No help 1 = Supervision / Reminders Needed 2 = Hands-on help 3 = Total dependence

Activities of Daily Living (ADL): Bathing ____ Dressing ____ Eating ____ Toileting ____ Transfers ____

Independent Activities of Daily Living (IADL): Walking ____ Medications ____ Meal Preparation ____

Continence (Bowel and/or Bladder Control) ________

Does someone in your family or community (neighbors) help you? Yes No

3. Behavioral Problems: (Circle all that apply)

Wandering Abusive / Assaultive Self-Injurious Verbally Aggressive Unsafe/Unhealthy Habits Threats to safety

Section D **Point of Contact**

Fill out this section if you would like us to communicate with another person who is helping you with this process. If the person helping you is your power of attorney, conservator, or guardian, please provide a copy of the supporting documents. If you want DSS to communicate with anyone else, staff will provide you with form W-298, Authorization for Disclosure of Information. Please complete this form and return it to the address at the bottom of this page.

Name_______________ Phone No._______________

Relationship (family, friend, conservator, power of attorney, etc.) _______________

X____

Applicant's signature or mark (X) **Date** **Witness' signature if signed with an X**

____

Person completing form **Relationship** **Phone Number**

FACILITY STAFF ONLY: Please complete if the person is in a hospital or a nursing home. (Not needed if a health screen is attached.)

Name of facility:_______________

Staff Member / Date _______________ **Phone #**_______________

Mail to: Department of Social Services, Community Options, 9th floor, 55 Farmington Ave, Hartford, CT 06105-3725 or Fax to 860 424-4963

Persons who are deaf or hard of hearing and have a TDD/TTY device can contact DSS at 1-800-842-4524. Persons who are blind or visually impaired, can contact DSS at 1-860-424-5040