

State-Administered General Assistance (SAGA)

INFORMATION SHEET

[updated March 2,2007]

Through the SAGA program, the Department provides cash and/or medical assistance to individuals who are unable to work for medical or other prescribed reasons, and to families that do not meet the blood-relationship requirements of the Temporary Family Assistance (TFA) program. Approximately 31,200 clients receive SAGA medical assistance, and approximately 4,180 individuals receive SAGA cash assistance. Employable individuals are not eligible for SAGA cash assistance. However, employable individuals who have substance abuse problems may be eligible to receive treatment and some financial support through the Department of Mental Health and Addiction Services' (DMHAS) Basic Needs Program. General application for SAGA services is made at a local office of the Department of Social Services. For referral to the closest DSS office to you, visit the About the Department section of this website (www.dss.state.ct.us/regions.htm); call Infoline at 2-1-1; or look in the blue government pages of your phone book.

General application for SAGA services is made at a local office of the Department of Social Services. For referral to the closest DSS office to you, visit the About the Department section of this website (regions.htm); call Infoline at 2-1-1; or look in the blue government pages of your phone book.

(The closest/regional DSS office for Avon & Canton residents is located at: 3580 Main St. in Hartford - Map/Directions/Hours are attached to this info. sheet)

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Qualifying for SAGA Medical Assistance benefits:

The SAGA program provides medical assistance to low-income persons who do not qualify for, or who are awaiting an eligibility determination, for other state or federal programs. The program operates under regulations of the Department of Social Services. There are no categorical program requirements; eligibility is based on income and assets only. The income limit for an individual ranges from \$476.19 monthly to \$574.86, depending on what region of the state he or she lives in; and the asset limit is \$1000.00 per assistance unit (household). SAGA medical is not automatically linked to SAGA cash.

SAGA medical assistance clients receive medical care from clinics and doctors enrolled with Community Health Network of Connecticut, a non-profit managed care organization experienced in HUSKY health care services. The Department of Social Services has contracted with Community Health Network to be the SAGA medical administrative services organization. Community Health Network, in turn, enrolls health centers, hospitals and individual doctors into the new SAGA primary care provider network.

The new system is primarily based at the state's network of Federally Qualified Health Centers. Community Health Network has also enrolled hospital outpatient clinics, primary care physicians specialists, dentists, and pharmacies in the SAGA medical network. Current SAGA medical assistance clients can call Community Health Network of Connecticut toll-free at 1-866-361-SAGA (7242) for information regarding covered services and referral to medical providers. Community Health Network of Connecticut's website can also be helpful. (www.chnct.org/Member/sagamembers.htm)

Qualifying for SAGA Cash Assistance benefits:

In order to qualify for SAGA cash benefits, individuals must meet the following requirements:

- **Categorical Eligibility:** With limited exceptions related to abuse or neglect, unemancipated minors (under age 18) are not eligible for cash assistance. In addition, individuals must qualify as Unemployable, Short-Term Transitional or Long-Term Transitional.
- **Unemployable:** Determined by the Department's disability examiners to have a physical and/or mental impairment (or combination or impairments) that will prevent employment for six months or more. The medical impairment criteria are identical to those used in the SSI and Medicaid programs, adjusted for duration and severity. Individuals may also qualify as unemployable for the following documentable non-medical reasons: under age 16; over age 65; over age 55 and no work history in the previous 5 years; full-time high school student; needed in the home to care for an incapacitated spouse or child; needed in the home to care for a child under age 2; or, pending receipt of a state or federal means-tested program, e.g., State Supplement or TFA.
- **Short-Term Transitional:** Medical documentation of inability to work for 2 - 6 months. Must have a recent work history in order to qualify under this category (earned at least \$500 in each of 3 of the last 5 calendar quarters, or was eligible to collect Unemployment Compensation during the previous six months).
- **Long-Term Transitional:** Medical documentation of inability to work for six months or more. No work history required; however, all cases are referred to the Department's disability examiners for a review of unemployability.

Benefit Levels: Unemployables - up to \$206 per month. Short-Term and Long-Term Transitionals - up to \$206 per month if applicant has a rental obligation or \$52 if living rent-free.

Income Rules: Adjusted income (gross minus certain exclusions and deductions) may not exceed \$52 or \$206 per month, depending upon the individual's Unemployable or Transitional status.

Asset Rules: The asset limit is \$250 per person, or up to \$1,000 for a family of four or more. In addition, automobile equity may not exceed \$4,500. Real property is subject to a lien or security mortgage.

Citizenship: Applicants must be citizens or qualified aliens. Rules are identical to those of the TFA program. Sponsor's income is deemed for entrants following December 1997.

Third Party Benefits: Applicants and recipients must pursue all third party benefits (including SSI and TFA) in order to qualify.

Substance Abuse: Active substance abusers (drug and/or alcohol) are required to participate in treatment.

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Connecticut Department of Social Services

Northern Region

Hartford Regional Office

Towns Served

Avon, Bloomfield, Canton, East Granby, Farmington, Granby, Hartford, Newington, Rocky Hill, Simsbury, Suffield, West Hartford, Wethersfield, Windsor, Windsor Locks

Address 3580 Main Street, Hartford, CT 06120-1187

General Information (860) 723-1000

TTY (860) 566-7913

Office Hours Monday-Friday 8:30am-4:30pm

Regional Administrator

Silvana M. Flattery, (860) 723-1111

Social Services Operations Managers

Alejandro Arbelaez, (860) 723-1008

Kenneth Derrick, (860) 723-1113

John Hesterberg, (860) 723-1114

Tom Prout, (860) 723-1112

Human Resources Regional Office (860) 723-1005

Long Term Care Ombudsman (860) 723-1390

Bureau of Child Support Enforcement (860) 723-1002

Bureau of Rehabilitation Services (860) 723-1400

Protective Services for the Elderly (860) 723-1003 (call 211 for after hours emergencies)

Programs and Services

You can find information about programs and services by using the links on the left side of this page.

[Click here for useful information from other sites.](#)

Directions

From East and West: I-84 East or West to I-91 North Follow directions for I-91 North

From the South: Route 91 North to Wilson Exit # 34, Hartford Town Line Left off ramp, go to light Left onto Main Street Office on left; brick factory building with tower

From the North: Route 91 South to Wilson Exit # 34, Hartford Town Line Right onto Main Street Office on left; brick factory building with tower

[Click here for information on bus service](#)

APPLICATION PART 2: SPECIAL ELIGIBILITY DETERMINATION DOCUMENT

| | | | | |
|--|--|--|---------------------------|--|
| For Worker's Use Only | Worker ID | Programs Applied For/Receiving | Assistance Unit Number(s) | Application Date |
| <p>Answer the following questions honestly and completely. Failure to give truthful and complete information may result in denial of assistance and criminal prosecution. Please print all answers.</p> | | | | |
| <p>What help do you need? (Check all that apply)</p> <p><input type="checkbox"/> Money Assistance <input type="checkbox"/> Help with Medical Costs <input type="checkbox"/> Other (explain) _____</p> <p><input type="checkbox"/> Food Stamp Assistance <input type="checkbox"/> Help with Cost of Nursing Home, Rest Home or Home Care</p> | | | | |
| <p>Do you or any other household member receive assistance now? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, from which program(s)? List ID numbers.</p> | | | | |
| <p>Do you need a reasonable accommodation or special help, because of a disability, in order to complete your application? <input type="checkbox"/> Yes <input type="checkbox"/> No What language do you speak best?</p> <p>What type of special help do you need?</p> | | | | |
| NAME AND ADDRESS | | | | |
| First Name | M.I. | Last Name | Maiden Name | Telephone Number |
| | | | Your # | Message # |
| Where do you live? | Number | Street | Apt. Number | Floor Number |
| | | | City | State |
| Where is your mail sent if different from above? | Number | Street | Apt. Number | Floor Number |
| | | | City | State |
| Previous Addresses: | | | | |
| If you have lived here less than 36 months, list your previous addresses in that time. | | | | |
| Address (Street, City, State, Zip Code) | | Dates | | Was this home owned by a household member? |
| | | From | To | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| AUTHORIZED REPRESENTATIVE | | | | |
| Do you wish to appoint an Authorized Representative to act on your behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you making this application as a representative for someone else? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered Yes to either question, complete the section below. | | | | |
| Type of Representative: | | Representative's Name | | |
| <input type="checkbox"/> Authorized Representative | <input type="checkbox"/> Hospital/Medical Substance Abuse Treatment Facility | | | |
| <input type="checkbox"/> Conservator | <input type="checkbox"/> Guardian | <input type="checkbox"/> Power of Attorney | | |
| Address (Street, City, State, Zip Code) | | Telephone Number | | |

Before you fill out the rest of this form, please read the following instructions.

If you are applying for State Supplement, Medicaid, State-Administered General Assistance (SAGA), Food Stamps or Home Care Programs, list yourself as the first household member and then list your spouse if he/she lives with you.

If you are applying for FOOD STAMP BENEFITS ONLY, you may want to use form "W-1FOOD" instead because it is easier to complete.

Finally, if you are not a citizen, you must include your sponsor and your sponsor's spouse as though they are household members, even if they do not live with you.

If you are not sure whom you should list, call your worker.

HOUSEHOLD MEMBERS

You are not required to provide race or ethnic origin information, however, your cooperation will help determine compliance with the federal civil rights law. If you do not wish to give this information, it will in no way affect consideration of your application. We are authorized to ask for this information under Title VI of the Civil Rights Act of 1964.

| | | | | | | |
|--|--|--|------------------------------------|---------------|-----|---|
| 1 | Name | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Relationship to you SELF | Date of Birth | Age | Place of Birth (optional if you are not applying for yourself) |
| | Name and Address of School or Training Program | | | | | |
| Are you any of the following? (check all that apply) | | | | | | |
| <input type="checkbox"/> Disabled <input type="checkbox"/> On Strike <input type="checkbox"/> Attending Day Care <input type="checkbox"/> Blind/Visually Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Pregnant: Expected Due Date | | | | | | |
| Marital Status (check one): <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed | | | | | | |
| Are you Hispanic or Latino? (check all that apply) | | | | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asian <input type="checkbox"/> Black or African Descent <input type="checkbox"/> Native American or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | | | | | | |
| If you are between 16 and 65 years old, are you able to work now? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain. | | | | | | |
| 2 | Name | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Relationship to you | Date of Birth | Age | Place of Birth (optional if you are not applying for this person) |
| | Name and Address of School or Training Program | | | | | |
| Is this person any of the following? (check all that apply) | | | | | | |
| <input type="checkbox"/> Disabled <input type="checkbox"/> On Strike <input type="checkbox"/> Attending Day Care <input type="checkbox"/> Blind/Visually Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Pregnant: Expected Due Date | | | | | | |
| Marital Status (check one): <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed | | | | | | |
| Are you Hispanic or Latino? (check all that apply) | | | | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asian <input type="checkbox"/> Black or African Descent <input type="checkbox"/> Native American or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | | | | | | |
| If this person is between 16 and 65 years old, are they able to work now? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain. | | | | | | |

-FOR WORKER'S USE ONLY-

HOUSEHOLD MEMBERS (CONTINUED)

If you are applying for State Administered General Assistance (SAGA), State Supplement or Food Stamps, have you or your spouse ever been convicted of a felony? Yes No If Yes, please answer the following questions about that household member. Is there a current felony charge against you or your spouse? Yes No

Name _____ Are you fleeing from the authorities? Yes No If Yes, please explain.

Are you on parole? Yes No If Yes, are you in violation of your parole? Yes No If Yes, please explain.

Have you been convicted of a drug related felony since 8/22/96? Yes No
 If Yes, have you completed the sentence imposed by the court? Yes No
 Are you complying with your probation requirements? Yes No
 Are you in the process of completing or have you completed participation in a substance abuse treatment or monitoring program?
 Yes No If Yes, please explain.

Does anyone else, other than your spouse, live with you? Yes No If Yes, complete below:

| Name | Relationship to you | Does this person: | Amount person pays |
|------|---------------------|---|---|
| | | <input type="checkbox"/> Share expenses | <input type="checkbox"/> Pay for room and meals |
| | | <input type="checkbox"/> Buy and cook food with you | <input type="checkbox"/> Pay for room only \$ _____ per _____ |
| | | <input type="checkbox"/> Share expenses | <input type="checkbox"/> Pay for room and meals |
| | | <input type="checkbox"/> Buy and cook food with you | <input type="checkbox"/> Pay for room only \$ _____ per _____ |

If you (or your spouse) are applying for benefits and are not a citizen, please give the following information. You do not need to complete this section if you are applying only for Emergency Medical assistance:

| Household Member's Name | Country of Origin | Date of Entry into U.S. CT. | Status (Permanent Resident, Refugee, etc.) and Registration Number | Name, Address, Relationship of Sponsor, and Date Affidavit Was Signed |
|-------------------------|-------------------|-----------------------------|--|---|
| | | | | |
| | | | | |

If you (or your spouse) are a veteran or a spouse, widow(er) or child of a veteran, please give the following information:

| Household Member's Name | Veteran's Name | Relationship To Veteran | Military Service Number | Veteran Claim Number |
|-------------------------|----------------|-------------------------|-------------------------|----------------------|
| | | | | |
| | | | | |

HOUSEHOLD MEMBERS (CONTINUED)

Do you (or your spouse) expect to receive an inheritance? Yes No If Yes, list amount \$ _____

Who expects to receive this inheritance? _____

From whose estate will this inheritance be coming? _____

Are you (or your spouse) suing anyone? [Include suit(s) due to an accident.] Yes No If Yes, provide the following information: person involved, reason for suit, amount of expected settlement, name and address of your attorney.

During the last 12 months were you (or your spouse) involved in a work related, automobile, or other type of accident which required medical attention? Yes No If you were, when did the accident occur? Please describe what happened.

MEDICAL INSURANCE

Indicate whether you (or your spouse) are covered by any of the following insurances.

| Insurance Type | You | Spouse | Policy/Claim Number | Effective Date | Insurance Company Name(s) | Premium Amount |
|--|--|--|---------------------|----------------|---------------------------|----------------|
| Medicare Part A - hospital? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Medicare Part B - medical? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Other medical/hospital insurance such as Blue Cross/Blue Shield, Health Maintenance Organization (HMO) or union coverage? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Long-Term Care insurance (coverage that will pay specifically for nursing home care, adult day care, assisted living care or home care and is separate insurance from medical/hospital insurance)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

If Yes, is your Long-Term Care policy approved under the Connecticut Partnership for Long-Term Care program (the face page of the policy will indicate whether the policy is approved under the Connecticut Partnership and provides Medicaid Asset Protection)? Yes No

If you checked Yes for any insurance other than Medicare, you must complete form W-1685 which asks more specific medical insurance questions.

Have you (or your spouse) received any hospital, doctor, or other medical services in the previous three months which have not been paid? Yes No

Do you (or your spouse) have any other medical bills for which you are making payment? Yes No

LEGALLY LIABLE RELATIVE INFORMATION

List your parents if you are not living with them and you are under age 18.

| Absent Parent's Name | Child(ren)'s Name(s) | Parent's Address | Date parent left home | Do you receive money from this person? |
|----------------------|----------------------|------------------|-----------------------|--|
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you are married and your spouse is not living with you, complete the following items:

| | | |
|-------------|---------|--------------------|
| Spouse Name | Address | Date of Separation |
| | | |

ASSETS

Tell us about the assets owned by you (or your spouse). Also, tell us about any asset with your name (or the name of your spouse) even if the asset is not yours. Answer each numbered section. Complete any section where you answered Yes.

| 1. CASH ON HAND (Money that is not in an account) <input type="checkbox"/> Yes <input type="checkbox"/> No | | Name | Amount |
|--|--|------|------------|
| | | | \$ |
| 2. BANK/CREDIT UNION ACCOUNTS <input type="checkbox"/> Yes <input type="checkbox"/> No List savings, checking, C.D., I.R.A., vacation, Christmas club, burial accounts or any other type of account. Include joint and trustee accounts listed under your name (or the name of your spouse), even if the money is not yours or theirs. Also, include accounts, such as those for children, held in trust for you (or your spouse). | | Name | Amount |
| | | | \$ |
| | | | \$ |
| | | | \$ |
| | | | \$ |
| 3. LIFE INSURANCE POLICIES/DEATH BENEFITS (Include group policies) <input type="checkbox"/> Yes <input type="checkbox"/> No | | Name | Face Value |
| | | | \$ |
| | | | \$ |

ASSETS (CONTINUED)

4. ANNUITIES/TRUST FUNDS/LIMITED PARTNERSHIPS Yes No

| Name | Company Name and Address | Account Number | Amount |
|------|--------------------------|----------------|--------|
| | | | \$ |

5. STOCKS/MUTUAL FUNDS/BONDS/U.S. SAVINGS BONDS Yes No For stocks and mutual funds, identify owner, name of company, number of shares and value. For bonds, identify owner, type of bond, serial number, date of purchase and denomination.

6. PREPAID FUNERAL CONTRACT Yes No

| Name | Funeral Home Name and Address | Amount |
|------|-------------------------------|--------|
| | | \$ |

Motor Vehicles

Do you (or your spouse) own, have registered or have listed in your/their name a car, truck, boat, camper, recreational vehicle, trailer, motorcycle or other vehicle (include unregistered vehicles)? Yes No If Yes, complete the following section:

| Owner Name | Vehicle Type | Year | Make | Model | Mileage | License Plate Number | Amount Owed |
|------------|--------------|------|------|-------|---------|----------------------|-------------|
| | | | | | | | \$ |
| | | | | | | | \$ |

Real Estate

Do you (or your spouse) own any real estate (include home, land, and non-home property)? Yes No If you are applying for SAGA or State Supplement does your spouse own any real estate (include home, land and non-home property)? Yes No If Yes to either question, please give the following information:

1 Owner(s) _____ Location (Street, Town, State)

Is this: land only single family dwelling two-family dwelling other (specify _____)

2 Owner(s) _____ Location (Street, Town, State)

Is this: land only single family dwelling two-family dwelling other (specify _____)

Do you (or your spouse) have life-use of any real estate? Yes No

Other Assets

Do you (or your spouse) own any other assets not listed above (for example, contents of safe deposit box, mortgage payable to you, jewelry, furs, paintings, etc.)? Yes No If Yes, identify owner, asset and value.

Transfer of Assets

Have you (or your spouse) sold, traded, given away, or transferred ownership of any motor vehicles, bank accounts, property of any kind, stocks, bonds, mutual funds or cash during the last thirty-six months (ninety days if only applying for Food Stamps)? Yes No
 Have you had assets transferred through the probate court/surrogate courts in state or out of state in the last 36 months? Yes No
 If Yes to either question, what was transferred, sold or given away, to whom, when, and how much money or what was received in return?
 (Attach an additional page if needed.)

Have you (or your spouse) established a trust or funded a trust with income or property of any kind within the past 60 months?
 Yes No If Yes, provide additional details. (Attach an additional page if needed.)

Have you (or your spouse) closed any type of account during the last thirty-six months (ninety days if only applying for Food Stamps)?
 Yes No If Yes, explain below. Include the bank name, address, account number and date closed.

Have you (or your spouse) sold or junked a motor vehicle in the last thirty-six months (ninety days if only applying for Food Stamps)?
 Yes No

INCOME

How have you paid your bills during the last six months? If you have no income or your expenses are greater than your income, how do you pay your bills?

Current and Previous Employment Income

Are you (or your spouse) employed full-time, part-time or temporarily? Yes No
 Is anyone self-employed? For example, does anyone own a business, baby-sit, give home demonstrations, work on construction, sell homemade crafts, clean house, etc.? Yes No
 If you answered Yes to either of the above two questions, complete the following section. If a person has more than one job, list each job separately. Include anyone who receives income from a job training program.
 If No, list the last job held by each person within the last year. Attach an additional page if needed.

| 1 | Name | Pay before deductions \$ | per | Tips? <input type="checkbox"/> Yes <input type="checkbox"/> No | Hours worked per week | Date Started | Date Ended |
|---|---------------------------|--------------------------|-----|--|-----------------------|--------------|------------|
| | Employer Name and Address | | | | | | |
| | Reason For Leaving | | | | | | |
| 2 | Name | Pay before deductions \$ | per | Tips? <input type="checkbox"/> Yes <input type="checkbox"/> No | Hours worked per week | Date Started | Date Ended |
| | Employer Name and Address | | | | | | |
| | Reason For Leaving | | | | | | |

Current and Previous Employment Income (continued)

Have you (or your spouse) quit or been fired from a job in the last ninety days? Yes No If Yes, list name(s) and reason(s) for quitting or being fired.

| | | |
|------|-------------------------|-------------------------|
| Name | Name of Former Employer | Reason for Quit or Fire |
| | | |
| | | |

Dependent Care

Do you (or your spouse) pay someone for day care for a child or disabled adult so that you, he or she can work, attend training or look for a job? Yes No If Yes, complete below:

| Name (Who day care is for) | Amount Per Week | Name and Address of Day Care Provider | Telephone Number |
|----------------------------|-----------------|---------------------------------------|------------------|
| | \$ | | |
| | \$ | | |

Does the State or anyone else pay your day care? Yes No If Yes, how much? Amount \$ _____

Students

Are there any students (full-time or part-time) in your household over 18 years of age? Yes No If Yes, complete the following section.

| | | | | |
|-----------------|-------------------|-----------------------------|----------------|--------------------------|
| Name of Student | School or Program | Expected Date of Graduation | Semester Hours | Tuition & Mandatory Fees |
| | | | | \$ |

Is this student on a meal plan? Yes No

Does this student have a job? Yes No If Yes, how many hours per week? _____

Does this student receive federally funded work-study? Yes No If Yes, how many hours each week? _____

Does this student receive any educational grants, loans, and scholarships, including work-study? Yes No If Yes, form W-1471, which asks more specific school information must be completed.

Other Income

Check Yes or No to indicate if you (or your spouse) receive or have applied for money from any of the following sources:

- 1) Child Support and/or Alimony Yes No
- 2) Social Security [Types are: Retirement (OA), Disability, Survivor's Disability Insurance (SDI)] Yes No
- 3) SS1 (Supplemental Security Income) Yes No
- 4) Unemployment Compensation Yes No
- 5) Other Government Benefits (Types are: Railroad Retirement, Educational Loans and Grants, Veterans Benefits, VA Aid and Attendance, Military Allotment and HUD Subsidy) Yes No
- 6) Other Private Benefits: Maternity/Sick Pay, Pensions, Worker's Compensation, Union Benefits Yes No
- 7) Other Income: from Stocks, Bonds, Annuities, Rental Property, Roomers, Boarders, Money from Friends or Relatives, Any Other Source Yes No

If you (or your spouse) are receiving income from any of the sources listed above, complete the following:

| Name | Type of Income | Amount Receiving/ How Often? | ID/Claim Number(s) (Optional if not applying for assistance) |
|------|----------------|---------------------------------|---|
| | | \$ _____ per _____ | |
| | | \$ _____ per _____ | |
| | | \$ _____ per _____ | |
| | | \$ _____ per _____ | |

If you (or your spouse) have applied for income from any of the sources listed above, complete the following:

| Name | Type of Income | Date of Application or Claim |
|------|----------------|------------------------------|
| | | |
| | | |
| | | |

Have you (or your spouse) received cash assistance for your family from any state or U.S. territory other than Connecticut since 10/1/96?

Yes No If Yes, from which state or U.S. territory? _____ When? From _____ To _____

Have you (or your spouse) received any other assistance from another state within the last 90 days? Yes No If Yes, which type of assistance? Food Stamps Medical From which State? _____

LIVING ARRANGEMENT AND SHELTER EXPENSES

Check one of the following boxes which most clearly describes your type of living arrangement:

Own Home Share Rent Homeless Other Medical Facility

Rent Living with another and not paying rent Rent a room (meals included) Nursing Home

Other (specify) _____ Rent a room (meals not included) Licensed Boarding Facility

If you checked "Licensed Boarding Facility" or "Other Medical Facility", do not answer the remaining questions A-I in this section. If you checked "Nursing Home", do you have a spouse in the community? Yes No If Yes, answer questions A, B, C, D, H and I in this section about your spouse's living arrangement and shelter expenses. If No, do not answer the remaining questions in this section.

A. Write in the amounts you are expected to pay each month for the following costs:

Rent \$ _____ Mortgage \$ _____ Condominium Fees \$ _____

Taxes \$ _____ Insurance \$ _____

B. Do you receive any type of rental or housing assistance, such as Section 8, HUD, or State Rental Assistance?

Yes No If Yes, enter amount you pay to the landlord \$ _____

C. Do you pay for heat? Yes No

D. Do you have an air conditioner and pay for electricity? Yes No

E. Does your landlord charge you extra for heat or cooling? Yes No

F. Did you receive a check from the Energy Assistance Program during the last year at this address? Yes No

G. Do you pay for any of the following utilities: electricity, gas for cooking, trash removal, water, sewer, septic maintenance?

Yes No

H. Do you pay a monthly phone bill (residential or cellular)? Yes No

I. If you rent, please provide the following information about your landlord.

| | | |
|---------------|------------------|------------------|
| Landlord Name | Landlord Address | Telephone Number |
| | | |

SPECIAL CLOTHING NEED FOR STATE SUPPLEMENT APPLICANTS

The department may be able to help you (or your spouse) if you do not have the proper type or amount of clothing.

Do you (or your spouse) have a need for clothing? Yes No

SPECIAL EATING ARRANGEMENT

Complete this section ONLY if you (or your spouse) are blind, disabled, or over age 65, and are applying for State Supplement or medical assistance.

Do you (or your spouse) eat at least one meal a day at a restaurant? Yes No

Do you (or your spouse) have a special diet? Yes No If Yes, why?

FOR ALL PROGRAMS (continued)

- I authorize the Department of Social Services to verify any information regarding anyone's non-citizen status with the Bureau of Citizenship and Immigration Services (BCIS). I understand that the department will not share the information given on this form with BCIS. I also understand that BCIS CANNOT use this application to deny admission to the U.S., harm permanent resident status or deport me.
- Any information I give on this form, including Social Security numbers, will be used to verify identity and eligibility and will be cross-matched against federal, state and local government files by computer.
- Information available to the State through the Income and Eligibility Verification System (IEVS) will be requested and used to process my request for assistance. This information will come from the Labor Department, the Social Security Administration and the Internal Revenue Service as well as other agencies when allowed by law. Information received may be verified directly with other sources such as banks and employers. Results from such verification may affect my household's eligibility and level of benefits.
- Information regarding child support payments, which are made to the State on behalf of my child, may be verified with the Bureau of Child Support Enforcement (BCSE).
- Giving the information requested on the application is voluntary. If I fail to give certain information, my application will be denied.
- I will cooperate with state and federal personnel in Quality Control Reviews.

FOR FOOD STAMPS

I understand and agree to the following:

- People who quit jobs or cut back on their hours without a reason cannot get Food Stamps. The first time it is for three months. It is six months the second time. It is forever the third time they quit a job.
- People who lie about who they are or where they live cannot get Food Stamps for ten years.
- People who do not follow the Food Stamp Employment and Training rules cannot get Food Stamps. The first time it is for three months. It is six months for any additional offenses.
- When people who receive Food Stamps break a program rule on purpose, they cannot get Food Stamps. The first time it is for one year. It is two years the second time. It is forever the third time they break a rule.
- People found guilty of trafficking in Food Stamps of more than \$500 cannot get Food Stamps. Trafficking in Food Stamps means selling them instead of using them to buy food for their family.
- People who are found guilty of buying illegal drugs with Food Stamps cannot get Food Stamps for two years.
- Law enforcement officers can get, from the Department of Social Services, the address, Social Security number and photograph of a person who gets Food Stamps when the person is a fleeing felon or violating parole or probation. They can also get this information about a person who may know something about a felony.
- Failure to report or verify actual expenses incurred by your household will be seen as a statement that you do not want to receive an allowable deduction for that expense.
- The money in my EBT Food Stamp account will be taken back by the department if I do not make any withdrawals from that account for 9 months (270 days). The amount taken back by the department may be used to reduce any Food Stamp overpayments that exist on my case.
- My application for and receipt of my Food Stamp benefits is a registration for work for myself and all members of my Food Stamp assistance unit who are required to register. I further understand that I and all other members of the Food Stamp assistance unit who are required to do so must participate in Employment Services unless there is good cause not to participate.
- People who live with me but who are not going to receive Food Stamps do not have to give their Social Security numbers. However, if they wish to do so it may be easier to verify their income and speed up the application process.
- People who misuse an Electronic Benefit Transfer (EBT) card may no longer get Food Stamps. They may also be fined up to \$250,000 or sent to jail for up to 20 years or both. Misuse of an EBT card means altering, selling, or trading a card, using someone else's card without permission or exchanging benefits for cash.
- Information on my application form can be given to federal and state agencies as well as private collection agencies if a Food Stamp claim is made against my household.

FOR STATE SUPPLEMENT

I understand and agree to the following:

- Inheritance money or money from a pending lawsuit will be assigned to the State.
- The State will place a lien against my home and the property of my spouse.
- I will be required to grant the department a security mortgage on the non-home property that I own.
- The State recovers monies from the estates of individuals who received cash assistance.
- My legally liable relative may be billed to repay the State for cash assistance paid to me.
- The State may recover an amount up to the total amount of benefits paid if I or anyone for whom I receive assistance receives money at a future date from sources including but not limited to lottery winnings, an inheritance, settlement of a lawsuit or the sale of property.

FOR SAGA CASH AND SAGA MEDICAL ASSISTANCE

I understand and agree to the following:

- Inheritance money or money from a pending lawsuit will be assigned to the State.
- The State will place a lien against my home. The State will also place a lien against the property of the spouse or parent of any member of the household. I understand that I will be required to grant the department a security mortgage on the non-home property that I own.
- The State may recover an amount up to the total amount of benefits paid if I, my spouse, or anyone for whom I receive assistance receives money at a future date from sources including, but not limited to, lottery winnings, an inheritance, settlement of a lawsuit or the sale of property.
- I must cooperate with the State in securing support from spouses and/or parents of all household members.
- If a member of my household has a substance abuse problem, he or she may be required to be in treatment in order to receive cash benefits.
- False or misleading statements made when applying for SAGA violate State law and may cause me to be disqualified for up to one year.

FOR ALL MEDICAL, MONEY AND HOME CARE PROGRAMS

I understand and agree to the following:

- Money from a pending lawsuit will be assigned to the State to recover any medical expenses paid by the State related to the lawsuit.
- False or misleading statements made when applying for Medical Assistance violate federal law and may be punishable by a fine up to \$25,000 or imprisonment for 5 years, or both.
- By applying for assistance, I assign my right of support from third parties to the department (section 1912 of the Social Security Act). I also understand that, if I am in a nursing facility or if I am applying for home and community-based services, and I want to assign my support rights, I must sign an additional assignment of support (section 1924 of the Social Security Act).
- By receiving medical assistance, I allow the State to recover the cost of my medical bills which may have been covered by other insurance directly from the insuring company.
- The State recovers monies from the estates of individuals who received long term care services, Home Care Services or who were age 55 or older at the time that community medical assistance benefits were paid and who do not have a living spouse or a surviving child who is under age 21 or blind or disabled.
- I give the Department of Social Services permission to apply for Medicare on my behalf. I understand that an application will be filed only if the department thinks I am eligible. I also agree to let the Department of Social Services file Medicare claims and pursue appeals. These actions may be taken by the department or its representative.
- I give permission to DSS or any health insurer, provider, or any other entity providing services to me or my family under the Medicaid program to release information about me or my family as necessary for the delivery of Medicaid program services and the administration of the Medicaid program, as permissible by federal or State law.
- I will not alter, trade, sell, or use someone else's medical services identification card.
- The State can place a lien, under certain conditions, on my home if I permanently enter a nursing facility.
- My legally liable relative may be billed to repay the State to repay the cost of my medical care.

