



W-1PE
(New 2/14)

State of Connecticut
Department of Social Services

**Application for HUSKY Presumptive
Eligibility**

DSS Use Only

CLID: _____

App. Date: _____

Name: _____
 First Middle initial Last

Residential Address: _____

Telephone Number: _____

Translation: Do you need a translator to help you fill out your application? No _____ Yes _____

If "yes," what language? _____

Section 1. Household Composition				
Please list all family members (spouse, children, parents, siblings) living in your household.				
Name	Relationship to Applicant	Date of Birth	Social Security # **(optional)	Gender
	Yourself			<input type="checkbox"/> M <input type="checkbox"/> F
				<input type="checkbox"/> M <input type="checkbox"/> F
				<input type="checkbox"/> M <input type="checkbox"/> F
				<input type="checkbox"/> M <input type="checkbox"/> F
				<input type="checkbox"/> M <input type="checkbox"/> F
Section 2. Income				
Please list Taxable Gross Income for you and anyone else for whom you are applying. Please include any gross wages from employment, <u>gross</u> Social Security (including your Medicare Part B premium), pensions, annuities, disability benefits, alimony, interest, Unemployment Compensation, dividends, rental property income, self-employment income.				
Name of Person Receiving Income	Source (List name of employer if working)	Taxable Gross Monthly Amount		
Self		\$		
		\$		
		\$		
Total Taxable Gross Monthly Income		\$		

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.

****Notice to Presumptive Eligibility applicant:** Presumptive Eligibility provides HUSKY coverage for a limited period of time: coverage will expire at the end of the month which follows the month of application. YOU MUST SUBMIT AN APPLICATION for extended Medicaid coverage.**

I certify I have read and understand this form. I declare that the information I have provided is true, correct and complete.

CITIZENSHIP: I also certify that I am a United States Citizen or have been lawfully present in the United States for at least five years. I may be required to document my status when I submit a full application for Medicaid.

Applicant or Authorized Representative's signature

Date

To be completed by the Presumptive Eligibility site

PE Site Name: _____

PE Site Representative: _____

Telephone Number: _____

Notice: Applications for on-going Medicaid may be submitted on-line at *AccessHealthCT.com* or by calling 1-855-805-4325.

Department of Social Services strongly encourages use of the Presumptive Eligibility On-line application available on the DSS *ConneCT* site: <https://connect.ct.gov/access/>.

**Fax To: Department of Social Services, Scanning Center
Fax Number: 860-812-0006**

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DO YOU WANT TO REGISTER TO VOTE?

Federal and state laws require the Department of Social Services (DSS) to give you the chance to register to vote. Please answer the questions below and print and sign your name in the space provided.

Are you registered to vote? Yes I am already registered No

If you are not registered to vote where you live now, would you like to apply to register to vote here today? Yes No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote will **not** affect the amount of assistance that you will be provided by this agency.
If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

To register, complete a voter registration application form and leave it at DSS or mail it in. The form is included with DSS applications that we mail to you, and you can also get one at all DSS offices. You can mail your completed form to DSS in the enclosed envelope or send it directly to your Town Hall. If you need help, please call **1-855-626-6632**.

_____ _____ _____
Print Your Name Your Signature Date

Address _____
 Number Street City State

For Worker's Use Only

Date _____ No check boxes checked Voter Registration Card Sent

Worker Name _____ Worker DMC Number _____

(Tear Here and Keep)

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose you own political party or other political preferences, you may file a complaint with: State Elections Enforcement Commission, 20 Trinity Street, Hartford, CT 06106; 860-256-2940, toll-free 866-733-2463, TDD: 1-800-842-9710; SEEC@ct.gov.

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