



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:

- ☐ Connecticut Homecare Program for Elders (CHCPE)
☐ 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