STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

W-982
(Rev. 12/14)

DSS USE ONLY
Date Received:_____
Number Assigned:_____

PERSONAL CARE ASSISTANCE (PCA) WAIVER REQUEST

1. Personal Data

Name_____

Address_____

_____

Telephone_____

Date of Birth_____/_____/_____
(month) (day) (year)

Social Security Number_____

I live ☐ Alone ☐ With Others

☐ In An Institution

Contact person if other than yourself:

Name_____

Relationship_____

Telephone_____

☐ Married ☐ Single ☐ Widowed ☐ Divorced

What is your Disability_____

Conservator, if applicable_____

Telephone_____

If you live with others, please identify:

Name	Relationship

2. Medicaid/Medicare Information

I am currently: ☐ On Medicaid ☐ On Spenddown

☐ Pending For Medicaid ☐ Not On Medicaid

Medicaid Number_____

I am currently on Medicare ☐ Yes ☐ No

Medicare Number_____

"Persons who are deaf or hard of hearing and have a TTD/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."

3. Complete This Section If You Currently Receive Any of These Services

I receive: **Home Health Aide Services** ☐ Yes ☐ No Hours Per Week_____

Agency _____

Nursing Services ☐ Yes ☐ No Hours Per Week_____

Agency _____

Physical Therapy ☐ Yes ☐ No Hours Per Week_____

Agency _____

Occupational Therapy ☐ Yes ☐ No Hours Per Week_____

Agency _____

Speech Therapy ☐ Yes ☐ No Hours Per Week_____

Agency _____

The above services are paid for by: ☐ Medicaid ☐ Medicare ☐ Both ☐ Neither

4. Other Program Participation

I receive the following services:

☐ DSS Community Based "Essential" Services (includes homemaker, companion, Meals on Wheels, emergency response system, adult day care).

List services_____ Hours per week_____

_____ Hours per week_____

Total monthly cost of these services, if known _____

Name of Social Worker_____

☐ Bureau of Rehabilitation (BRS) Services, please describe:

_____

_____

Name of Counselor_____

☐ Services from the Department of Mental Retardation or the Department of Mental Health, please identify:

_____

_____

Total cost of these services, if known_____

Name of your case manager_____

5. Assistance Needs

I need physical (hands on) assistance (check all that apply):

To Be Bathed	☐ Yes	☐ No
To Be Dressed	☐ Yes	☐ No
With Bowel and Bladder Care	☐ Yes	☐ No
To Complete Transfers	☐ Yes	☐ No
To Be Fed	☐ Yes	☐ No

6. Financial Data

My total monthly income (not including funds from the programs identified in Section 4) is:

Amount	**Source**
_____	_____
_____	_____
_____	_____

My total assets are:

Amount	**Source**
_____	_____
_____	_____
_____	_____

If this form was completed by someone other than the potential applicant, identify that person:

Name_____

Relationship to potential applicant_____

Please explain why this form was not completed by the potential applicant:_____

_____

_____

I attest that the information provided is true and accurate to the best of my knowledge.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Witness if applicant signs with an X Date

_____ _____
Signature of person completing this form if other than the applicant Date

_____ _____
Signature of Conservator, if applicable Date

Return This Form To: Department of Social Services, 55 Farmington Avenue, Hartford, CT 06105-3724
Attention: Alternate Care Unit