# NCAAA ASSIST APPLICATION

Revised 11/2023

**Please do not leave any questions blank. PLEASE PRINT.**

**Name of Person Requesting Assistance:** _____

**Gender:** ☐ Male ☐ Female ☐ Non-Binary **Veteran or dependent**: ☐ Yes ☐ No

**Age:** **Date of Birth:** ____/___/_____ **Social Security Number: XXX-XX**-_____
MO/DAY/YR

**Home Address:**

_____
Street City/CT/Zip

Telephone: _____ Email Address: _____

**Marital Status:**

☐ Single/Never married ☐ Married ☐Widowed ☐Separated ☐Divorced

**Living Arrangement:**

☐ Alone ☐ With spouse only ☐ With spouse & children ☐ With children only
☐ Other: _____

**Housing:**

☐ Private home ☐ Board and care home ☐ Senior Housing ☐ Public housing
☐ Private apartment ☐ Nursing home/Institution ☐ Congregate housing
☐ Other: _____

**Ethnicity:** ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Unknown

**Race:** ☐ Non-Minority/White ☐ Native American/Alaskan Native ☐ Native Hawaiian/Pacific Islander
☐ Asian ☐ Black/African American ☐ Hispanic/white ☐ Other: _____

**Primary Language:** _____ **Speaks English:** ☐ Very Well ☐ Well ☐ Not Well ☐ Not at All

**Monthly Income:** _____ **Type:** ____Individual ____ Joint (Applicant and Spouse)

**Disabled:** ☐ Yes _____ ☐ No

**Primary Physician:** _____ **Telephone:** _____

**Medical Diagnosis:**

_____

_____

**Any Pets:** _____ **Smoker:** ☐ Yes ☐ No

1. Do you currently receive **MEDICAID (TITLE 19)**? ☐ Yes ☐ No If

   No, are you currently applying for **MEDICAID (TITLE 19)**? ☐ Yes ☐ No

2. Do you currently receive services from the other programs?

   ☐ Yes ☐ No

   If no, are you currently applying for services from another program?

   ☐ Yes ☐ No

3. Do you currently receive services from the **CT Home Care Program for Elders**?

   ☐ Yes ☐ No

   If no, are you currently applying for the **CT Home Care Program for Elders**?

   ☐ Yes ☐ No

4. Do you need assistance with any of the following activities? (please check all that apply)

☐Eating ☐Bathing ☐Dressing ☐Using the Bathroom ☐Walking ☐Moving in and out or bed or chair

5. **Explain the reason(s) services are being requested:** _____

_____

6. **Explain the type of assistance needed:** _____

_____

_____

7. **Do you receive any *additional* home or community based services (such as a visiting nurse or going to an Adult Day Center)? If yes, please list the services:**

_____

8. **Additional Comments:**_____

_____

How did you hear about the Program? (Check all that apply)

☐ Newspaper ☐ From a Friend ☐ Area Agency on Aging ☐ TV/Radio ☐ Social Media
☐ Internet ☐ Other* (please describe) _____

*** If agency, please write the agency name and phone number of person making referral.**

_____

## CERTIFICATION AND AUTHORIZATION

I certify that the information on this form is true, accurate, and complete.

I further authorize any health care provider to release any medical records to ensure that appropriate services are provided by the program.

_____

SIGNATURE OF APPLICANT DATE

I understand that if I have questions I can contact:


**NORTH CENTRAL AREA AGENCY ON AGING (NCAAA)**
**151 NEW PARK AVE, BOX 75, HARTFORD, CT 06106**
**PHONE: 860-724-6443 or 1-800-994-9422**
**FAX: 860-251-6107**
**WEB: www.ncaaact.org**
**EMAIL: info@ncaaact.org**

## *PHYSICIAN STATEMENT

(*A physician's statement must be obtained for applicants under the age of 60 who have irreversible or deteriorating dementia.)

An application has been made to North Central Area Agency on Aging (NCAAA) for the individual named below. In order to evaluate the application, information is needed regarding the disability, health and medical problems, and the level of care of the individual. Please answer the following questions.

**Patient's Name:** _____

**Date of Birth:** _____

**Address:** _____

**Phone:** _____

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***For Physician use only:***

## Does this patient have irreversible and deteriorating dementia?

☐ **Yes** ☐ **No**

_____

**SIGNATURE OF PHYSICIAN** **DATE**

Name of Physician (Please Print): _____

Address: _____

_____

Telephone: _____

Please return form to:

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## PERMISSION FOR RELEASE OF MEDICAL INFORMATION

**APPLICANT: Please complete this page and send it, along with the physician's statement, to your physician.**

I agree to the release of medical information on:

_____

Name of Patient

_____

Address

_____

Phone

_____

Date of Birth

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**SIGNATURE OF APPLICANT**

_____

**DATE**

**Please return this form to:**


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