FAX

TO: Advancing Connecticut Together- Client Assistance, Fax # 860-761-6711

FROM:_____ Email:_____

DATE:_____ PAGES:_____ (including cover)

RE: ACT Client Assistance Request

Required Checklist

Service Category:

- ❑ Health Insurance Premium & Cost Sharing Assistance
  - ❑ W9 for Healthcare Provider

- ❑ Transportation Assessment Form
  - ❑ *Uber:* Request Form, Ride Chart, & ROI to Uber Health
  - ❑ *Uber Voucher:* Request Form & Ride Chart
  - ❑ *Buss Pass*: Request Form & Ride Chart
  - ❑ *Gas Card:* Request Form & Ride Chart

- ❑ Food Voucher

- ❑ EFA Utilities
  - ❑ Request Form & Billing Statement
  - ❑ W9 if applicable (i.e individual business)

Intake Packet

In CW	Attached	
❑	❑	Signature of Medical Case Manager & Supervisor
❑	❑	CAREWare Referral
❑	❑	CAREWare Demographic Report & Up-to-date Annual Review
❑	❑	Signed Eligibility Worksheet and Income Verification (or Zero Income Affidavit)
❑	❑	Release of Information to ACT
❑	❑	Signed ACT Bill of Rights
❑	❑	Signed Ryan White Consent
❑	❑	Signed ACT CAREWare Consent for Sharing
❑	❑	Lab report of CD4 and/or Viral Load within the past 12 months

RW Part A Food Program/Meal Services Assessment Form

CLIENT INFORMATION

Client ID:		
Case Manager (if one is assigned to the client)	**Food Allergies**: ◯ Yes ◯ No **Dietary Restrictions**: ◯ Yes ◯ No	**RW eligibility worksheet completed:** ◯ Yes ◯ No **Food Stamp amount if any**:

Has client applied for other services: ◯ Yes ◯ No ◯ SNAP

Service Date:

Type of Food Service to be provided:

Amount Requested:

Reason for this need:

Action taken by RW staff to address this need:

If service denied, please explain the reason and if resolved (Wellness Center only):

Was CAREWare referral competed? ◯ Yes ◯ No

Additional Case Notes:

Funds utilized for this need: ◯ RW Part A ◯ RW Part B

Case Manager Signature _____ **Date:**