

# Premium Assistance Contributions

Allied Community Resources      Or  
 PO Box 479  
 East Windsor, CT 06088  
 Email: [ACR@alliedgroup.org](mailto:ACR@alliedgroup.org)

Sunset Shores  
 67 Bridgeport Avenue  
 Milford, CT 06460-3931  
 Email: [PremiumAssistance@sunsetshoresfi.com](mailto:PremiumAssistance@sunsetshoresfi.com)

Department of Social Services (DSS)      Or

Department of Developmental Services (DDS)

## APPLICATION SUBMISSION INSTRUCTIONS

### **ALLIED: *Electronic / Fillable Form Submission***

Complete the application online & upload the denial letter  
<https://form.jotform.com/223605680164050>

### **SUNSET SHORES: *Hard copy (faxed or emailed)***

Complete hard copy and fax/email with denial letter  
 Email: [PremiumAssistance@sunsetshoresfi.com](mailto:PremiumAssistance@sunsetshoresfi.com)  
 Toll free fax 1-866-380-0149

Employee Name	Employer of Record Name	Date
Employee Phone Number	Employer of Record Phone Number	
Employee Email Address	Consumer Name (if different than Employer of Record)	

I CERTIFY THE FOLLOWING:

- I have been employed for a full 6 months and earned a wage under the consumer-employer indicated above.
- I am employed and have “actively worked” defined as: receive a wage or is an identified support on a care plan/individual plan under the consumer-employer indicated above.
- I currently do not have medical coverage options through any other entity, for example, through another job or through a spouse and have attached the required attestation form.
- I attached proof of documentation that I have applied for and been denied coverage through both [Medicaid](#) (Husky) and [Covered CT](#)

I, \_\_\_\_\_, am self-attesting that I am not currently enrolled or eligible for enrollment in health insurance coverage under my spouse and or any other employment source.

I understand that this self-attestation is required for access to the Collective bargaining Agreement (CBA) Article 13A, Premium Assistance Contribution. The Premium Assistance Contribution benefit will provide up to a maximum of \$5000 and is calculated at 6% of my total wages earned over the previous 6 months of active employment per each individual consumer-employer. If I have not worked a full 6 months, then I will not be eligible until a full six (6) months have been worked. I hereby certify that the statements I have attested to above are true and accurate

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_.

THIS SECTION COMPLETED BY FI

Was proof of denial for Medicaid (Husky) and Covered CT provided with application? Y \_ N \_

Has the employee been actively employed by the individual consumer-employer for 6 months? Y\_ N\_

Name of Fiscal Intermediary Employee Recording Information and Certification from Employee Requesting Premium Assistance

FI \_\_\_\_\_ Date \_\_\_\_\_