Premium Assistance Contributions

☐ Allied Community Resources
PO Box 479
East Windsor, CT 06088
Email: ACR@alliedgroup.org

Or

☐ Sunset Shores
67 Bridgeport Avenue
Milford, CT 06460-3931
Email:PremiumAssistance@sunsetshoresfi.com

☐ Department of Social Services (DSS)

Or

☐ Department of Developmental Services (DDS)

APPLICATION SUBMISSION INSTRUCTIONS

***See sample application for reference**

ALLIED: ***Electronic / Fillable Form Submission***
Complete the application online & upload the denial letter
https://web.alliedgroup.org/Allied/application_premium-assistance

SUNSET SHORES: Hard copy (faxed or emailed)
Complete hard copy and fax/email with denial letter
Email: 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 an annual 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.

Name_____Date_____