



**PRELIMINARY SCREENING:
 Likely Eligibility for Public Health Insurance and Financial Assistance Programs**

RESPONSES PROVIDED BY ELIGIBILITY TECHNICIAN

What is the eligibility technician's full name? _____
 Hospital facility name? _____
 Facility phone number? _____
 What is today's date? _____
 Date of service applying to cover? _____

Did patient receive a CICP-eligible service at a CICP provider, or is the patient scheduled to receive a CICP-eligible service? _____
 Did patient receive care for a medical emergency? _____

RESPONSES PROVIDED BY PATIENT

Patient Contact Information

Patient's Last Name _____
 Patient's First Name _____
 Patient's Middle Initial (OPTIONAL) _____
 Patient's street address _____
 Patient's city of residence _____
 Patient's zip code _____
 Patient's county _____
 Patient's primary phone number _____
 Patient's primary email address _____
 Patient's preferred method of contact _____
 Is the patient experiencing homelessness? _____

Patient Demographic Information

What is your birthday? [MM/DD/YYYY] _____

Patient Residency

Are you a resident of or currently living in Colorado?
 You can say "yes," "no," or "I don't want to answer." _____

Pregnancy and Children (Optional)

Are you currently pregnant?
 You can say "yes," "no," or "I don't want to answer."
 People who are pregnant sometimes qualify for some additional programs. _____

Is anyone in your household under 19 years old?
 You can say "yes," "no," or "I don't want to answer."
 Children sometimes qualify for some programs that adults don't qualify for. _____

Disabilities

Do you have a disability?
You can say "yes," "no," or "I don't want to answer."
People with disabilities sometimes qualify for programs that people without disabilities don't qualify for.

Do you receive federal disability income?
You can say "yes," "no," or "I don't want to answer."
People who receive federal disability income can automatically qualify for Medicare.

Patient Insurance Status and Benefits

Are you uninsured [or are you about to lose your health insurance]?
You can say "yes," "no," or "I don't want to answer."
Health Sharing Ministries count as third party payers but not insurance.

Have you ever been covered under Medicaid or CHP+?
If so, do you have or know your ID number?
Do you have an unexpired Colorado Indigent Care Program rating?

Household Size and Household Income

How many people live in your household, including yourself?
Do you have any income? If so, about how much money do you receive each month?

Is anyone in your household pregnant right now?
If so, how many babies are expected?
(Add unborn children as household members below)
Some programs take pregnancy into account when counting how many people are in your household. When there are more children in your household, you may be more likely to qualify for some programs.

Household Member 2

Name of Household Member 2 (OPTIONAL)
What is the relationship to Household Member 2 to you?
Does Household Member 2 have any income? If so, about how much money do they receive each month? If not, enter \$0.
Is this household member included in patient/guardian's taxes?

\$0.00

Household Member 3

Name of Household Member 3 (OPTIONAL)
What is the relationship to Household Member 3 to you?
Does Household Member 3 have any income? If so, about how much money do they receive each month? If not, enter \$0.
Is this household member included in patient/guardian's taxes?

\$0.00

Household Member 4

Name of Household Member 4 (OPTIONAL)
What is the relationship to Household Member 4 to you?
Does Household Member 4 have any income? If so, about how much money do they receive each month? If not, enter \$0.
Is this household member included in patient/guardian's taxes?

\$0.00

Household Member 5

Name of Household Member 5 (OPTIONAL)
What is the relationship to Household Member 5 to you?
Does Household Member 5 have any income? If so, about how much money do they receive each month? If not, enter \$0.
Is this household member included in patient/guardian's taxes?

\$0.00

Household Member 6

Name of Household Member 6 (OPTIONAL)

What is the relationship to Household Member 6 to you? _____
Does Household Member 6 have any income? If so, about how much money
do they receive each month? If not, enter \$0. \$0.00
Is this household member included in patient/guardian's taxes? _____

Household Member 7

Name of Household Member 7 (OPTIONAL) _____
What is the relationship to Household Member 7 to you? _____
Does Household Member 7 have any income? If so, about how much money
do they receive each month? If not, enter \$0. \$0.00
Is this household member included in patient/guardian's taxes? _____

Household Member 8

Name of Household Member 8 (OPTIONAL) _____
What is the relationship to Household Member 8 to you? _____
Does Household Member 8 have any income? If so, about how much money
do they receive each month? If not, enter \$0. \$0.00
Is this household member included in patient/guardian's taxes? _____

Household Member 9

Name of Household Member 9 (OPTIONAL) _____
What is the relationship to Household Member 9 to you? _____
Does Household Member 9 have any income? If so, about how much money
do they receive each month? If not, enter \$0. \$0.00
Is this household member included in patient/guardian's taxes? _____

Household Member 10

Name of Household Member 10 (OPTIONAL) _____
What is the relationship to Household Member 10 to you? _____
Does Household Member 10 have any income? If so, about how much
money do they receive each month? If not, enter \$0. \$0.00
Is this household member included in patient/guardian's taxes? _____

Household Member 11

Name of Household Member 11 (OPTIONAL) _____
What is the relationship to Household Member to you? _____
Does Household Member 11 have any income? If so, about how much
money do they receive each month? If not, enter \$0. \$0.00
Is this household member included in patient/guardian's taxes? _____

Household Member 12

Name of Household Member 12 (OPTIONAL) _____
What is the relationship to Household Member 12 to you? _____
Does Household Member 12 have any income? If so, about how much
money do they receive each month? If not, enter \$0. \$0.00
Is this household member included in patient/guardian's taxes? _____

Household Member 13

Name of Household Member 13 (OPTIONAL) _____
What is the relationship to Household Member 13 to you? _____
Does Household Member 13 have any income? If so, about how much
money do they receive each month? If not, enter \$0. \$0.00
Is this household member included in patient/guardian's taxes? _____

Household Member 14

Name of Household Member 14 (OPTIONAL) _____
What is the relationship to Household Member 14 to you? _____
Does Household Member 14 have any income? If so, about how much
money do they receive each month? If not, enter \$0. \$0.00
Is this household member included in patient/guardian's taxes? _____



UNIFORM APPLICATION

Eligibility technician's full name _____
 Hospital facility name _____
 Facility phone number _____
 Today's date _____
 Date of service applying to cover? _____

Client Demographic Information

Patient's Last Name _____
 Patient's First Name _____
 Patient's Middle Initial _____
 Patient's Social Security Number (CICP Only) _____
 Patient's Date of Birth _____
 Patient's street address _____
 Patient's city of residence _____
 Patient's zip code _____
 Patient's county _____
 Patient's primary phone number _____
 Patient's primary email address _____
 Patient's preferred method of contact _____
 Patient's Health First CO/CHP+ number (if applicable) _____
 Is the patient experiencing homelessness? _____

Screening for Health First CO/CHP+ Ineligibility

(CICP ONLY)

Has the Patient received a Health First CO denial letter? _____
 Has the Patient received a CHP+ denial letter? _____
 Is the Patient a US citizen? _____
 Has the Patient been lawfully present for less than 5 years? _____
 Does the Patient have refugee status? _____
 Have Transitional Medical Benefits been discontinued? _____
 Does the Patient's household income exceed the Health First CO limit? _____
 Is the Patient a child? _____
 Is the Patient pregnant? _____
 Is the Patient disabled? _____
 Does the Patient have primary insurance? _____
 Other (provide brief explanation): _____

**Health First
 CO/CHP+
 Ineligibility Code**

Household Member 2

Household Member's Full Name _____
 Household Member's relationship to Patient _____
 Household Member's Birthday _____
 Household Member's Health First CO/CHP+ number (if applicable) _____
 Household Member's Social Security Number (CICP Only) _____

Screening for Health First CO/CHP+ Ineligibility

(CICP ONLY)

Has the Household member received a Health First CO denial letter? _____
 Has the Household member received a CHP+ denial letter? _____
 Is the Household member a US citizen? _____
 Has the Household member been lawfully present for less than 5 years? _____
 Does the Household member have refugee status? _____
 Have Transitional Medical Benefits been discontinued? _____
 Does the household income exceed the Health First CO limit? _____
 Is the Household member a child? _____
 Is the Household member pregnant? _____
 Is the Household member disabled? _____
 Does the Household member have primary insurance? _____
 Other (provide brief explanation): _____

**Health First
 CO/CHP+
 Ineligibility Code**

Household Member 3		
Household Member's Full Name		
Household Member's relationship to Patient		
Household Member's Birthday		
Household Member's Health First CO/CHP+ number (if applicable)		
Household Member's Social Security Number (CICP Only)		
Screening for Health First CO/CHP+ Ineligibility (CICP ONLY)		Health First CO/CHP+ Ineligibility Code
Has the Household member received a Health First CO denial letter?		
Has the Household member received a CHP+ denial letter?		
Is the Household member a US citizen?		
Has the Household member been lawfully present for less than 5 years?		
Does the Household member have refugee status?		
Have Transitional Medical Benefits been discontinued?		
Does the household income exceed the Health First CO limit?		
Is the Household member a child?		
Is the Household member pregnant?		
Is the Household member disabled?		
Does the Household member have primary insurance?		
Other (provide brief explanation):		

Household Member 4		
Household Member's Full Name		
Household Member's relationship to Patient		
Household Member's Birthday		
Household Member's Health First CO/CHP+ number (if applicable)		
Household Member's Social Security Number (CICP Only)		
Screening for Health First CO/CHP+ Ineligibility (CICP ONLY)		Health First CO/CHP+ Ineligibility Code
Has the Household member received a Health First CO denial letter?		
Has the Household member received a CHP+ denial letter?		
Is the Household member a US citizen?		
Has the Household member been lawfully present for less than 5 years?		
Does the Household member have refugee status?		
Have Transitional Medical Benefits been discontinued?		
Does the household income exceed the Health First CO limit?		
Is the Household member a child?		
Is the Household member pregnant?		
Is the Household member disabled?		
Does the Household member have primary insurance?		
Other (provide brief explanation):		

Household Member 5		
Household Member's Full Name		
Household Member's relationship to Patient		
Household Member's Birthday		
Household Member's Health First CO/CHP+ number (if applicable)		
Household Member's Social Security Number (CICP Only)		
Screening for Health First CO/CHP+ Ineligibility (CICP ONLY)		Health First CO/CHP+ Ineligibility Code
Has the Household member received a Health First CO denial letter?		
Has the Household member received a CHP+ denial letter?		
Is the Household member a US citizen?		
Has the Household member been lawfully present for less than 5 years?		
Does the Household member have refugee status?		
Have Transitional Medical Benefits been discontinued?		
Does the household income exceed the Health First CO limit?		
Is the Household member a child?		
Is the Household member pregnant?		
Is the Household member disabled?		
Does the Household member have primary insurance?		
Other (provide brief explanation):		

Household Member 6		
Household Member's Full Name		
Household Member's relationship to Patient		
Household Member's Birthday		
Household Member's Health First CO/CHP+ number (if applicable)		
Household Member's Social Security Number (CICP Only)		
Screening for Health First CO/CHP+ Ineligibility (CICP ONLY)		Health First CO/CHP+ Ineligibility Code
Has the Household member received a Health First CO denial letter?		
Has the Household member received a CHP+ denial letter?		
Is the Household member a US citizen?		
Has the Household member been lawfully present for less than 5 years?		
Does the Household member have refugee status?		
Have Transitional Medical Benefits been discontinued?		
Does the household income exceed the Health First CO limit?		
Is the Household member a child?		
Is the Household member pregnant?		
Is the Household member disabled?		
Does the Household member have primary insurance?		
Other (provide brief explanation):		

Household Member 7		
Household Member's Full Name		
Household Member's relationship to Patient		
Household Member's Birthday		
Household Member's Health First CO/CHP+ number (if applicable)		
Household Member's Social Security Number (CICP Only)		
Screening for Health First CO/CHP+ Ineligibility (CICP ONLY)		Health First CO/CHP+ Ineligibility Code
Has the Household member received a Health First CO denial letter?		
Has the Household member received a CHP+ denial letter?		
Is the Household member a US citizen?		
Has the Household member been lawfully present for less than 5 years?		
Does the Household member have refugee status?		
Have Transitional Medical Benefits been discontinued?		
Does the household income exceed the Health First CO limit?		
Is the Household member a child?		
Is the Household member pregnant?		
Is the Household member disabled?		
Does the Household member have primary insurance?		
Other (provide brief explanation):		

Household Member 8		
Household Member's Full Name		
Household Member's relationship to Patient		
Household Member's Birthday		
Household Member's Health First CO/CHP+ number (if applicable)		
Household Member's Social Security Number (CICP Only)		
Screening for Health First CO/CHP+ Ineligibility (CICP ONLY)		Health First CO/CHP+ Ineligibility Code
Has the Household member received a Health First CO denial letter?		
Has the Household member received a CHP+ denial letter?		
Is the Household member a US citizen?		
Has the Household member been lawfully present for less than 5 years?		
Does the Household member have refugee status?		
Have Transitional Medical Benefits been discontinued?		
Does the household income exceed the Health First CO limit?		
Is the Household member a child?		
Is the Household member pregnant?		
Is the Household member disabled?		
Does the Household member have primary insurance?		

Other (provide brief explanation): _____

Household Member 9

Household Member's Full Name _____
Household Member's relationship to Patient _____
Household Member's Birthday _____
Household Member's Health First CO/CHP+ number (if applicable) _____
Household Member's Social Security Number (CICP Only) _____

Screening for Health First CO/CHP+ Ineligibility
(CICP ONLY)

**Health First
CO/CHP+
Ineligibility Code**

Has the Household member received a Health First CO denial letter? _____
Has the Household member received a CHP+ denial letter? _____
Is the Household member a US citizen? _____
Has the Household member been lawfully present for less than 5 years? _____
Does the Household member have refugee status? _____
Have Transitional Medical Benefits been discontinued? _____
Does the household income exceed the Health First CO limit? _____
Is the Household member a child? _____
Is the Household member pregnant? _____
Is the Household member disabled? _____
Does the Household member have primary insurance? _____
Other (provide brief explanation): _____

Household Member 10

Household Member's Full Name _____
Household Member's relationship to Patient _____
Household Member's Birthday _____
Household Member's Health First CO/CHP+ number (if applicable) _____
Household Member's Social Security Number (CICP Only) _____

Screening for Health First CO/CHP+ Ineligibility
(CICP ONLY)

**Health First
CO/CHP+
Ineligibility Code**

Has the Household member received a Health First CO denial letter? _____
Has the Household member received a CHP+ denial letter? _____
Is the Household member a US citizen? _____
Has the Household member been lawfully present for less than 5 years? _____
Does the Household member have refugee status? _____
Have Transitional Medical Benefits been discontinued? _____
Does the household income exceed the Health First CO limit? _____
Is the Household member a child? _____
Is the Household member pregnant? _____
Is the Household member disabled? _____
Does the Household member have primary insurance? _____
Other (provide brief explanation): _____



UNIFORM APPLICATION
 Worksheet 1 - Earned and Unearned Income

Payment Sources	Monthly Income			Annualized Income
Earned Income:				
Employment Income	\$0.00			\$0.00
Monthly Unearned Income Sources:				
		Documented	Self-Declared	
Social Security Income (SSI)		<input type="checkbox"/>	<input type="checkbox"/>	\$0.00
Social Security Disability Income (SSDI)		<input type="checkbox"/>	<input type="checkbox"/>	\$0.00
Disbursement from Retirement Accounts		<input type="checkbox"/>	<input type="checkbox"/>	\$0.00
Pension Payments		<input type="checkbox"/>	<input type="checkbox"/>	\$0.00
Payments from Trust Funds		<input type="checkbox"/>	<input type="checkbox"/>	\$0.00
Disbursement from Lottery Winnings		<input type="checkbox"/>	<input type="checkbox"/>	\$0.00
Annual or One Time Income Sources:				
Bonuses (enter full amount of bonuses included on pay stubs)				\$0.00
Short Term Disability (enter full amount of payments from STD)				\$0.00
Unemployment Income (use calculator to right)	\$0.00			\$0.00
Tips and Commissions (only if not normal on pay stub)				\$0.00
Infrequent Overtime				\$0.00
	Earned Income Total	\$0.00		\$0.00
	Unearned Income Total	\$0.00		\$0.00
Total Income:				\$0.00

Eligibility Technician Signature	Date
Facility	Phone

Version 1.6

This worksheet must be signed and included with all applications.

Combined Earned Monthly Gross Income	
Patient/Guardian	
Total Household Gross Income	\$0.00

Year-to-Date Methodology	
Cumulative Year-to-Date Earnings	
Pay Period Type	
Number of Paychecks Received Year-to-Date	
Number of Annual Pay Periods	0
Gross Monthly Income	\$0.00

Average Pay Methodology	
Pay Period Type	
Pay Stubs	Gross Earnings
	1
	2
	3
	4
	5
Paystub TOTAL	\$0.00
Number of Paystubs	0
Monthly Income	\$0.00



UNIFORM APPLICATION
 Worksheet 2 - Net Self-Employment Income

Does the self-employed household member operate their business from their home? **Yes**
 Square footage of household's home:
 Square footage used for household member's home business:
 Hours per week household member works out of their home:

Yes

		Monthly	Annualized
Revenue:	Gross Business Income		\$0.00
Business Property Expenses:	Mortgage/Rent of Business Property		\$0.00
	Utilities		\$0.00
			\$0.00
			\$0.00
Other Expenses:	Advertising		\$0.00
	Business Phone		\$0.00
	Business Taxes (non-personal)		\$0.00
	Fuel for Business-related Travel		\$0.00
	Gross Wages		\$0.00
	Insurance		\$0.00
	Legal Fees		\$0.00
	License/Certification Fees Paid		\$0.00
	Merchandise/Cost of goods		\$0.00
	Office Supplies		\$0.00
	Repairs/Upkeep of Equipment		\$0.00
	Tools/Equipment		\$0.00
			\$0.00
		\$0.00	
Total Expenses:		\$0.00	\$0.00
Net Profit		\$0.00	\$0.00

Eligibility Technician Signature

Date

Facility

Phone

Version 1.6

This worksheet only needs to be signed and included if a household member owns their own business.



UNIFORM APPLICATION
 Worksheet 3 - Deductions

Type of Deduction	Amount	Frequency	Annualized Amount
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
			\$0.00
Grand Total:			\$0.00

Patient/Guardian declares they have no deductions

Eligibility Technician Signature	Date
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Facility	Phone
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**UNIFORM APPLICATION
 PATIENT APPLICATION**

Section I: PATIENT/APPLICANT

Experiencing Homelessness

Today's Date: _____ Effective Date: _____ End Date: _____

First Name	Middle Initial	Last Name	Phone Number			
Address	City	Zip Code	County			
List Household Members	Relationship to Patient	Date of Birth	Health First CO/CHP+ Number	SSN (CICP Only)	Health First CO/CHP+ Ineligibility Code (CICP Only)	Selected Program for Household Member
1. _____	PATIENT/APPLICANT	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____	_____	_____
9. _____	_____	_____	_____	_____	_____	_____
10. _____	_____	_____	_____	_____	_____	_____
11. _____	_____	_____	_____	_____	_____	_____
12. _____	_____	_____	_____	_____	_____	_____
13. _____	_____	_____	_____	_____	_____	_____
14. _____	_____	_____	_____	_____	_____	_____
15. _____	_____	_____	_____	_____	_____	_____

Section II: Calculating Income

Income Source	Monthly Income	Annualized Total
1. Gross Employment Income	\$0.00	\$0.00
2. Unearned Income	\$0.00	\$0.00
3. Self-Employment Income	\$0.00	\$0.00
4. Total Income (Lines 1 + 2 + 3)	\$0.00	\$0.00
5. Deductions (See Worksheet 3)	\$0.00	
6. Grand Total Annual Income	\$0.00	

FPG Percentage: 0 Household Size 1

CICP Annual Cap: N/A HDC Facility Monthly Max.: \$0 HDC Physician Monthly Max.: \$0

Hospital Discounted Care/CICP
(NOT Insurance)

Name: _____

Rate: 0 CICP Copay Cap: N/A

HDC Facility: \$0 HDC Phys.: \$0

County Code: _____

Begin Date: _____ End Date: _____

Technician's Signature _____ Phone _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Show this card any time you visit a hospital

CICP Copays Due

Ambulatory Surgery _____

Inpatient _____

Hospital Physician _____

Emergency Room _____

Emergency Transportation _____

Outpatient Hospital _____

Specialty Outpatient Hospital _____

CICP Copays Due

Prescriptions _____

Laboratory _____

Basic Radiology & Imaging _____

High-Level Radiology & Imaging _____

Hospital Discounted Care

Facility Monthly 4% Max: \$0

Each Physician Monthly
2% Max: \$0



CICP

Colorado Indigent Care Program

Clients applying for or receiving discounted CICP services shall:

1. Acknowledge that the CICP is not health insurance, does not offer a specific benefit package, is not an entitlement to medical benefits and that there are limitations to services discounted;
2. Acknowledge that discounted CICP health care services vary by provider location;
3. Give the CICP provider all the necessary financial information and documentation needed to complete the application;
4. Not give false information with the intent to commit fraud;
5. Tell the CICP provider if a CICP financial rating was issued by another provider and notify the CICP provider within 15 days if the CICP rating is disputed;
6. Be responsible for paying any money owed on time, and as required, or work with the CICP provider to make payment arrangements;
7. Notify the CICP provider promptly of changes in resources, income and all other household changes that may affect the CICP rating;
8. Communicate any information, concerns and/or questions related to the financial screening to the appropriate representative;
9. Keep track of all copayments made to CICP providers for services discounted by CICP and inform the provider once the household copayment cap has been met;
10. Respect the property of the CICP provider, fellow clients and others; and
11. Follow all other rules and regulations of the CICP provider's location relating to respectful treatment and rights of other clients and provider staff.



CICP

Colorado Indigent Care Program

Welcome to the Colorado Indigent Care Program (CICP)

The Colorado Indigent Care Program (CICP) is a discounted health care program for residents of Colorado. Health care providers who participate in the CICP offer discounted health care services to people who qualify for the program.

The CICP health care provider has assigned you a rating based on your household income. Your rating determined what your CICP copayment is. The copayment is the portion of your medical bills under the CICP that you will be responsible for. Payment of the copayment is expected at the time of service, unless you have made other payment arrangements with the CICP Provider.

The CICP is not health insurance and the CICP cannot guarantee benefits. Services must be received from a qualified CICP provider. Available discounted services and copayments may be different from provider to provider. If your CICP provider refers you to a non-CICP health care provider for care, you may be responsible for the bill without a discount. Please check with your health care provider before receiving care so that you understand what CICP will discount and what it will not discount.

Please discuss questions about your medical bills and medical care directly with your CICP provider at the following phone number:

If you need more information about CICP, or have concerns that have not been resolved with your CICP provider, call:

Colorado Department of Health Care Policy and Financing
Customer Contact Center
1-800-221-3943

Information about CICP is also available on the Department of Health Care Policy and Financing's Website, including a Provider Directory: Go to www.Colorado.gov/hcpf and click the link "Explore Programs and Benefits", "Adults", Colorado Indigent Care Program (CICP), then select "Program Information Page", and then "CICP Provider Directory" at the bottom of the page.

(Turn the page over for more information)

Your CICIP provider can enter your copayment amount for health care services in the table below. Copayments are different for different types of medical care, and your CICIP provider may not offer all types of services. You should ask your CICIP provider about what health care services are available at a discount and which copayment applies.

Your household rating: 0

CICIP Copayment Information for Clients based on rating:

Service/Setting	Copayment per Visit (depends on rating)
Ambulatory Surgery	
Inpatient Hospital Facility*	
Hospital Physician Services	
Emergency Room Facility Charge*	
Emergency Transportation	
Outpatient Hospital Services	
Specialty Outpatient Hospital Services	
Prescription Drugs	
Laboratory	
Basic Radiology and Imaging	
High-Level Radiology and Imaging**	

*Hospital Physician Services may be applied separately to Inpatient Hospital and Emergency Room charges.

**High-Level Radiology and Imaging includes Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Positron Emission Tomography (PET) or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory (cath lab) in the outpatient hospital, emergency room, or clinic setting. Some providers may charge a lower copay amount for certain High-Level Radiology and Imaging services.

NO SOCIAL SECURITY NUMBER AFFIDAVIT
Colorado Indigent Care Program

I, _____, swear or affirm under penalty of perjury under the laws of the State of Colorado that I do not have a Social Security Number because (check one):

- I am experiencing homelessness and I am unable to provide my Social Security Number.
- I am not eligible to receive a Social Security Number.
- I can only be issued a Social Security Number for a valid non-work reason.
- I hold a well-established religious objection to having a Social Security Number.

Applicant Signature

Date