

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?	
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?	
- 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 1	
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]	
What is your birdiday. [Till your Fire	
Patient Residency	
Are you a resident of or currently living in Colorado?	
You can say "yes," "no," or "I don't want to answer."	
Tou can say yes, no, or 1 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.	
Dations In commence Challenge and Danielle	
<u>Patient Insurance Status and Benefits</u> Are you uninsured <i>[or are you about to lose your health insurance]?</i>	
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?	
Do you have an anexpired colorado maigent care riogram ruting.	
Household Size and Household Income	
How many poonle live in your household, including vermals	
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?	
caci month:	
is anyone in your nousenoid 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)	
Name of Household Member 2 (OPTIONAL) What is the relationship to Household Member 2 to you?	
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	
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.	\$0.00
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	\$0.00
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
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? Household Member 3	\$0.00
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? Household Member 3 Name of Household Member 3 (OPTIONAL)	\$0.00
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? Household Member 3 Name of Household Member 3 (OPTIONAL) What is the relationship to Household Member 3 to you?	\$0.00
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? 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	
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? 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.	\$0.00 \$0.00
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? 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	
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? 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.	
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? 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? Household Member 4	
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? 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? Household Member 4 Name of Household Member 4 (OPTIONAL)	
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? 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? Household Member 4	
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? 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? Household Member 4 Name of Household Member 4 (OPTIONAL) What is the relationship to Household Member 4 to you?	
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? 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? 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	\$0.00
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? 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? 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.	\$0.00
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? 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? 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? Household Member 5	\$0.00
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? 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? 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? Household Member 5 Name of Household Member 5 (OPTIONAL)	\$0.00
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? 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? 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? Household Member 5 Name of Household Member 5 (OPTIONAL) What is the relationship to Household Member 5 to you?	\$0.00
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? 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? 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? 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	\$0.00
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? 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? 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? 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.	\$0.00
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? 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? 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? 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	\$0.00
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? 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? 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? 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
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? 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? 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? 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.	\$0.00

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?	40.00
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?	φ0.00
15 this household member included in patient/guardian's taxes:	
H	
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	
	+0.00
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?	φοιοσ
15 this household member meladed in patient, gadraid to taxes.	
Household Member 12	
Name of Household Member 12 (OPTIONAL)	
What is the relationship to Household Member 12 (OPTIONAL)	
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?	75.50
_	
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	
	40.00
money do they receive each month? If not, enter \$0.	\$0.00
Is this household member included in patient/guardian's taxes?	

Household Member 15	
Name of Household Member 15 (OPTIONAL)	
What is the relationship to Household Member 15 to you?	
Does Household Member 15 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?	
Facility Deductions	
Estimate of monthly deductions per Facility's deduction policies:	
[Enter Deduction Type]	
Total Monthly Deductions:	\$0
•	·
AUTO-CALCULATE FEDERAL POVERTY GUIDELINES	
Estimated household size as presented	1
Estimated annual household income as presented	\$0.00
Estimated FPG as presented	
•	
HEALTH FIRST COLORADO, CHP+, EMERGENCY MEDICAID	
Estimated household size	1
Estimated annual household income	
Estimated FPG	1
	·
CICP AND HOSPITAL DISCOUNTED CARE	
Estimated household size	1
Estimated annual household income including deductions	
Estimated drindar household meaning deadedals	·
	· ·
SCREENING RESULTS	
Note these are not official determinations of eligibility. For an official determin	
Health First Colorado (Medicaid)	Likely eligible
CHP+ (Minors and Pregnant People only)	Likely not eligible
Medicare	Potentially eligible
Colorado Indigent Care Program	Could not determine residency
Hospital Discounted Care	Could not determine residency
If the patient does not qualify for Health First Colorado due only to immigration	
the patient does not qualify for Emergency Medicaid	JII Status and they received emergency services,
If the patient does not qualify for Health First Colorado, CHP+, or Medicare, t	thou may be eligible for financial assistance to
purchase private health insurance through the Marketplace	They may be eligible for infuridur assistance to
purchase private nearth insurance through the marketplace	
Screening Notes	
·	·



UNIFORM APPLICATION

	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 Cocial Security Number (CICD Only)		
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?		
25 the patient expending nemelossiness.		
	<u>He</u>	alth First
Screening for Health First CO/CHP+ Ineligibility	<u> </u>	CO/CHP+
(CICP ONLY)		lity Code
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):		
other (provide brief explanation).		
Hansakald Mandan 2		
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)		
	На	alth First
Screening for Health First CO/CHP+ Ineligibility	·	O/CHP+
(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?		
Does the nousehold 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):		
		I

Ususaka di Mambara	
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)	
1.00001.010 1.011.001.0 000001.0, 1.011.001. (0.101. 0.11,7)	
	Health First
Screening for Health First CO/CHP+ Ineligibility	· · · · · · · · · · · · · · · · · · ·
(CICP ONLY)	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):	
Hanashald Manile and	
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)	
(
	Health First
Screening for Health First CO/CHP+ Ineligibility	
(CICP ONLY)	<u>Ineligibility Code</u>
Has the Household member received a Health First CO denial letter?	211011glibility Goud
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):	
Other (provide blief 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)	
	Hanlik First
Consenies for Health First CO/CHD : Tradicibility	Health First
Screening for Health First CO/CHP+ Ineligibility	
(CICP ONLY)	<u>Ineligibility Code</u>
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 (1) limit?	
Does the household income exceed the Health First CO limit? Is the Household member a child?	
Is the Household member a child? Is the Household member pregnant? Is the Household member disabled?	
Is the Household member a child? Is the Household member pregnant? Is the Household member disabled? Does the Household member have primary insurance?	
Is the Household member a child? Is the Household member pregnant? Is the Household member disabled?	

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)		
		Health First
Screening for Health First CO/CHP+ Ineligibility		CO/CHP+
(CICP ONLY)		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):	_	
outer (provide biter 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)		
		Usalah Pissa
Careening for Houlth First CO/CUD Inclinibility		Health First
Screening for Health First CO/CHP+ Ineligibility (CICP ONLY)		<u>CO/CHP+</u> Ineligibility Code
Has the Household member received a Health First CO denial letter?		Ineligibility Code
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)		
		Hoolth Eirct
Screening for Health First CO/CHP+ Ineligibility		<u>Health First</u> CO/CHP+
(CICP ONLY)		Ineligibility Code
Has the Household member received a Health First CO denial letter?		Incligibility Couc
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?		

Other (provide brief explanation):	
Harvahald Marshard	
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)	
	Health First
Screening for Health First CO/CHP+ Ineligibility	CO/CHP+
(CICP ONLY)	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)	
Commenter for the lab First CO (CUR), To all all like	Health First
Screening for Health First CO/CHP+ Ineligibility	CO/CHP+
(CICP ONLY) Has the Household member received a Health First CO denial letter?	Ineligibility Code
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 a child? Is the Household member pregnant?	
Is the Household member pregnant? Is the Household member disabled?	
Does the Household member have primary insurance?	
Other (provide brief explanation):	
Other (provide brief explanation):	



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) \$0.00 Social Security Disability Income (SSDI) \$0.00 \$0.00 Disbursement from Retirement Accounts Pension Payments \$0.00 Payments from Trust Funds \$0.00 Disbursement from Lottery Winnings \$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

Date

Phone

This worksheet must be signed and included with all applications.

Eligibility Technician Signature

Facility

Version 1.6

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: 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: \$0.00 Advertising **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 \$0.00 Total Expenses: \$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 Frequency **Annualized Amount** 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 **Grand Total:** \$0.00 Patient/Guardian declares they have no deductions Eligibility Technician Signature Date Facility Phone Version 1.6



UNIFORM APPLICATION PATIENT APPLICATION

Section I: PATIENT/APPLICANT		Experiencing Homelessness				
Today's Date:	Effective Date:		End Dat	te:		
First Name	Middle Initial	Last Name			Phone Number	
Address		City		Zip Code	County	
List Househould 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
	PATIENT/APPLICANT					
						
·						
•						
		 -				
' <u> </u>						
<u></u>						
ection II: Calculating Income						
Income Source		Mor	nthly Income		Annualized Total	
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	2)		\$0.00	_	\$0.00	
5. Deductions (See Worksheet 3)	I			\$0.00		
6. Grand Total Annual Income			_	\$0.00	_	
			PG Percentage:	0	Household Size 1	
CICP Annual Cap: N/A	HDC Facilit	y Monthly Max.:	\$0			\$0

PENALTY CLAUSE, CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

CICP ONLY: I certify that the information provided to complete this application is true and correct to the best of my knowledge. I understand that any misrepresentations made with the intent to defraud the CICP program may result in criminal prosecution. Additionally, if I misrepresent my eligibility knowing that I am not eligible, I may be charged with a crime.

I authorize the provider to use any information contained in the application to verify my eligibility for assistance under CICP or Hospital Discounted Care, and to obtain records pertaining to eligibility from a bank or other financial institution as defined in section 15-15-201(4), C.R.S., or from any insurance company.

CICP ONLY: I understand it is my responsibility to notify the provider of an income or household change that may influence the rating on this application in relation to CICP and failure to do so voids this application for CICP.

YOU HAVE 30 CALENDAR DAYS TO APPEAL YOUR ELIGIBILITY DETERMINATION FOR CICP AND HOSPITAL DISCOUNTED CARE (Ask your eligibility technician for more information on the appeal process) Patient/Guardian Signature and Date Print Patient/Guardian Name ☐ Patient was contacted by ☐ phone ☐ email ☐ other: and documentation of contact is attached in lieu of signature. Print Eligibility Technician Name Eligibility Technician Signature and Date Print Hospital Name Hospital Phone Number Version 1.6 **Application Notes**

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: 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: Each Physician Monthly 2% Max: \$0



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.



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 CICP 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 CICP provider may not offer all types of services. You should ask your CICP provider about what health care services are available at a discount and which copayment applies.

Your household rating: 0

CICP 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.

	RITY NUMBER AFFIDAVIT igent Care Program
the State of Colorado that I do not h I am experiencing homeless I am not eligible to receive a I can only be issued a Social	wear or affirm under penalty of perjury under the laws of lave a Social Security Number because (check one): ness and I am unable to provide my Social Security Number. Social Security Number. Security Number for a valid non-work reason. gious objection to having a Social Security Number.
Applicant Signature	Date