COLORADO
Department of Health Care Policy & Financing

Version 1

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 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?	$0.00
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.	$0.00
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
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
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
Is this household member included in patient/guardian's taxes?	

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?	
Facility Deductions	
Estimate of monthly deductions per Facility's deduction policies:	
[Enter Deduction Type]	
[Enter Deduction Type]	
[Enter Deduction Type]	
[Enter Deduction Type]	
[Enter Deduction Type]	
[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	0
HEALTH FIRST COLORADO, CHP+, EMERGENCY MEDICAID	
Estimated household size	1
Estimated annual household income	$0.00
Estimated FPG	0
CICP AND HOSPITAL DISCOUNTED CARE	
Estimated household size	1
Estimated annual household income including deductions	$0.00

Estimated FPG 0

SCREENING RESULTS Note these are not official determinations of eligibility. For an official determination, the patient must apply for the program.	
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 status and they received emergency services, the patient should qualify for Emergency Medicaid	
If the patient does not qualify for Health First Colorado, CHP+, or Medicare, they may be eligible for financial assistance to purchase private health insurance through the Marketplace	

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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)		**Health First CO/CHP+ Ineligibility 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):		

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)		**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 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):		

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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)		☐	☐	$0.00
Social Security Disability Income (SSDI)		☐	☐	$0.00
Disbursement from Retirement Accounts		☐	☐	$0.00
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 (enter current amount of UBI bank)				$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

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

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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:			
	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

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

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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
		Grand Total:	$0.00

Patient/Guardian declares they have no deductions ☐

Eligibility Technician Signature

Date

Facility

Phone

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UNIFORM APPLICATION
PATIENT APPLICATION

Section I: PATIENT/APPLICANT

Experiencing Homelessness

Today's 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.							

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.:** **N/A** **HDC Physician Monthly Max.:** **N/A**

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 that if I am a legal immigrant or legally present non-citizen, that while I am receiving assistance under the CICP, I agree to refrain from executing an affidavit of support for the purpose of sponsoring an immigrant.

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)

Print Patient/Guardian Name _____ Patient/Guardian Signature and Date _____

☐ 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

Application Notes

Colorado Indigent Care Program (NOT Insurance)

Name: _____

Rate: 0 Copay Cap: N/A

County Code: _____ SSN: _____

Begin Date: _____ End Date: _____

_____

Technician's Signature Phone

Name: _____ SSN: _____
Name: _____ SSN: _____
Name: _____ SSN: _____
Name: _____ SSN: _____
Name: _____ SSN: _____
Name: _____ SSN: _____
Name: _____ SSN: _____
Name: _____ SSN: _____
Name: _____ SSN: _____

Show this card any time you visit a CICP Provider

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/CICP
(NOT Insurance)

Name: _____

Rate: 0 CICP Copay Cap: N/A

County Code: _____ _____

Begin Date: _____ End Date: _____

_____

Technician's Signature Phone

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: N/A

Each Physician Monthly 2% Max: N/A

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 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.

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**