COLORADO INDIGENT CARE PROGRAM AND CLINICA FAMILY HEALTH PROGRAM

CLIENT APPLICATION

Section I: APPLICANT Homeless:

Todays Date:

Last Name **First Name** **Middle Initial** **Phone Number**

Address **City** **Zip Code** **County**

	List Household Members	Dependent Code	Residency Code	Date of Birth	Social Security Number or Health First CO/CHP+ Number	Health First CO/CHP+ Ineligibility Code
1.	APPLICANT					
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Comments:

Dependent Code 1. Self 2. Spouse/Civil Union Partner 3. Minor 4. Senior 5. Adult Student 6.Other

Residency Codes

1. Colorado Resident & U.S. Citizen
2. Colorado Resident & Documented Legal Immigrant
3. Migrant Farm Worker & U.S. Citizen
4. Migrant Farm Worker & Documented Legal Immigrant
5. Counted in Family Size Only
6. Clinica Sliding Fee Only

Health First CO/CHP+ Ineligibility Code

A. The applicant received a Medicaid/ CHP + Denial letter
B. Applicant is not a U.S. Citizen, has not been a legal resident for at least 5 years, or does not have refugee status.
C. Transitional Medicaid Benefits have been discontinued
D. Over Income for Medicaid and is:
   a. Not a Child
   b. Not pregnant
   c. Not Disabled
E. Has Primary Insurance- Not Eligible for CHP+
F. Other- Provide Brief Explanation

Section II: Calculating Income

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

(CICP ONLY 201-250%) FPL Percentage: _____

Client Copayment Annual Cap CICP Only (Line 6 times 0.10):$_____

CICP PENALTY CLAUSE,CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the information provided to complete this application is true. I understand that if I make false statements on this application, I commit a Class 5 Felony. In addition, misrepresenting my eligibility for assistance under this program is a Class 2 Misdemeanor (26-15-112, C.R.S.)

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

I understand that the provider has a right to obtain any recovery or right of recovery for a patient who would have a right of recovery. This means that if I am found to have a claim for any benefits payable for any treatment, which is given, while I am eligibile for assistance under this program that the provider has the right to be included in the claims process.

If applicable, I understand that legal immigrants receiving assistance under this program shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997.

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

SLIDING FEE PENALTY CLAUSE,CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the information provided to complete this application is true. I understand that if I make false statements on this application, I commit a Felony.

YOU HAVE 15 DAYS TO APPEAL YOUR RATE

(Ask your eligibility technician for more information on the appeal process)

Print Applicant Name

Date:

Applicant Signature

Print Eligibility Technician Name

Date:

Eligibility Technician Signature

Clinica Family Health

Print Facility Name

(303) 650-4460

Facility Phone Number

COLORADO INDIGENT CARE PROGRAM AND CLINICA FAMILY HEALTH PROGRAM

Worksheet 1 - Earned, Self-Employment and Unearned Income

Payment Sources	Monthly Income	Annualized Income	Documented	Self-Declared
Earned Income:				
Employment Income	$	$		
Self-Employment Income:				
Net Self-Employment Income	$	$		
Unearned Income:				
Unemployment/Workers Compensation	$	$	☐	☐
Old Age Pension (OAP)	$	$	☐	☐
Supplemental Security Income (SSI/SSDI)	$	$	☐	☐
Retirement Plans/Pensions:				
_____	$	$	☐	☐
_____	$	$	☐	☐
_____	$	$	☐	☐
Commissions, Bonuses, Gifts, Tips	$	$	☐	☐
Alimony Received	$	$	☐	☐
Rental Property Income	$	$	☐	☐
Interest Income from interest bearing accounts	$	$	☐	☐
Monetary/Capital Gains	$	$	☐	☐
Monetary Settlements (do not annualize, show total amount received)	$	$	☐	☐
Income from other Sources:				
_____	$	$	☐	☐
_____	$	$	☐	☐
_____	$	$	☐	☐
_____	$	$	☐	☐
Total Income	**$**	**$**		

Applicant Signature Date

Eligibility Technician Signature Date

Clinica Family Health **303-650-4460**

Facility Phone

AFFIDAVIT FOR LAWFUL PRESENCE
Colorado Indigent Care Program

I,_____', swear or affirm under penalty of perjury under the laws of the State of Colorado that (check one):

- ☐ I am a United States citizen.
- ☐ I am not a United States citizen, but I am a Permanent Resident of the United States.
- ☐ I am not a United States citizen, but I am lawfully present in the United States pursuant to federal law.

I understand that this sworn statement is required by law because I have applied for a "state public benefit", as that term is defined under section 24-76.5-102(3), C.R.S. (2016). I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this state public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under section 18-8-503, C.R.S. (2016) and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Applicant Signature **Date**

FOR INTERNAL USE ONLY

Please mark the box that indicates which document was verified for lawful presence and keep a photocopy of the document presented in the applicant's file.

- ☐ A current, valid Colorado driver's license or a Colorado identification card, issued pursuant to article 2 of title 42, C.R.S., unless the applicant holds a license or card that states, "Not Valid for Federal Identification, Voting, or Public Benefit Purposes", or
- ☐ Any out-of-state driver's license or state issued identification if that state requires that the Applicant prove lawful presence prior to issuance of the license or identification card, or
- ☐ A United States military card or a military dependent's identification card, or
- ☐ A United States Coast Guard Merchant Mariner card, or
- ☐ A Native American tribal document, or
- ☐ Other documentation pulled from SAVE or found on a Federal list of acceptable documentation for establishing lawful presence (see 1 CCR 204-30 sections 2.1.4 and 2.1.6)
  Name of document accepted (include document number):
  _____

Date verified in SAVE (if applicable): _____

Please Note: If the applicant is a United States citizen or non-citizen national and is unable to present any of the documents listed on this form they may submit a written declaration or a third-party written declaration. <u>These options should be used with caution.</u>

<u>SELF DECLARATION</u>

I, _____', self-declare and swear or affirm under penalty of perjury, and possibly subject to later verification of status, that I am a United States citizen or non-citizen national.

Signature Date:

<u>THIRD-PARTY DECLARATION</u>

I, _____, swear or affirm under penalty of perjury,and possibly subject to later verification of status, that I have personal knowledge that the Applicant is a United States citizen or non-citizen national.

Signature Date

For Colorado Department of Revenue's Lawful Presence Rule, see 1 CCR 204-30 Rule 5:
http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=6860&fileName=1%20CCR%20204-30

States that require Applicants to prove lawful presence prior to issuing a driver's license or identification card are also called REAL ID compliant states. A list of REAL ID compliant states can be found here:
https://www.dhs.gov/current-status-states-territories

COLORADO INDIGENT CARE PROGRAM AND CLINICA FAMILY HEALTH
Worksheet 2 - Allowable Deductions

	Monthly Expenses	Annualized Expenses
Elderly Care	$	$
Day Care	$	$
Paid alimony	$	$
Child Support	$	$
Health Insurance Premium(s)	$	$
Pharmaceuticals	$	$
Use of Personal Vehicle for Business Purposes	$	$
Subtotal	$	$

Outstanding Medical Bills from a CICP Provider incurred more than 90 days prior to the application date. ***PAYMENT PLANS MUST BE DOCUMENTED***

CICP Provider	Date Incurred	Outstanding $ Amount	Total Monthly $ Amount Paid	Annualized $ Amount
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
			Subtotal:	$

Outstanding Medical Bills from a non-CICP Provider incurred regardless of age. ***PAYMENT PLANS MUST BE DOCUMENTED***

Non-CICP Provider	Date Incurred	Outstanding $ Amount	Total Monthly $ Amount Paid	Annualized $ Amount
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
			Subtotal:	$

Fully paid and Single Payment MedicalExpenses incurred during the past 12 months, applied as a single flat deduction to income. ***MUST BE DOCUMENTED (attach reciepts)***

Medical Expense Description	Date Paid	Total Monthly $ Amount Paid	Annualized $ Amount
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$
		Subtotal:	$
		Grand Total:	$

(use this figure on Line 5 of Section II of the application)

Applicant Signature — Date

Eligibility Technician Signature — Date

Clinica Family Health — **303-650-4460**
Facility — Phone