COLORADO
Department of Health Care Policy & Financing

COLORADO INDIGENT CARE PROGRAM
CLIENT APPLICATION

Section I: APPLICANT

Today's Date:

Homeless Rate: _____

Emergency Application:

Last Name	First Name	Middle Initial

Address	City	Zip Code	County	Phone Number

List Household Members	Relationship Code	Date of Birth	Medicaid Number	Social Security Number	Residency Code	Medicaid/CHP+ Ineligibility Codes
1. APPLICANT						
2.						
3.						
4.						
5.						
6.						
7.						

Notes:

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)	$	$

Equity In Resources	Vehicle Equity	Liquid Resources
Value	$	$
Amount Owed	$	
Equity (Value - Amount Owed)	$	
Minus Protected Portion	$7,500	
5. Total Equity	$	$
6. Total Resources **(See Worksheet 3)**	$	
7. Family Size Deduction	Family Size _____ X $2,500 = $ _____	
8. Equity In Resources (cannot be negative)	$	
9. **Total Family Financial Status (Lines 4 + 8)**	$	
10. Allowable Deductions **(See Worksheet 4)**	$	
11. Net Family Financial Status (Lines 9 - 10)	$	
12. Liquid Asset Spend Down	$	
13. **Grand Total** Net CICP Income (Lines 11 - 12)	$	

CICP Rate: _____ **Client Copayment Annual Cap (Line 13 times 0.10):** $ _____

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 eligible 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.**

YOU HAVE 15 DAYS TO APPEAL YOUR RATE
(Ask your eligibility technician for more information on the appeal process)

Print Applicant Name _____ Applicant Signature and Date _____

Print Eligibility Technician Name _____ Eligibility Technician Signature and Date _____

Print Facility Name _____ Facility Phone Number _____

Section 1.02 Ineligibility Code Legend

Relationship Codes

1. Self
2. Spouse/Civil Union Partner
3. Child
4. Stepchild
5. 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. Non-Resident
6. Medicaid Eligible
7. Counted in Family Size Only

Medicaid/CHP+ Ineligibility Codes

A. Has 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 Medicial 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 a brief Explanation**

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Worksheet 1 - Earned and Unearned Income

Payment Sources	Monthly Income	Annualized Income
Earned Income:		
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 bearning accounts	$	$
Monetary/Capital Gains	$	$
Monetary Settlements (do not annualize, show total amount received)	$	

Income from other Sources:

	$	$
	$	$
	$	$
	$	$
Earned Income Total	$	$
Unearned Income Total	$	$
Total Income	$	$

Applicant Signature Date

Eligibility Technician Signature Date

Facility Phone

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COLORADO INDIGENT CARE PROGRAM
Worksheet 2 - Net Self-Employment Income

		Monthly	Annualized
Revenue:	Gross Business Income	$	$
Expenses:	Mortgage/Rent of Business Property	$	$
	Phone/Utilities	$	$
	Business Taxes (non-personal)	$	$
	Insurance	$	$
	Gross Wages	$	$
	Tools/Equipment	$	$
	Office Supplies	$	$
	Merchandise/Cost of goods	$	$
	Repairs/Upkeep of Equipment	$	$
	License/Certification Fees Paid	$	$
	Fuel for Business-related Travel	$	$
	Legal Fees	$	$
	Advertising	$	$
	Day Care Provider Reductions (if applicable)	$	$

Other Expenses: _____	$ _____	$ _____
_____	$ _____	$ _____
_____	$ _____	$ _____
_____	$ _____	$ _____
Total Expenses:	$ _____	$ _____
Total Expenses Attributed to Business:	$ _____	$ _____
Net Profit	$ _____	$ _____
		(use this figure on line 3, Section II of the CICP

_____
Applicant Signature Date

_____
Eligibility Technician Signature Date

_____
Facility Date

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COLORADO INDIGENT CARE PROGRAM

Worksheet 3 - Equity In Resources

Applicant's Vehicle Value

	Vehicle Make/Model	Value	Amount Owed
Vehicle 1		$	$
Vehicle 2		$	$
Vehicle 3		$	$
	TOTAL VALUE	$	$

Liquid Resources

	Value	Amount Owed
Checking Accounts	$	$
Savings Accounts	$	$
Trust Accounts	$	$
Certificate of Deposit	$	$
TOTAL VALUE	$	$

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Worksheet 4 - Allowable Deductions

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

Paid or Outstanding Medical Bills from CICP Provider incurred more than 90 days after the application date. ***MUST BE DOCUMENTED*** *(attach receipts)*

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

Subtotal: _____

Paid or Outstanding Medical Bills from a non-CICP Provider incurred regardless of age. ***MUST BE DOCUMENTED*** *(attach receipts)*

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

Subtotal: _____