COLORADO
Department of Health Care Policy & Financing

PATIENT APPLICATION
Hospitals and Hospital Based Clinics

Section I: PATIENT/APPLICANT

Today's Date:

Homeless: _____

Emergency Application: _____

Last Name | **First Name** | **Middle Initial**

Address | **City** | **Zip Code** | **County** | **Phone Number**

List Household Members	Relationship to Patient	Date of Birth	Health First CO Number	Health First CO/CHP+ Ineligibility Codes (CICP Only)	Selected Program for Household Member (CICP, Hospital Discounted Care, or CICP & Hospital Discounted Care)
1.	PATIENT/APPLICANT				
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Section II: Calculating Income

Income Source	Monthly Income	Annualized Total
1. Gross Employment Income	$	$
2. Unearned Income	$	$
3. Self-Employment Income	$	$
4. Total Income (Lines 1 + 2 + 3)	$	$

5. Allowable Deductions **(See Worksheet 3)**	$
6. Grand Total Annual Income	$

CICP Annual Cap (Line 6 times .10): $ **FPG Percentage:** Household Size:

HDC Facility Monthly Max: **HDC Physician Monthly Max:**

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)

Print Patient/Applicant Name

Applicant 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 Facility Name

Facility Phone Number

Application Notes:

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Worksheet 1 - Earned and Unearned Income

Payment Sources	Monthly Income	Annualized Income	Documented	Self-Declared
Earned Income:				
Employment Income	$	$		
Monthly Unearned Income Sources:				
Social Security Income (SSI)	$	$	☐	☐
Social Security Disability Income (SSDI)	$	$	☐	☐
Disbursement from Retirement Account	$	$	☐	☐
Pension Payments	$	$	☐	☐
Payments from Trust Funds	$	$	☐	☐
Disbursement from Lottery Winnings	$	$	☐	☐
Annual or One Time Income Sources:				
Bonuses (enter full amount of bonuses included on pay stubs)	$	$		
Short Term Disability (enter full amount of remaining payments from STD)	$	$		
Unemployment Income (weekly amount multiplied by 52 to ensure corrct annual FPG calculation)	$	$		
Tips and Commissions (only if not normal on paystub)	$	$		
Infrequent Overtime	$	$		
Earned Income Total	$	$		
Unearned Income Total	$	$		
Total Income	$	$		

Eligibility Technician Signature Date

Facility Phone

Revised June 2024

This worksheet must be signed and included with all client applications.

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Worksheet 2 - Net Self-Employment Income

Does the client operate their business from their home? _____

Square footage of applicant's home: _____

Square footage used for applicant's home business: _____

Hours per week applicant works out of their home: _____

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

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

Eligibility Technician Signature Date

Facility Date

Revised June 2024

This worksheet only needs to be signed and included if the applicant owns their own business.

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Worksheet 3 - Allowable Deductions

Type of Deduction	Amount	Frequency	Annualized Amount
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$

Household declares they have no deductions ☐ **Grand Total** $

Eligibility Technician Signature Date

Facility Phone

Revised June 2024

If your facility includes deductions, this worksheet must be signed and included with all client applications.