



Section I: PATIENT/APPLICANT

Homeless: _____

Today's Date: _____

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**

**Selected Program for Household Member
(Hospital Discounted Care, Charity Care,
Hospital Discounted Care & Charity Care,
HH Size Only)**

1. _____	<u>PATIENT/APPLICANT</u>	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____
9. _____	_____	_____	_____	_____
10. _____	_____	_____	_____	_____
11. _____	_____	_____	_____	_____
12. _____	_____	_____	_____	_____
13. _____	_____	_____	_____	_____
14. _____	_____	_____	_____	_____
15. _____	_____	_____	_____	_____

Section II: Calculating Income

Income Source

Monthly Income

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	\$ _____	

FPG Percentage: _____ **Household Size:** _____
HDC Facility Monthly Max: _____ **HDC Physician Monthly Max:** _____

PENALTY CLAUSE, CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the provider to use any information contained in the application to verify my eligibility for assistance under 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.

YOU HAVE 30 CALENDAR DAYS TO APPEAL YOUR ELIGIBILITY DETERMINATION FOR 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 <input type="checkbox"/> phone <input type="checkbox"/> email <input type="checkbox"/> 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:



Worksheet 1 - Earned and Unearned Income

Payment Sources Monthly Income Annualized Income

Earned Income:

Employment Income \$ _____ \$ _____

Monthly Unearned Income Sources:

Documented Self-Declared

Social Security \$ _____ \$ _____ ☐ ☐

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 correct 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 2025

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



COLORADO
Department of Health Care
Policy & Financing

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: _____

Revenue:

	<u>Monthly</u>	<u>Annualized</u>
Gross Business Income	\$ _____	\$ _____

Business Property Expenses:

Mortgage/Rent of Business Property	\$ _____	\$ _____
Utilities	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

Other Expenses:

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

Eligibility Technician Signature

Date

Facility

Date

Revised June 2025

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



<u>Type of Deduction</u>	<u>Amount</u>	<u>Frequency</u>	<u>Annualized Amount</u>
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[illegible]

Grand Total \$

Date _____

Phone

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