



**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 CICIP-eligible service at a CICIP provider, or is the patient scheduled to receive a CICIP-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 third party payers but not 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.
Is this household member included in patient/guardian's taxes?

\$0.00

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

\$0.00

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

\$0.00

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

\$0.00

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.

