COLORADO
Department of Health Care Policy & Financing

SOLICITUD DEL PACIENTE
Hospitales y Clínicas Basadas en Hospitales

SECCIÓN I: PACIENTE/SOLICITANTE

Fecha de hoy:

¿Persona sin hogar?: _____

¿Solicitud de Emergencia?: _____

Apellido	**Nombre**	**Inicial**

Direccion	**Ciudad**	**Código**	**Condado**	**Numero de Telefono**

	Lisa de miembros del hogar	**Relacion con el Paciente**	**Fecha de Nacimiento**	**Numero Health First CO/CHP+**	**Health First CO/CHP+ Ineligibility Codes (CICP Only)**	**Selected Program for Household Member (CICP, Hospital Discounted Care, or CICP & Hospital Discounted Care)**
1.		Paciente / Solicitante				
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						

SECCIÓN II: Cálculo de Ingresos

Fuente de Ingreso	**Ingreso Mensual**	**Total Anual**
1. Ingreso Bruto por Empleo	$	$
2. Ingreso No Derivado del Trabajo	$	$
3. Ingreso por Trabajo Independiente	$	$
4. Ingreso Total (Lineas 1 + 2 + 3)	$	$

5. Deducciones Permitidas **(Ver Hoja de Trabajo 3)**	$ _____
6. Ingreso Annual Total	$ _____

Porcentaje FPG: _____ Tamano del Hogar: _____

Limite Annual CICP

(Linea 6 times .10): $_____ **Maximo Mensual Instalacion HDC:** _____ **Maximo Mensual Medico HDC:** _____

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		
Earned Income:				
Employment Income	$	$		
Monthly Unearned Income Sources:			Documented	Self-Declared
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.