Check if Emergency Application ☐

SECTION I : Applicant Information

Last Name	First Name	M.I.	Phone Number
			-

Address	City/Zip
	CO

	Household Members (First & Last Names)	Residency Code	Relation Code	Birth Date	Social Security or State ID #	Ineligibility Codes Medicaid and CHP+ A	B	C	D	E	F
1	APPLICANT										
2											
3											
4											
5											
6											
7											

Other Information:

Reference Codes

Medicaid & CHP+ Ineligibility Codes

A	Received Medicaid OR CHP+ denial letter, attached to application
B	Applicant is not a U.S. citizen and has not been a legal resident for at least 5 years or have refugee status
C	Transitional Medicaid Benefits discontinued
D	Over Income for Medicaid AND is not: ☐ NOT A CHILD ☐ NOT PREGNANT ☐ NOT DISABLED
E	Has Primary Insurance- Not Eligible for CHP+
F	Other (Provide a Brief Explanation)

Relation Codes: 1 Self 2 Spouse/Civil Union Partner 3 Child 4 Stepchild 5 Other

Residency Codes:

1. **Colorado resident & US Citizen**
2. **Colorado resident & documented legal immigrant**
3. **Migrant farm worker & US Citizen**
4. **Migrant farm worker & documented legal immigrant**
5. **Non-resident, counted in family size only**
6. **Medicaid eligible, counted in family size only**
7. **Counted in family size only**

SECTION II: Calculating Income and Resources — **If Homeless, Assign CICP Rate Z**

INCOME SOURCE	Monthly Amount	Annualized Total
1. Gross Employment Income	$0.00	$0.00
2. Self-Employment Income	$0.00	$0.00
3. Unearned Income	$0.00	$0.00
4. Total Income (Lines 1+2+3)	$0.00	$0.00
5. CICP Income Calculation (Line 4)	$0.00	$0.00
Is It 3AND?	NO	
CICP Rate: N	**Dental Rate:**	N
Type of Application	**IN HOUSE**	
Client Copayment Annual Cap (Excluding Dental Copays)		N/A

EQUITY IN RESOURCES	Actual Value	Minus Amount Owed	Equals Equity	Minus Protected	CICP Equity Calculation
6. Vehicle Equity	$0.00	$0.00	$0.00	$4,500.00	$0.00
7. Liquid Resources	$0.00	$0.00	$0.00	$0.00	$0.00
8					
9					
10. Total Equity (Lines 6+7)					$0.00
11. Less Family Size Deduction — Family Size	1	X	$2,500		$2,500.00
12. Equity Resources CICP Calculation (Line 10 minus line 11; cannot be a negative number)					$0.00
13. Total Family Financial Status (Lines 5+12)					$0.00
14. Minus Allowable Deductions					$0.00
15. Equals CICP Income and Equity in Resources (Line 13 minus Line 14)					**$0.00**

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.) 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 (26-15-104.3, C.R.S.).

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 this provider has the right to be included in the claims process. I authorize the provider to use any information contained in this 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 give permission for the pharmaceutical manufacturer or its designee to review records for audit purposes.

YOU HAVE 15 DAYS TO APPEAL YOUR CICP RATE. Ask your eligibility technician for more information on the appeal process. **I understand it is my responsibility to notify the provider of any income, household, and/or insurance change that may influence the rating on this application; and failure to do so voids this application.**

Print or Type Applicant Name	**8/14/2015** **Applicant Signature and Date**
PICK ONE	**8/14/2015**
Print or Type Eligibility Technician Name — **Site**	**Eligibility Technician Signature and Date**
Peak Vista Community Health Centers **Print or Type Facility Name**	**719-632-5700** **Facility Phone Number**