



PATIENT APPLICATION
Hospitals and Hospital Based Clinics

Section I: PATIENT/APPLICANT

Homeless: _____
Emergency Application: _____

Today's Date: _____

Last Name	First Name	Middle Initial	
Address	City	Zip Code	County
List Household Members	Relationship to Patient	Date of Birth	Health First CO Number
1. _____	PATIENT/APPLICANT	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____
			Phone Number Selected Program for Household Member (CICP, HDC, or)
			Social Security Number (CICP Only)
			Health First CO/CHP + Ineligibility Codes (CICP Only)

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 that if I am a legal immigrant or legally present non-citizen, that while I am receiving assistance under the CICP, I agree to refrain from executing an affidavit of support for the purpose of sponsoring an immigrant.

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:



Worksheet 1 - Earned and Unearned Income

Payment Sources	Monthly Income	Annualized Income
Earned Income:		
Employment Income	\$ _____	\$ _____

Monthly Unearned Income Sources:			<u>Documented</u>	<u>Self-Declared</u>
Social Security Income (SSI)	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Social Security Disability Income (SSDI)	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Disbursement from Retirement Account	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Pension Payments	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Payments from Trust Funds	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Disbursement from Lottery Winnings	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>

Annual or One Time Income Sources:			<u>Documented</u>	<u>Self-Declared</u>
Bonuses (enter full amount of bonuses included on pay stubs)	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Short Term Disability (enter full amount of payments from STD)	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Unemployment Income (enter full amount of current UBI bank)	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Tips and Commissions (only if not normal on paystub)	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Infrequent Overtime	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Earned Income Total	\$ _____	\$ _____		
Unearned Income Total	\$ _____	\$ _____		
Total Income	\$ _____	\$ _____		

Eligibility Technician Signature _____ Date _____

Facility _____ Phone _____



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

Eligibility Technician Signature Date

Facility Date

Revised August 2022

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

