



Colorado Department of Health Care Policy and Financing administers a variety of Medical Assistance Programs for qualifying persons who live in Colorado and meet eligibility requirements.

Application For Medical Assistance

This application is to be used to apply for Colorado’s Medical Assistance Programs for yourself, your children, or for a family member.

This application is for Medical Assistance Programs only. It is not for cash benefits or food assistance. To get an application for cash benefits or food assistance visit: cdhs.state.co.us/servicebycounty.htm or your county department of human services. For online access visit: Colorado.gov/PEAK

Please check the programs you are interested in:

- Medical Assistance Programs for Children, Families, and Pregnant Women:**
For children 18 and under, families and pregnant women, including Family Medicaid and Child Health Plan Plus (CHP+). Immediate, temporary coverage may be available for pregnant women and children through the Presumptive Eligibility Program.
- Medical Assistance Programs for Adults and Disabled Children:**
For persons who are disabled, blind or 19 and older.
 - Please check if this is an application from a Women’s Wellness Connection (WWC) site for breast or cervical cancer.
- Long-Term Care (LTC) Services, such as Nursing Facility Care and Home and Community-Based Services (HCBS) Waivers for Adults and Children:**
For persons needing help to pay for services received in their homes or a medical facility for more than 30 days. A medical and functional assessment is required.
 - Personal Needs Allowance (PNA):**
For persons residing in a nursing home who have income less than \$50 per month for personal needs—up to \$50 per month.
- Medicare Savings Programs (MSP):**
For persons needing help to pay for some of their Medicare costs, such as premiums, deductibles and co-insurance.
- Emergency Medical Assistance:**
For certain non-citizens who need help with an emergency medical expense and meet program eligibility criteria.

some services that may be available are:

- Preventative Care
- Office Visits
- Prescriptions
- Hospital Care
- Dental Care
- Mental Health Care
- Nursing Home Assistance
- Prenatal and Postpartum Care
- Immunizations (Shots)
- Medicare Part B Premiums
- Medicare Co-Pays and Deductibles
- Case Management for those under 21 years of age

next steps

- **Check the “Not Applicable” box in the upper right hand corner of the page and the NA boxes within the application if there is a section that does not apply to you.**
- Pregnant women and children may be eligible for temporary coverage while their Family Medicaid or CHP+ application is being processed. Go to: [Colorado.gov/hcpf](https://colorado.gov/hcpf) to find an approved Presumptive Eligibility (PE) location in your area.
- You can print the application and fill it out by hand OR you can enter your information online and print the application. Be sure to sign the printed application.
- If we have everything we need, your application will be reviewed and you will be sent a letter within 45 days. The letter will tell you if you qualify for Medical Assistance. If you need a disability determination, you will be sent a letter within 90 days.
- If we do not have everything we need, we will contact you. The processing of your application will be delayed.
- If you are applying for HCBS Children Waiver Services, complete the application with the child as the Head of Household. Parents' income and resources will not be considered for these programs.
- Never send original citizenship, identity or income documents with your application.
- If you need assistance in completing the application, visit an approved Application Assistance site or your local county department of human/social services. A directory of these locations can be found at [Colorado.gov/hcpf](https://colorado.gov/hcpf)
- Complete and sign the application. Include copies of your certified citizenship and identification documents and other required verification, such as income and expenses.
- Take or mail your application to a Medical Assistance eligibility site or your county department of human/social services. Visit [Colorado.gov/hcpf](https://colorado.gov/hcpf) for your local county contact information.
- **If applying for medical coverage for your family or children, you can mail the application to: Colorado Medical Assistance Program, PO Box 929, Denver, CO 80201-0929.**

citizenship and identity

You do not have to be a U.S. citizen to apply for assistance. Both U.S. citizens and qualified non-citizens may be eligible for Medical Assistance. Please do not let the fear about immigration status stop you from seeking benefits for your family. Receiving Medical Assistance will not stop you from gaining lawful permanent residence or U.S. citizenship.

U.S. citizens who are applying for Medical Assistance Programs (except for MSP) must provide proof of citizenship and identity. Some U.S. citizens are exempt from providing proof of citizenship and identity. Some of these exemptions include newborns born to mothers receiving Medicaid or CHP+ at the time of birth, SSI & SSDI eligible clients, current Medicare recipients, and children in foster care.

There are four documents that prove **both** citizenship and identity:

- A U.S. Passport,
- A Certificate of Naturalization,
- A Certificate of Citizenship, and
- An Indian Tribal Document

If an applicant does not have one of these documents, they must provide:

- One document that proves U.S. citizenship, **AND**
- One document that proves identity.

Some examples of proof of citizenship are a U.S. birth certificate, a U.S. National ID card (form I-197 or I-179), final adoption decree, or an official military record showing a U.S. place of birth.

Some examples of proof of identity are a driver's license, a state ID card with a picture, a school ID with a picture, or verified school, nursery or childcare records for children under 16.

If an applicant does not have any of these documents, there are many more options. For more information call customer service:

- Within Denver metro area: 303-866-3513
- Outside Denver metro area: 800-221-3943

Copies of the original citizenship and identity documents (or certified originals) will be accepted **only** after originals have been viewed and verified by a site approved by the State of Colorado. You can take your original documents to be verified at your county department of human/social services office or to an Application Assistance Site.

Notarized copies will not be accepted.

A list of Presumptive Eligibility and Application Assistance Sites can be found at the Department of Health Care Policy and Financing's Web site: [Colorado.gov/hcpf](https://colorado.gov/hcpf)

general information

COMPLETE FOR ALL PROGRAMS

Tell us about the Head of Household or person completing this application who wants Medical Assistance for themselves, their family or the children in their care:

Full Last Name _____ Maiden Name _____ First Name _____ Middle Initial _____

Physical Address _____ Apt # _____ City _____ State _____ Zip Code _____

Mailing Address/PO Box _____ Apt # _____ City _____ State _____ Zip Code _____

Phone (Home) _____ Phone (Work) _____ Phone (Cell/Message) _____ Email _____

What language(s) are spoken in the household? _____

Tell us about all of the people living in your home. (For Adult, LTC and MSP programs, be sure to include information about the applicant living outside of the home and information about the spouse.)

Full Last Name	First Name	Middle Initial	Birth Date (mm/dd/yyyy)	How Is This Person Related To You? (Self, Child, Step-Child, Spouse, Friend, etc.)	Does This Person Receive At Least 50% Financial Support From The Household? Yes/No	Is This Person Applying? Yes/No
				SELF		

- Is anyone who is in the household or for whom you are applying have a medical or developmental condition which has lasted, or is expected to last, more than 12 months? Yes No
 Person's Name _____
 If yes, has the household member applied for SSI? Yes No
 Date of application? (mm/dd/yyyy) _____ What is the status of application? (pending, approved, denied) _____
- Is anyone who is in the household or for whom you are applying currently in a medical facility, such as a nursing home, hospital, a mental health institution or a group home (or has been within the last 90 days)? Yes No NA If yes, complete the following:
 Name of Person in Facility _____ Relationship _____ Date Entered _____
 Name of Facility _____ Facility Address _____
- Special services may be available to children and pregnant women. Please check any health services that any of your children get or use: Medical Services Mental or Behavioral Health Services School Health Services Prescriptions Other _____
- Has any child been to the emergency room for treatment since his or her last visit to the doctor? Yes No
- Is anyone in the household pregnant?** Yes No If yes, what is her name? _____
 When is her due date? _____ How many babies does she expect? _____
 Name of father, if in the household _____

tell us about anyone 18 and under needing Medical Assistance

NOT APPLICABLE

One child/person 18 and under per page. For more than 3 children, please attach an additional page(s).

This person is: Male Female

Full Last Name	First Name	Middle Initial
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Social Security Number ___ / ___ / _____ Check here if this person does not have a social security number

Mother's name if living in the home: Last Name _____ First Name _____ MI _____

Father's name if living in the home: Last Name _____ First Name _____ MI _____

1. Is this child a U.S. citizen? Yes No If yes, in which state was the child born? _____
If no, is this child a legal permanent resident? Yes No
2. Enter the child's alien registration number if he or she has one _____
Include a copy of the front and back of the U.S. Citizenship and Immigration Services card.
Does this child have an immigration sponsor? Yes No
3. Does this child receive SSDI or SSI? Yes No
4. Do you have any medical expenses for this child within the last 3 months? Yes No
If yes, what was the date(s) of care? _____ You **may** qualify for assistance with **some** of these expenses.
5. Does either parent or legal guardian of this child work for a Colorado state government agency and have access to State health benefits? Yes No Children of Colorado state agency employees may not be eligible for CHP+ due to federal law.
6. Is this child a full-time student? Yes No Name of school _____
Last grade completed _____ Expected graduation date from high school, vocational or trade school (mm/dd/yyyy) _____
7. Does this child have an absent parent(s)? Yes No If yes, have there been steps taken to obtain medical support for the child's absent parent(s)? Yes No
8. Please check the child's ethnic group(s). Certain groups may not have a CHP+ enrollment fee. This is not required but we want to make sure that all races and ethnicities are recognized and supported.
 Caucasian Hispanic/Latino African American Native American
 Asian Alaskan Native Pacific Islander Other: _____

Proof of identification is also required for your child (for example, school ID with picture). Complete the information in the box below if your child is 15 or younger and no other identification is available at the time of application:

AFFIDAVIT TO ESTABLISH IDENTITY

I, (name of parent/guardian) _____, (relationship) _____ of
(child's full name) _____ state under penalty of perjury that I have personal
knowledge that (child's full name) _____ was born on (mm/dd/yyyy) _____,
in (city, state, country of birth place) _____.

I affirm and declare that the facts stated in this Affidavit are true and correct.

Name of parent/guardian _____

Signature of parent or guardian _____ Date signed _____

tell us about the next person 18 and under needing Medical Assistance

NOT APPLICABLE

One child/person 18 and under per page. For more than 3 children, please attach an additional page(s).

This person is: Male Female

Full Last Name	First Name	Middle Initial
----------------	------------	----------------

Social Security Number ___ / ___ / _____ Check here if this person does not have a social security number

Mother's name if living in the home: Last Name _____ First Name _____ MI _____

Father's name if living in the home: Last Name _____ First Name _____ MI _____

1. Is this child a U.S. citizen? Yes No If yes, in which state was the child born? _____
If no, is this child a legal permanent resident? Yes No

2. Enter the child's alien registration number if he or she has one _____
Include a copy of the front and back of the U.S. Citizenship and Immigration Services card.
Does this child have an immigration sponsor? Yes No

3. Does this child receive SSDI or SSI? Yes No

4. Do you have any medical expenses for this child within the last 3 months? Yes No
If yes, what was the date(s) of care? _____ You **may** qualify for assistance with **some** of these expenses.

5. Does either parent or legal guardian of this child work for a Colorado state government agency and have access to State health benefits? Yes No Children of Colorado state agency employees may not be eligible for CHP+ due to federal law.

6. Is this child a full-time student? Yes No Name of school _____
Last grade completed _____ Expected graduation date from high school, vocational or trade school (mm/dd/yyyy) _____

7. Does this child have an absent parent(s)? Yes No If yes, have there been steps taken to obtain medical support for the child's absent parent(s)? Yes No

8. Please check the child's ethnic group(s). Certain groups may not have a CHP+ enrollment fee. This is not required but we want to make sure that all races and ethnicities are recognized and supported.
 Caucasian Hispanic/Latino African American Native American
 Asian Alaskan Native Pacific Islander Other: _____

Proof of identification is also required for your child (for example, school ID with picture). Complete the information in the box below if your child is 15 or younger and no other identification is available at the time of application:

AFFIDAVIT TO ESTABLISH IDENTITY

I, (name of parent/guardian) _____, (relationship) _____ of
(child's full name) _____ state under penalty of perjury that I have personal
knowledge that (child's full name) _____ was born on (mm/dd/yyyy) _____,
in (city, state, country of birth place) _____.

I affirm and declare that the facts stated in this Affidavit are true and correct.

Name of parent/guardian _____
Signature of parent or guardian _____ Date signed _____

tell us about the next person 18 and under needing Medical Assistance

NOT APPLICABLE

One child/person 18 and under per page. For more than 3 children, please attach an additional page(s).

This person is: Male Female

Full Last Name	First Name	Middle Initial
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Social Security Number ___ / ___ / _____ Check here if this person does not have a social security number

Mother's name if living in the home: Last Name _____ First Name _____ MI _____

Father's name if living in the home: Last Name _____ First Name _____ MI _____

1. Is this child a U.S. citizen? Yes No If yes, in which state was the child born? _____
If no, is this child a legal permanent resident? Yes No

2. Enter the child's alien registration number if he or she has one _____
Include a copy of the front and back of the U.S. Citizenship and Immigration Services card.
Does this child have an immigration sponsor? Yes No

3. Does this child receive SSDI or SSI? Yes No

4. Do you have any medical expenses for this child within the last 3 months? Yes No
If yes, what was the date(s) of care? _____ You **may** qualify for assistance with **some** of these expenses.

5. Does either parent or legal guardian of this child work for a Colorado state government agency and have access to State health benefits? Yes No Children of Colorado state agency employees may not be eligible for CHP+ due to federal law.

6. Is this child a full-time student? Yes No Name of school _____
Last grade completed _____ Expected graduation date from high school, vocational or trade school (mm/dd/yyyy) _____

7. Does this child have an absent parent(s)? Yes No If yes, have there been steps taken to obtain medical support for the child's absent parent(s)? Yes No

8. Please check the child's ethnic group(s). Certain groups may not have a CHP+ enrollment fee. This is not required but we want to make sure that all races and ethnicities are recognized and supported.
 Caucasian Hispanic/Latino African American Native American
 Asian Alaskan Native Pacific Islander Other: _____

Proof of identification is also required for your child (for example, school ID with picture). Complete the information in the box below if your child is 15 or younger and no other identification is available at the time of application:

AFFIDAVIT TO ESTABLISH IDENTITY

I, (name of parent/guardian) _____, (relationship) _____ of (child's full name) _____ state under penalty of perjury that I have personal knowledge that (child's full name) _____ was born on (mm/dd/yyyy) _____, in (city, state, country of birth place) _____.

I affirm and declare that the facts stated in this Affidavit are true and correct.

Name of parent/guardian _____
Signature of parent or guardian _____ Date signed _____

tell us about anyone 19 and over needing Medical Assistance

NOT APPLICABLE

This person is: Male Female

Full Last Name	First Name	Middle Initial

Social Security Number ___ / ___ / ____

Check here if the adult does not have a social security number

1. Does this adult receive SSDI or SSI? Yes No
2. Is this adult a U.S. citizen? Yes No If yes, in which state was the adult born? _____
If no, is this adult a legal permanent resident? Yes No
3. Enter this adult's alien registration numbers (if there is one) _____
Include a copy of the front and back of the U.S. Citizenship and Immigration Services card.
Does this adult have an immigration sponsor? Yes No
4. Is the applicant or spouse a veteran? Yes No
5. Has this adult had any medical expenses within the last 3 months? Yes No
If yes, what was the date(s) of care? (mm/dd/yyyy) _____ You **may** qualify for assistance with **some** of these expenses.
6. Does this adult work for a Colorado state government agency and/or have access to State health benefits? Yes No Colorado state agency employees may not be eligible for CHP+ due to federal law.
7. This adult's marital status is: Married Single Divorced Separated Widowed
8. Please check this adult's ethnic group(s). This is not required but we want to make sure that all races and ethnicities are recognized and supported.
 Caucasian Hispanic/Latino African American Native American
 Asian Alaskan Native Pacific Islander Other: _____

tell us about the next person 19 and over needing Medical Assistance

NOT APPLICABLE

This person is: Male Female

Full Last Name	First Name	Middle Initial

Social Security Number ___ / ___ / _____

Check here if the adult does not have a social security number

1. Does this adult receive SSDI or SSI? Yes No
2. Is this adult a U.S. citizen? Yes No If yes, in which state was the adult born? _____
If no, is this adult a legal permanent resident? Yes No
3. Enter this adult's alien registration numbers (if there is one) _____
Include a copy of the front and back of the U.S. Citizenship and Immigration Services card.
Does this adult have an immigration sponsor? Yes No
4. Is the applicant or spouse a veteran? Yes No
5. Has this adult had any medical expenses within the last 3 months? Yes No
If yes, what was the date(s) of care? (mm/dd/yyyy) _____ You **may** qualify for assistance with **some** of these expenses.
6. Does this adult work for a Colorado state government agency and/or have access to State health benefits? Yes No Colorado state agency employees may not be eligible for CHP+ due to federal law.
7. This adult's marital status is: Married Single Divorced Separated Widowed
8. Please check this adult's ethnic group(s). This is not required but we want to make sure that all races and ethnicities are recognized and supported.
 Caucasian Hispanic/Latino African American Native American
 Asian Alaskan Native Pacific Islander Other: _____

1. If you or **anyone** in the household has **income from a job**, complete the following. Income must be from the same month and show a normal full month's pay. **If no one in the household has any income from a job, please check: NA**

All household income may need to be verified when applying for Medical Assistance. It is not required, but if you provide your Social Security Number (SSN), we may be able to verify your income electronically through the Department of Labor's system. You may be asked for further information if needed.

Name of Person Working First and Last Name SSN (Optional)	Employer Name and Phone	Month and Hours Worked	Paid Weekly, Every 2 Weeks, Twice a Month or Monthly?	Total Monthly Amount Before Taxes and Deductions
SSN:				\$
SSN:				\$
SSN:				\$
SSN:				\$

2. Has **anyone who is applying** received a lump sum payment? (lawsuit or insurance settlement, Social Security, SSI, SSDI, Veterans, inheritance, surrender of annuity or life insurance, other.)
Yes No If yes, please complete the information below:

Name of Person Who Received Lump Sum	Type of Lump Sum	Amount Received	Date Received (mm/dd/yyyy)
		\$	
		\$	
		\$	
		\$	

tell us about household income

COMPLETE FOR ALL PROGRAMS

(continued)

3. Tell us about **other income** anyone in your household received this or last month, even if they are not applying. Fill out a line for each item. **If no one in the household has other income, please check: NA**

Examples of **other income** include: • Public Assistance (cash) Benefits • Railroad Retirement • Rental Income • Survivor Benefits • Retirement/Pension • Social Security Benefits • SSI • SSDI • Veterans Benefits • Veteran Widow Benefits • Child Support • Dividends/Interest • Alimony • Unemployment • Worker's Compensation • Disability Benefits • Financial Aid • Other Cash Received Monthly

Type of Other Income	Month	Who is it for?	Monthly Amount Before Taxes and Deductions
			\$
			\$
			\$
			\$
			\$

4. Is anyone in your household **self-employed**? Yes No If **yes**, please **fill in** the following **chart(s)**. Include one full month of gross income. **Expenses must be for the same month as the gross income.** Complete one box for each self-employed person.

SELF-EMPLOYMENT

Is the business in the home? Yes No

Name:	Month:
One Month's Gross Income	\$
Business rent/mortgage expense	\$
Gross business labor costs	\$
Utilities paid for business	\$
Business taxes paid	\$
Interest paid for business	\$
Cost of merchandise for business	\$
Business equipment costs	\$
Other business costs	\$
Net Income	\$

Is the business in the home? Yes No

Name:	Month:
One Month's Gross Income	\$
Business rent/mortgage expense	\$
Gross business labor costs	\$
Utilities paid for business	\$
Business taxes paid	\$
Interest paid for business	\$
Cost of merchandise for business	\$
Business equipment costs	\$
Other business costs	\$
Net Income	\$

Net income is your gross income minus expenses.

1. Is anyone who is applying for Medical Assistance receiving Medicare? Yes No If yes, please complete:

Name of person receiving Medicare _____ Medicare Number _____

Check for: Part A Part B Part D

Please include a copy of the front and back of the Medicare card if it is available.

2. Has anyone who is applying had group health insurance **through an employer** within the last 3 months?
Yes No **If no, go to question 3.**

Why did this insurance end? It has not ended
 The policyholder is no longer employed by company
 The company no longer offers insurance
 The employee voluntarily withdrew

Amount you pay/paid each month \$ _____ Amount employer pays/paid each month \$ _____

Name(s) of person(s) covered _____

Policyholder's Name _____ Name of Insurance Company _____

Insurance Company Phone Number () _____ Policy Number _____

Group Number _____ When did this insurance end? (mm/dd/yyyy) _____

3. Does anyone who is applying have any **other** type of medical health insurance? Yes No
If no, go to question 4.

Is this insurance COBRA? Yes No

Name(s) of person(s) covered _____

Policyholder's Name _____ Name of Insurance Company _____

Policy/Group Number _____ Insurance Company phone number () _____

Please include a copy of the front and back of the insurance card if it is available.

4. Do any members of this household have access to group health insurance and want help paying the monthly premium? Yes No

YOU MUST COMPLETE THIS SECTION FOR CHILDREN 18 AND UNDER

- To receive health care insurance through CHP+, you must choose a Health Maintenance Organization (HMO) for the child(ren) applying. You must select the same HMO for all children in the household requesting Medical Assistance. Name of HMO selected: _____
- You can find information about HMOs in your county at ChpPlus.org or refer to the HMO chart.
- If your children qualify for Medicaid, **HealthColorado** will contact you to enroll in an HMO.

Medical Assistance Programs use some of your expenses from your income when determining eligibility and benefits. All expenses must be paid from the same month of income reported on the income sections of this application.

Examples are included for each program.

- **Family Medicaid or CHP+:**

Family Medicaid and CHP+ do not need proof of expenses unless it is requested.

Examples of expenses that may be considered:

- Child Care • Dependent Elder Care • Medical Expenses • Child Support • Alimony
- Health Insurance Premiums • Prescriptions

- **Long-Term Care (LTC):**

LTC programs may need proof of expenses. Include the expenses for the applicant and for the applicant's spouse.

Examples of expenses that may be considered:

- Rent • Mortgages (first, second, third) • Heating • Cooling • Electricity • Water • Sewer • Trash
- Phone/Cell • HOA Fees • Facility • Care Provider • Medical

- **Medicare Savings Programs (MSP):**

MSP may need proof of expenses. Include the expenses for the applicant and for the applicant's spouse.

Examples of expenses that may be considered:

- Rent • Mortgages (first, second, third) • Heating • Cooling • Electricity • Water • Sewer • Trash • HOA Fees

Please list expenses:

Type of Expense	Who Pays this Expense	Who is it for	Month	Amount Paid
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$

tell us about resources

ONLY complete for Medical Assistance for adults, disabled children, MSP and LTC programs

Do not complete for Family Medicaid or CHP+

NOT APPLICABLE

Adult Medical, LTC and MSP programs require proof of resources.

- Tell us about resources, such as • Cash • Checking and Saving Accounts • Certificates of Deposits (CD) • Annuities • Mutual Funds • Inheritance • PASS Accounts • Individual Development Accounts • Retirement Accounts • Stocks • Bonds • Trusts • Promissory Notes • College Funds • Education Accounts • Property (Land, Homes) • Proceeds from Sale of Home(s):

Type of Resource	Owner	Account Number	Amount	Name of Institution	Jointly Owned? Yes or No
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		

- Does this applicant or spouse own or are they buying any land or property? (For example, house, rental property, timeshare, warehouse, or empty lot.) Yes No If yes, please complete:

Owner's Name	Jointly Owned? Yes or No	Full Address of Property	Type of Property	Value	Amount Owed
				\$	\$
				\$	\$
				\$	\$

tell us about resources (continued)

ONLY complete for Medical Assistance for adults, disabled children, MSP and LTC programs

Do not complete for Family Medicaid or CHP+

NOT APPLICABLE

3. Does this applicant or spouse have any vehicles? (car, van, truck, RV, boat, trailer) Yes No
If yes, please complete:

Owner(s)	Jointly Owned? Yes or No	Type of Vehicle	Year	Make/Model	Value	Amount Owed

4. Does this applicant or spouse have any life insurance policies? Yes No If yes, please list below:

Policy Owner	Policy Number	Individuals Covered	Insurance Company	Face Value	Cash Value

5. Does this applicant or spouse have a burial policy or any money set aside to be used for burial, cremation, or other funeral expenses? Yes No If yes, please complete:

Name of Applicant or Spouse	Amount	Is it Irrevocable? Yes or No	Name of Institution or Person Holding the Money

6. There may be help with funeral expenses for some recipients. If your family should need such help, what would the recipient prefer? Cremation Burial No Preference

7. Has the applicant or spouse given away anything of value within the last 5 years? For example, land, home, money, buildings, cars, boats. Yes No If yes, please complete the following:

Person Who Gave Item Away	Item Given Away	Date Given Away	Value of Item	Amount Owed

I know that when I sign this application, the State of Colorado can check to see if the information I gave is true and correct.

- To help you organize your documents, please check off the items you are sending with this application.
 - Proof of citizenship and identification for all applicants. (Except MSP)
 - Copy of the front and back of U.S. Citizen and Immigration Services (INS) card, if you have one, for any non-citizen who will receive care and who is applying for Medical Assistance.
 - For each applicant that is pregnant, send a health care provider's note showing the due date with the number of babies expected.
 - Reported income **from a job** needs to be from this month or last month. The income must be from the same month and represent a full month's pay. If self-employed, complete the self-employment boxes in this application. Parents living in the household who are applying for Medical Assistance for their children must report all earned and unearned income.
 - If covered by health insurance, send a copy of the insurance card (front and back), if you have it.
 - If asking for **Medicaid** to cover old medical expenses, report the income for the month(s) of service(s) on page 10, question 1.
 - Choose an HMO for your child(ren).
- How did you hear about Medical Assistance Programs? county department of human/social services community organization Medicaid/Medical Assistance web site media other _____
- If you would like to register to vote you can go to: sos.state.co.us → Voter Registration
- If we are in need of additional information regarding your application and are unable to contact you or the applicant, is there someone we may contact? Yes No
Name _____
Phone (_____) _____ Address _____
Relationship to Applicant _____

SIGNATURE AND CERTIFICATION:

By signing this application I am giving my permission to the State of Colorado and its designees to make contacts to verify the information given on this application. I certify that I have read and understand the information on the "what I should know" insert and have been given a copy for my records. Under penalty of perjury I certify all information I have given is true and correct.

Print Name Here _____ Sign Here _____ Date _____

Authorized Representative, Conservator, Guardian, other contact: (please print) _____

Phone (_____) _____ Signature _____ Date _____

Print name of Agency Representative or Outreach Specialist who helped fill out the application _____

Signature of person who helped fill out the application _____

Date _____ Phone _____ Agency or Site Name _____







By signing the Medical Assistance Application I understand the following:

- The Department of Health Care Policy and Financing is the state agency responsible for Medical Assistance Programs in Colorado.
- If I receive **Medical Assistance, including Medicaid**, I must tell my county department of human/social services within 10 days about income or any other changes.
- The information given is confidential. However, it can be used or shared by the program(s) that each of my family members is enrolled in for purposes of treatment, payment, program operations, and other purposes permitted by law.
- I must tell the truth and answer all the questions on this application. If I do not tell the truth, I will lose my Medical Assistance, and I may have to pay the Department for the Medical Assistance received.
- My information will be checked with other federal and state agencies and that information received may affect my eligibility.
- It is a crime punished by fines and/or jail time to take benefits that I know my family is not eligible to receive.
- I must cooperate fully with state and federal staff if my case is reviewed.
- If there is an absent parent(s) from my home and I am applying for Medicaid, I must seek medical support from the absent parent(s). I may contact Child Support Enforcement for assistance.
- My information on this application may be reviewed and verified by my county department of human/social services, the Department, or its representatives.
- I am responsible for paying fees and copayments for myself and my family if they are required.
- If enrolled in **Medicaid** and other insurance is paying for medical care, **Medicaid** will pay last.
- I must give the needed proof and documents before qualifying for benefits.
- I will have to pay back any medical payments, including premium payments, which have been paid for by Medicaid if found ineligible during the time services were covered.
- The law says the Department must check the immigration status and citizenship for anyone who is applying for Medical Assistance. They will not check immigration status of family members who are not applying for Medical Assistance.
- The Department will review my application no matter what my race is, or my color, sex, age, disability, religion, national origin, or political beliefs.
- The Americans with Disabilities Act (ADA) of 1990 gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. If you would like more information please contact our Client/ADA Liaison at (303) 866-6010.
- If I think the **CHP+** program made a mistake, I can ask for an appeal. **CHP+** tells me about how to make an appeal in every letter that they send.
- I may request a Fair Hearing if I disagree with any action taken by Medical Assistance Programs, except for **CHP+**, when this application is processed. Information on how to ask for a Fair Hearing is printed on the back of all letters sent by Medical Assistance Programs (including **Medicaid**).
- I will immediately notify the State of any claim or lawsuit I have; I will cooperate with the State in collecting the medical bills the State has paid. The State may collect from any insurance company or court settlement for medical bills that the State has paid. If I am on Medicaid and receive money for the same medical bills that the State has paid, I will give the money to the State. I assign to the State all rights to payment for medical expenses and treatment. I also assign my right to appeal a denial of benefits by another party responsible for payment for the benefits to the State.
- The Medical Assistance Estate Recovery Program authorizes the Department to recover all Medical Assistance benefits paid on behalf of Medicaid clients, including capitation payments, from the estates of deceased Medicaid clients who were permanently institutionalized or were over the age of 55 when benefits were provided. The Federal and State laws governing estate recovery also provide for certain exemptions to the Medical Assistance Estate Recovery Program. For further information or questions please contact your county and request "The Medical Assistance Estate Recovery Program" brochure.
- I am allowing the agency to get records from financial institutions to show assets held for the person(s) named in this application. This includes banks, savings and loans, credit unions, insurance companies, and other financial institutions.

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COLORADO HEALTH CARE COVERAGE — CHP+ HMO COMPARISON CHART

Below is information on the CHP+ health plans you may choose. Please choose a health plan that is in your county.

					
Phone Numbers	888-214-1101 or 303-751-9021	800-700-8140 or 303-602-2100	800-346-4643	303-338-3800 or 800-632-9700 TTY 303-338-3820	800-475-8466 or 719-589-3696
What counties are CHP+ health plans in? <small>*State Managed Care Network is the health plan for pregnant women in every county.</small>	Adams, Alamosa, Arapahoe, Bent, Boulder, Broomfield, Clear Creek, Conejos, Costilla, Crowley, Custer, Denver, Douglas, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Kiowa, Larimer, Lincoln, Logan, Mineral, Morgan, Otero, Park, Phillips, Prowers, Pueblo, Rio Grande, Saguache, Washington, Weld and Yuma	Adams, Arapahoe, Denver and Jefferson	Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, Lake, La Plata, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel and Summit	Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas and Jefferson	Alamosa, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Kit Carson, Las Animas, Mineral, Otero, Prowers, Rio Grande, Saguache, Washington and Yuma
How do members get medical care?	1. Call Colorado Access and choose a PCP 2. Make an appointment with the PCP 3. Present Colorado Access ID card to PCP at the appointment	1. Call Denver Health Medical Plan (DHMP) and choose a PCP 2. Make an appointment with the PCP 3. Present the DHMP ID card to PCP at the appointment	1. Call Rocky Mountain Health Plans (RMHP) and choose a PCP 2. Make an appointment with the PCP 3. Present the RMHP ID card to the PCP at the appointment	1. Call Kaiser Permanente and choose a PCP 303-338-4477 or TTY 303-338-4448 2. Make an appointment with the PCP 303-338-4545 or TTY 303-338-4428 3. Present the Kaiser Permanente ID card at the appointment	1. Call Colorado Choice Health Plans and choose a PCP 2. Make an appointment with the PCP 3. Present the Colorado Choice Health Plans ID card to the PCP at the appointment
What hospitals can CHP+ members use?	<ul style="list-style-type: none"> • Avista Hospital • Centura facilities • The Children's Hospital • Longmont United • McKee Medical Center • Medical Center of Aurora • Medical Center of the Rockies • National Jewish • North Colorado Medical Center • Platte Valley Medical Center • Poudre Valley Hospital • Presbyterian/St. Luke's Medical Center • Saint Joseph Hospital • San Luis Valley Regional Medical Center • Sky Ridge • St. Mary Corwin Hospital • Swedish Medical Center • University of Colorado Hospital • Plus many more 	<ul style="list-style-type: none"> • The Children's Hospital* • Denver Health Medical Center • University of Colorado Hospital* <p><small>* Certain other services may be provided only if not offered at Denver Health Medical Center. Prior authorization from Denver Health Managed Care is required for all services except emergency and urgent care. Emergency and urgent care covered at nearest facility.</small></p>	Any participating RMHP hospital. Call Customer Service at 800-346-4643 for a list or to check if a specific hospital is participating.	<ul style="list-style-type: none"> • The Children's Hospital • Exempla Good Samaritan Medical Center • Exempla St. Joseph's Hospital 	<ul style="list-style-type: none"> • Any Colorado Choice Health Plans hospital participating in the network. • Call Customer Service at 800-475-8466 for a list or to check if a specific hospital is participating.
What pharmacies can CHP+ members use?	<ul style="list-style-type: none"> • Albertsons • Kmart • King Soopers • Medicine Shoppe • Rite Aid • Safeway • Target • Walgreens • Wal-Mart • Plus many local pharmacies 	<ul style="list-style-type: none"> • Albertsons • Denver Health • Kmart • King Soopers • Rite Aid • Safeway • Walgreens • Plus many local pharmacies <p>Call 303-602-2100 for more participating pharmacies.</p>	Any participating RMHP Pharmacy. Call Customer Service at 800-346-4643 for a list or to check if a specific pharmacy is participating.	Kaiser Permanente pharmacies are available in all Kaiser Permanente medical offices. Mail order is also available.	Any Colorado Choice Health Plans pharmacy participating in the network. Call Customer Service at 800-475-8466 for a list or to check if a specific pharmacy is participating.
What special services are available to CHP+ members?	<ul style="list-style-type: none"> • \$150 toward glasses or contacts per benefit year • Reduced co-payments for prescriptions • More than 200 over-the-counter medicines like vitamins & Tylenol, with a prescription • Health care education programs like Safe T. Tiger • Food for Shots - get a \$10 grocery certificate & a chance to win a \$250 gift card when children are up to date on shots before age 2 • Customer Service staff speak many languages, including Spanish 	<ul style="list-style-type: none"> • No co-payments for covered visits and prescriptions • Many over-the-counter medicines at no cost, with a prescription and filled at a Denver Health pharmacy • \$150 toward eyeglasses or contact lenses per benefit year • \$0 copay for 40 outpatient visits per benefit year for physical, occupational & speech therapy • \$0 copay for 30 outpatient mental health visits per benefit year • Healthy Heroes Club to help kids learn healthy habits • Nurse Advice line available 24 hours • Quarterly member newsletter • Health coaches available for kids with chronic diseases, call 303-602-2164 • Customer Service staff speaks many languages, including Spanish, Vietnamese, Cambodian, Russian • Interpreter services and many bilingual providers 	<ul style="list-style-type: none"> • Health education and case management for pregnancy, asthma, diabetes, heart disease and other chronic conditions • Quarterly member newsletter • \$50.00 toward eyeglasses • A covering doctor when the primary doctor's office is closed • Spanish speaking customer service staff • Interpreter services 	<ul style="list-style-type: none"> • Nurse advice line at 303-338-4545/after hours at 303-861-3434 (TTY 303-338-4428 or visit kp.org) • Interpreter services, Spanish speaking customer service staff, and many bilingual providers • Access to many case management programs • Personal health evaluation & screening • Member newsletter once you have registered on kp.org • Access to smoking cessation, women's health, diet & nutrition and stress management classes • Access to secure member Web site, kp.org. Members can create a personal health assessment; email doctors; order prescription refills; make appointments; and get health information 	<ul style="list-style-type: none"> • Care Management programs specialized towards children that include asthma, diabetes, high blood pressure, and other chronic conditions • Access to secure Member Web site enables Members to select a PCP, view claims history & roster of participating providers, order a new ID Card and much more • Health education materials available for over 5000 different topics on health related conditions & procedures • Customer Services phones answered by a person, not a machine, access to Spanish speaking customer service staff and interpreter services • \$50 towards eyeglasses
What if my child needs special care?	The PCP provides a referral to specialty care.	The PCP provides a referral to specialty care.	Members may make an appointment directly with any participating RMHP specialist without a referral. Present the ID card at the time of service.	Each member's PCP will help coordinate timely access to specialty care, making sure the member sees the right specialist for his/her unique needs.	Members may make an appointment directly with a Colorado Choice Health Plans specialist participating in the network without a referral. Present your ID card at the time of service.
How do members get mental health services?	Members can go to any mental health provider that is in our network of mental health providers. Members can verify that their provider is in our network by contacting our Customer Service department.	Members can self-refer to a mental health provider in the DHMP Network. A DHMP clinical psychiatric nurse is available for questions and appointments at 303-602-8270.	Members may make an appointment directly with any participating RMHP mental health provider without a referral. Present the ID card at the time of service.	Members may access mental health services by contacting the Kaiser Permanente mental health office closest to their home. Visit kp.org, to see the Facility Directory.	Members may make an appointment directly with a Colorado Choice Health Plans mental health provider participating in the network without a referral. Present your ID card at the time of service.

COLORADO HEALTH CARE COVERAGE — CHP+ HMO MAP

