Please make sure these things are on your application. It takes longer to see if your child(ren) and/or yourself are eligible if these things are missing. So, sending a complete application is the way to go!

- Fill out each section completely.
- If something does not apply, mark “none.”
- For non-citizens applying for benefits, include a copy of the applicant’s INS card (front and back).
- Proper Identification Documents for applicants 18 years of age or older along with a signed affidavit form (see attached Important Notice and Affidavit).
- If you are self-employed, be sure to fill out Section 2, page 6.
- Pick an HMO if one is available in your area. (Need help finding an HMO? Visit www.chpplus.org to see which HMO’s are in your area!)
- Initial the back page.
- Sign and date the application on the back page.
- Include all pay stubs or an employer letter showing your family’s Gross Pay for the previous or current month (see below for an example). CHP+ needs pay stubs with a Pay Date from the current month or the month prior to your application date.

Send your completed application to:

CHP+
PO Box 929
Denver, CO 80201

Questions?? Please call 800.359.1991

2/2007
IMPORTANT NOTICE

Effective August 1, 2006, proof of lawful presence in the United States per House Bill 06S-1023 is required for new and renewing clients who are 18 years of age or older in the Child Health Plan Plus (CHP+) program. Clients in the CHP+ prenatal program are included in the population impacted by the new requirements.

Below is a list of the documentation that is being requested for applicants 18 years of age or older. It is necessary to receive this documentation in order to be able to determine eligibility.

***A copy of the documentation is acceptable as long as a licensed notary notarizes it.

Please provide one of the following:

1. Valid Colorado Driver License or Colorado State Identification card
2. US Military Card or a Military Dependents ID card
3. A US Coast Guard Merchant Mariner card
4. A Native American tribal document
5. Certificate of naturalization bearing intact photograph and embossed agency seal
6. Certificate of US citizenship by an authorized agency bearing intact photograph and embossed agency seal
7. Valid state Driver License or Identification card with photo from: AL, AZ, AR, CA, CT, DE, DC, FL, GA, ID, IN, IA, KS, KT, LA, ME, MN, MS, MO, MT, NV, NH, NJ, NY, ND, OH, OK, PA, RI, SC, SD, VA, WV and WY
8. The following immigration documents:
   a. Unexpired foreign passport bearing an unexpired “Processed for I-551” stamp or with an attached unexpired “Temporary I-551” visa
   b. Unexpired foreign passport accompanied by an “I-94” indicating a specific future “until” date
   c. “I-94” with refugee or asylum status
   d. Any one of the following unexpired cards:
      i. “Resident Alien” card
      ii. “Permanent Resident” card
      iii. “Temporary Resident” card
      iv. “Employment Authorization” card
REQUIRED AFFIDAVIT FORM TO BE SIGNED BY APPLICANTS 18 YEARS OF AGE OR OLDER. Please send along with notarized copy of the document proving lawful presence in the United States.

AFFIDAVIT
for the Colorado Department of Human Services
and the Department of Health Care Policy and Financing
as Proof of Lawful Presence in the United States

I, __________________, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check one):

___ I am a United States citizen, or
___ I am a legal Permanent Resident of the United States, or
___ I am lawfully present in the United States pursuant to federal law.

I understand that this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

___________________________    _______________
Signature        Date
Get the health care your family needs at a price you can afford! Fill out this form to apply for Colorado health coverage: Medicaid and Child Health Plan Plus (CHP+). The program you qualify for is based on the size of your family and how much money your family makes.

What will Medicaid or CHP+ cost my family?
There are no monthly payments (premiums) or co-payments for children or pregnant women who qualify for Medicaid. Adults may have a small co-payment for each doctor visit or prescription (medicine).

Some families with children who qualify for CHP+ will pay a small annual enrollment fee. At most, the annual enrollment fee will be $35, no matter how many children are covered. Some families may also have to make small co-payments when they receive services or prescriptions. Payments for most services are between $1 and $5.

Who is qualified?
Medicaid is for families and pregnant women. CHP+ is for children 18 years of age and younger. Chances are someone in your family may be covered by one of these programs.

What is covered?
• Regular checkups
• Doctor visits
• Shots
• Prenatal and postpartum care
• Hospital care
• Medicine
• Mental health care
• Dental

How do I apply?
Give your family every chance to qualify by filling out all of the forms. BE SURE TO SIGN THE FORM and include copies of all the things we ask you to send (like paycheck stubs). We can’t see if you qualify until all of the forms are filled out and we have all of the things we need!

What documents do I need?
✓ Paycheck stubs or a letter from the employer for each working person in the household showing gross earnings for the previous month or this month, if the whole month’s earnings have been received.
✓ If anyone applying is pregnant, a note from the doctor that says when the baby is due.
✓ Proof of payment for medical expenses.
✓ Do you need Medicaid to pay for health care received in the last 3 months? If yes, provide proof of income for those months.
✓ An INS card, if available, for anyone who will receive care.

What do I do when I have filled in all of the forms and have copies of documents?
You can take the application back to the place where you picked it up or mail it to the place where you picked it up.

When will I know if I qualify?
It can take from 2 weeks up to 2 months to let you know if you qualify. We will send you a letter telling you if you are qualified and for which program. It is possible one child may qualify for Medicaid and another for CHP+. If you do not qualify, we will send you a letter telling you why not.

Colorado Indigent Care Program (CICP)
If you are not eligible for Medicaid or CHP+, you may be able to receive limited services through a CICP provider. To find a CICP provider near you, go to the Department of Health Care Policy and Financing’s website at www.chcpf.state.co.us and click on the CICP link.
By signing the Application for Colorado Health Care I understand the following:

- The Department of Health Care Policy and Financing is the state agency responsible for administering Medicaid, CICP, and CHP+.
- I may request a Fair Hearing if I disagree with any action taken by Medicaid when this application is processed. Information on how to request a Fair Hearing is printed on the back of all notices of action sent by Medicaid.
- I may request an appeal if I disagree with my rating for CICP or CHP+. Information on this process is included in all notices of action sent by CHP+ or available from the CICP provider where my application was processed.
- This application will be reviewed without regard to race, color, sex, age, disability, religion, national origin, or political belief.
- I do NOT have to give information on citizenship or immigration status of family members who are NOT applying for health care benefits.
- If my family is enrolled in Medicaid or CICP and other insurance is paying for their medical care, Medicaid or CICP will pay last.
- The information given on this application may be reviewed and verified by my county Department of Human Services, the Department of Health Care Policy and Financing, or its designees.

- I must show proof that my family is eligible for benefits.
- If I receive Medicaid, I must tell my county Department of Human Services within 10 days of any changes to my case.
- The information I have given is confidential. However, it can be used or disclosed by the program(s) in which my family member(s) is enrolled for purposes of treatment, payment, program operations, and other purposes permitted by law.
- If I give false information on purpose so that my family member(s) can get health care, I must pay the program(s) back for any medical care received.
- It is a crime punished by fines and/or jail time to take benefits that I know I am not eligible to get.
- I am responsible for paying appropriate fees and co-payments for myself and my family if they are required.
- I must cooperate fully with State and federal staff if my case is reviewed.

Please complete and return all forms (pages 1-8) and keep the cover for your information.
1. **TELL US HOW TO CONTACT YOU** (WE WANT THE PERSON FILLING OUT THE FORMS.)

   CONFIDENTIAL INFORMATION WILL BE SENT TO THE MAILING ADDRESS YOU PROVIDE.

   ALSO, YOU MAY BE CONTACTED AT THE PHONE NUMBER(S) YOU PROVIDE ABOUT THIS APPLICATION AND ITS CONTENTS.

<table>
<thead>
<tr>
<th>Your last name</th>
<th>Maiden name</th>
<th>First name</th>
<th>Middle initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing address (if you can’t receive mail at street address)</td>
<td>Apartment #</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Street address (fill in if different than mailing address)</td>
<td>Apartment #</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Home phone (No phone number! Give us a number where you can get messages.)</td>
<td>Work phone</td>
<td></td>
<td>Other phone</td>
</tr>
</tbody>
</table>

2. **TELL US ABOUT ALL THE PEOPLE LIVING IN YOUR HOME, INCLUDING YOURSELF.**

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle initial</th>
<th>Birth date (month/day/year)</th>
<th>How is this person related to you? (self, child, step-child, spouse, friend, etc.)</th>
<th>Full-time student? yes no</th>
<th>Is this person applying for health coverage? yes no</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**THE FOLLOWING SERVICES MAY BE AVAILABLE TO PREGNANT WOMEN AND CHILDREN WHO QUALIFY FOR MEDICAID.**

3. **WOULD YOU LIKE HELP GETTING ANY OF THESE SERVICES? □ YES □ NO**

   **IF YES, PLEASE CHECK THE SERVICES YOU WOULD LIKE TO RECEIVE.**

<table>
<thead>
<tr>
<th>□ Pregnancy care</th>
<th>□ Medical checkups</th>
<th>□ Baby shots</th>
<th>□ Sick care</th>
<th>□ Medicine</th>
<th>□ Dental checkups</th>
<th>□ Eye exams</th>
<th>□ WIC or supplemental food benefits</th>
<th>□ Hearing exam</th>
</tr>
</thead>
</table>

4. **ARE YOU OR ANYONE LISTED IN THE HOUSEHOLD PREGNANT? □ YES □ NO**

   If yes, give the first and last name ___________________________ How many babies are expected? _______ When is the due date? ________________
# Colorado Health Care Programs

## child form

Complete this page for anyone 18 years of age or younger who wants health coverage.

**CHOOSE AN HMO AND DOCTOR FOR THE CHILDREN LISTED BELOW. IF YOUR CHILDREN RECEIVE MEDICAID, YOU WILL BE CONTACTED BY HEALTH COLORADO TO ENROLL WITH A HEALTH PLAN.**

Make your choice now from the list enclosed with this application. (If there is not a list enclosed, we will contact you after we review your completed application.) If HMOs are listed in your county, choose an HMO and a doctor. If there is no HMO listed in your county, just choose a doctor.

HMO (if available): ___________________________ Doctor’s name or clinic: ___________________________

## 1. Child’s General Information

<table>
<thead>
<tr>
<th>Child's last name</th>
<th>First name</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>___ ___ ___ * ___ ___ * ___ ___ ___</td>
</tr>
</tbody>
</table>

Mother’s name if living in the home (last name, first name)

Father’s name if living in the home (last name, first name)

<table>
<thead>
<tr>
<th>Is this child a U.S. citizen (circle)? yes no</th>
</tr>
</thead>
<tbody>
<tr>
<td>• if no, enter the child’s alien registration number if he or she has one:</td>
</tr>
</tbody>
</table>

| • on what date did the child receive the INS card: month day year |
| • country where born |

1. Child’s sex (circle) Male Female

2. Circle the child’s ethnic group (you can choose not to answer this).
   - White, Hispanic, Black, Native American, Asian, Alaskan Native, Native Hawaiian, Other Pacific Islander, Other __________________________

3. Does either parent of this child work more than 20 hours a week for a Colorado State Government agency and have access to State health benefits (circle)? yes no

4. Does this child have a medical or developmental condition expected to last more than 12 months (circle)? yes no

5. If eligible, do you want Medicaid to cover medical care received by this child in the last three months (circle)? yes no
   - If yes, please give date(s) of care: __________________________
Colorado Health Care Programs
child #2 & #3 form

Complete this page for anyone 18 years of age or younger who wants health coverage.

2. CHILD #2 GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Child’s last name</th>
<th>First name</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mother’s name if living in the home (last name, first name)

<table>
<thead>
<tr>
<th></th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is this child a U.S. citizen (circle)? yes no
* if no, enter the child’s alien registration number if he or she has one:

Father’s name if living in the home (last name, first name)

<table>
<thead>
<tr>
<th></th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* on what date did the child receive the INS card: month day year
* country where born

1. Child’s sex (circle) Male Female
2. Circle the child’s ethnic group (you can choose not to answer this).
   White, Hispanic, Black, Native American, Asian, Alaskan Native, Native Hawaiian, Other Pacific Islander, Other
3. Does either parent of this child work more than 20 hours a week for a Colorado State Government agency and have access to State health benefits (circle)? yes no
4. Does this child have a medical or developmental condition expected to last more than 12 months (circle)? yes no
5. If eligible, do you want Medicaid to cover medical care received by this child in the last three months (circle)? yes no If yes, please give date(s) of care: ____________________________

3. CHILD #3 GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Child’s last name</th>
<th>First name</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mother’s name if living in the home (last name, first name)

<table>
<thead>
<tr>
<th></th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is this child a U.S. citizen (circle)? yes no
* if no, enter the child’s alien registration number if he or she has one:

Father’s name if living in the home (last name, first name)

<table>
<thead>
<tr>
<th></th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* on what date did the child receive the INS card: month day year
* country where born

1. Child’s sex (circle) Male Female
2. Circle the child’s ethnic group (you can choose not to answer this).
   White, Hispanic, Black, Native American, Asian, Alaskan Native, Native Hawaiian, Other Pacific Islander, Other
3. Does either parent of this child work more than 20 hours a week for a Colorado State Government agency and have access to State health benefits (circle)? yes no
4. Does this child have a medical or developmental condition expected to last more than 12 months (circle)? yes no
5. If eligible, do you want Medicaid to cover medical care received by this child in the last three months (circle)? yes no If yes, please give date(s) of care: ____________________________

Parents, ask your employer if you are eligible for State employee health benefits.

If you circled yes on #5, you must give us income documents for the same month as the care AND you may be contacted about your assets for that month.
Complete this page for anyone 19 years of age or older who wants health coverage.  
(CHP+ is for children 18 years of age or younger)

**IF YOU RECEIVE MEDICAID, YOU WILL BE CONTACTED BY HEALTH COLORADO TO ENROLL WITH A HEALTH PLAN.**

### 1. ADULT #1 GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Adult’s last name</th>
<th>First name</th>
<th>Middle initial</th>
<th>Sex (circle): Male Female</th>
<th>Social Security Number</th>
</tr>
</thead>
</table>

1. Language spoken ____________________________

2. Is this adult a U.S. citizen (circle)? yes no
   - if no, enter the adult’s alien registration number if he or she has one: ____________________________
   - on what date did the adult receive the INS card: month________day________year________
   - country where born___________________________

3. Has this adult received Medicaid in the past three months (circle)? yes no

4. Circle the adult’s ethnic group (you can choose not to answer this).
   - White, Hispanic, Black, NativeAmerican, Asian, Alaskan Native, Native Hawaiian, Other Pacific Islander, Other ____________________________

5. If eligible, does this person want Medicaid to cover medical care received in the last three months (circle)? yes no
   - If yes, please give date(s) of care: ____________________________

### 2. ADULT #2 GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Adult’s last name</th>
<th>First name</th>
<th>Middle initial</th>
<th>Sex (circle): Male Female</th>
<th>Social Security Number</th>
</tr>
</thead>
</table>

1. Language spoken ____________________________

2. Is this adult a U.S. citizen (circle)? yes no
   - if no, enter the adult’s alien registration number if he or she has one: ____________________________
   - on what date did the adult receive the INS card: month________day________year________
   - country where born___________________________

3. Has this adult received Medicaid in the past three months (circle)? yes no

4. Circle the adult’s ethnic group (you can choose not to answer this).
   - White, Hispanic, Black, NativeAmerican, Asian, Alaskan Native, Native Hawaiian, Other Pacific Islander, Other ____________________________

5. If eligible, does this person want Medicaid to cover medical care received in the last three months (circle)? yes no
   - If yes, please give date(s) of care: ____________________________
# Health Insurance Form

## 1. Is anyone in the household currently covered by health insurance (circle)?

If no, skip this section and go to question #2 below.

**IF YES, THE ENTIRE SECTION MUST BE COMPLETED.**

<table>
<thead>
<tr>
<th>Name(s) of person(s) covered</th>
<th>Policy Number/Group Number</th>
<th>Policyholder’s Social Security No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policyholder’s name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of insurance company</td>
<td>Circle policy type:</td>
<td></td>
</tr>
<tr>
<td>Mailing address of insurance company</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Group**: Individual
- **Commercial HMO**:
- **Medicare HMO**
- **Other**

## 2. Has any person in the household had health insurance through an employer’s group policy in the last three months (circle)?

If no, skip this section and go to question #3 below.

**IF YES, THE SHADED SECTIONS MUST BE COMPLETED.**

<table>
<thead>
<tr>
<th>Name(s) of person(s) previously covered on the health plan</th>
<th>When did this insurance end?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policyholder’s name</td>
<td>Name of employer’s insurance company</td>
</tr>
<tr>
<td>Amount you paid each month $</td>
<td>Amount employer paid each month $</td>
</tr>
<tr>
<td>Phone number of employer’s insurance company ( )</td>
<td>Phone number of employer’s insurance company ( )</td>
</tr>
</tbody>
</table>

- **Did the policyholder lose this insurance because**:  
  - He or she is no longer employed by the company (circle)?
  - The employer cancelled the health insurance benefit (circle)?

## 3. Do you or any member of your household have access to group health insurance and want help paying the monthly premiums (circle)?

**YES NO**

---

1. For CHP+ only: Parents, if your children are currently covered by health insurance, they may not be eligible for CHP+. School accident insurance, dental or vision insurance, or Health Care Program for Children with Special Needs (HCP) coverage will not affect eligibility for CHP+.

2. For CHP+ only: Parents, if your children were covered by health insurance through either parent’s employer in the last 3 months and the employer paid at least 50% of the health insurance premiums, your children may not be eligible for CHP+ until 3 months after coverage ended unless you are no longer employed by the company, the employer stopped paying at least 50% of the premiums, or the employer stopped providing the coverage.
Colorado Health Care Programs

income and assets form

Make sure you complete this page.

1. **TELL US ABOUT INCOME EACH PERSON IN YOUR HOUSE EARNED FROM EMPLOYMENT.**

   WE WILL PROCESS YOUR APPLICATION, BUT WE CANNOT DETERMINE ELIGIBILITY UNLESS WE HAVE DOCUMENTS THAT PROVE THE EARNINGS OF ALL WORKERS LISTED BELOW.

<table>
<thead>
<tr>
<th>Name of person working</th>
<th>Employer name/phone number</th>
<th>Paid how often? (weekly, monthly, etc.)</th>
<th>Total monthly amount received before taxes and deductions</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

2. **ARE YOU OR IS ANYONE WHO LIVES IN YOUR HOUSE SELF-EMPLOYED (CIRCLE)?**

   YES  NO

   IF NO, SKIP TO QUESTION #3 BELOW. IF YES, COMPLETE ONE TABLE BELOW FOR EACH SELF-EMPLOYED WORKER.

<table>
<thead>
<tr>
<th>Name of person:</th>
<th>One month of income and expense</th>
<th>Name of person:</th>
<th>One month of income and expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross income (before expenses)</td>
<td>$</td>
<td>Gross income (before expenses)</td>
<td>$</td>
</tr>
<tr>
<td>Business rent/mortgage expense</td>
<td>$</td>
<td>Business rent/mortgage expense</td>
<td>$</td>
</tr>
<tr>
<td>Gross business labor costs</td>
<td>$</td>
<td>Gross business labor costs</td>
<td>$</td>
</tr>
<tr>
<td>Cost of merchandise for business</td>
<td>$</td>
<td>Cost of merchandise for business</td>
<td>$</td>
</tr>
<tr>
<td>Business taxes paid</td>
<td>$</td>
<td>Business taxes paid</td>
<td>$</td>
</tr>
<tr>
<td>Interest paid for business</td>
<td>$</td>
<td>Interest paid for business</td>
<td>$</td>
</tr>
<tr>
<td>Utilities paid for business</td>
<td>$</td>
<td>Utilities paid for business</td>
<td>$</td>
</tr>
<tr>
<td>Business equipment costs</td>
<td>$</td>
<td>Business equipment costs</td>
<td>$</td>
</tr>
<tr>
<td>Other business costs</td>
<td>$</td>
<td>Other business costs</td>
<td>$</td>
</tr>
</tbody>
</table>

3. **TELL US ABOUT OTHER INCOME ANYONE IN YOUR HOUSEHOLD RECEIVES.**

   INCLUDE EVERYONE IN THE HOUSE, NOT JUST THE PEOPLE WHO ARE APPLYING. FILL OUT A LINE FOR EVERY ITEM.

<table>
<thead>
<tr>
<th>Type of income</th>
<th>Person money is used or meant for</th>
<th>Monthly amount (before taxes and deductions)</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

1. We need documents that show all earnings for one calendar month. We can use either: 1) the previous whole month, OR 2) this month if you’ve already received a whole month’s earnings. Send us copies of pay stubs or get a letter from your employer with the amount. The income documents need to be from the same calendar month for all workers listed in section 1.

2. When your household includes a self-employed worker, we need documents that show a full calendar month. We like to get a profit and loss statement or a copy of your bookkeeping ledgers. If nothing else is available, copy all your receipts for the previous month.

3. Other types of income may come from alimony, child support, retirement pensions, military allotments, Social Security, educational grants, unemployment compensation, veteran’s benefits, worker’s compensation, Colorado Works cash, interest in savings, rental income, cash contributions from others, in-kind income.

3. Do not combine income received. For example, if your household receives a child support check, list how much each child receives on a separate line.
4. **DOES ANYONE IN YOUR HOUSEHOLD HAVE ANY OF THE FOLLOWING ASSETS?**
   INCLUDE EVERYONE IN THE HOUSE, NOT JUST THE PEOPLE WHO ARE APPLYING. FILL OUT A LINE FOR EVERY ITEM.

<table>
<thead>
<tr>
<th>VEHICLES OR BOATS (Include cars, vans, trucks, motorcycles, tractors, recreational vehicles, boats, etc. Be sure you include all vehicles listed in anyone’s name.)</th>
<th>Name of owner(s)</th>
<th>Male/Model</th>
<th>Year</th>
<th>$ Dollar value</th>
<th>Amount still owed</th>
</tr>
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<tr>
<th>BANK ACCOUNTS AND FINANCIAL ASSETS (Include checking accounts, savings accounts, certificates of deposit, stocks and bonds, trust funds, etc.)</th>
<th>Name of owner(s)</th>
<th>Type of account</th>
<th>Amount in account</th>
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<tr>
<th>REAL ESTATE, BUSINESS OR BUSINESS EQUITY, OTHER VALUABLES</th>
<th>Name of owner(s)</th>
<th>Type of asset</th>
<th>Value $</th>
<th>Amount still owed</th>
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4. **EXPENSES**
   COMPLETE A LINE BELOW FOR EACH HOUSEHOLD MEMBER WHO PAYS CHILD CARE, DEPENDENT ELDER CARE, CHILD SUPPORT, ALIMONY, HEALTH INSURANCE OR MEDICAL EXPENSES.

<table>
<thead>
<tr>
<th>Type of expense</th>
<th>Name of person paying expense</th>
<th>Name of person cared for</th>
<th>Amount paid this month</th>
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</thead>
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</table>

4. Do not include the home you live in. List all other real estate owned by anyone living in your home. Include personal items over $1,000, such as life insurance with a cash value.

5. Please provide receipts, cancelled checks, or other proof of how much and when you paid any medical expenses.

5. Do not combine expenses. For example, if a household member pays child care, list the amount paid for each child on a separate line.
Colorado Health Care Programs

signature form

1. CHECK EACH BOX AFTER YOU ATTACH A COPY OF YOUR DOCUMENTS.

☐ An INS card, if available, for any non-citizen who will receive care. Copy front and back.

☐ If pregnant, a doctor’s statement showing due date.

☐ Proof of income: Pay stubs or letters from employers that show all earnings for one calendar month: either the previous month (days 1 through 31), or this month if you’ve already received a whole month’s salary.

☐ If covered by insurance, a copy of the insurance card (front and back), if available. (Remember, CHP+ needs you to complete the health insurance form on page 5.)

☐ If requesting Medicaid to cover old medical bills, proof of income back to the month of the bill.

☐ Proof of payment for most recent month of medical expenses.

2. PUT YOUR INITIALS HERE TO TELL US THAT YOU READ “WHAT YOU SHOULD KNOW” ON THE INSIDE COVER. (WE WILL NOT PROCESS YOUR APPLICATION UNLESS YOU COMPLETE THIS SECTION.)

3. READ BELOW, THEN SIGN, PRINT YOUR NAME AND DATE. (WE WILL NOT PROCESS YOUR APPLICATION UNLESS YOU COMPLETE THIS SECTION.)

By signing this Application for Colorado Health Care, I am giving my permission to the State of Colorado and its designees to make the necessary contacts to verify my statements made on this application. By signing this application, I hereby assign to the Department of Health Care Policy and Financing all rights I may have to medical support or payments for medical expenses from any other person on my own behalf or on behalf of any other member of my family listed on this application.

Sign Here: ___________________________ Print Name Here: ___________________________

Date: ___________________________
The Department of Health Care Policy and Financing is the state agency responsible for administering Medicaid, CICP, and CHP+. I may request a Fair Hearing if I disagree with any action taken by Medicaid when this application is processed. Information on how to request a Fair Hearing is printed on the back of all notices of action sent by Medicaid.

I may request an appeal if I disagree with my rating for CICP or CHP+. Information on this process is included in all notices of action sent by CHP+ or available from the CICP provider where my application was processed.

This application will be reviewed without regard to race, color, sex, age, disability, religion, national origin, or political belief.

I do NOT have to give information on citizenship or immigration status of family members who are NOT applying for health care benefits.

If my family is enrolled in Medicaid or CICP and other insurance is paying for their medical care, Medicaid or CICP will pay last.

The information given on this application may be reviewed and verified by my county Department of Human Services, the Department of Health Care Policy and Financing, or its designees.

I must show proof that my family is eligible for benefits.

If I receive Medicaid, I must tell my county Department of Human Services within 10 days of any changes to my case.

The information I have given is confidential. However, it can be used or disclosed by the program(s) in which my family member(s) is enrolled for purposes of treatment, payment, program operations, and other purposes permitted by law.

If I give false information on purpose so that my family member(s) can get health care, I must pay the program(s) back for any medical care received.

It is a crime punished by fines and/or jail time to take benefits that I know I am not eligible to get.

I am responsible for paying appropriate fees and co-payments for myself and my family if they are required.

I must cooperate fully with State and federal staff if my case is reviewed.

By signing the Application for Colorado Health Care I understand the following:

Please complete and return all forms (pages 1-8) and keep the cover for your information.
Get the health care your family needs at a price you can afford! Fill out this form to apply for Colorado health coverage: Medicaid and Child Health Plan Plus (CHP+).

**Health Coverage for Your Family**

**How do I apply?**
- **State of Colorado**
  - Department of Health Care Policy and Financing
  - Medicaid
  - Child Health Plan Plus
  - Medically Indigent / Colorado Indigent Care Program
  - www.chcpf.state.co.us

**What will Medicaid or CHP+ cost my family?**
- There are no monthly payments (premiums) or co-payments for children or pregnant women who qualify for Medicaid. Adults may have a small co-payment for each doctor visit or prescription (medicine).
- Some families with children who qualify for CHP+ will pay a small annual enrollment fee. At most, the annual enrollment fee will be $35, no matter how many children are covered. Some families may also have to make small co-payments when they receive services or prescriptions. Payments for most services are between $1 and $5.

**Who is qualified?**
- Medicaid is for families and pregnant women.
- CHP+ is for children 18 years of age and younger. Chances are someone in your family may be covered by one of these programs.

**What is covered?**
- Regular checkups
- Hospital care
- Doctor visits
- Medicine
- Shots
- Mental health care
- Prenatal and postpartum care
- Dental

**How do I apply?**
- Give your family every chance to qualify by filling out all of the forms. BE SURE TO SIGN THE FORM and include copies of all the things we ask you to send (like paycheck stubs). We can’t see if you qualify until all of the forms are filled out and we have all of the things we need!

**What documents do I need?**
- ✓ Paycheck stubs or a letter from the employer for each working person in the household showing gross earnings for the previous month or this month, if the whole month’s earnings have been received.
- ✓ If anyone applying is pregnant, a note from the doctor that says when the baby is due.
- ✓ Proof of payment for medical expenses.
- ✓ Do you need Medicaid to pay for health care received in the last 3 months? If yes, provide proof of income for those months.
- ✓ An INS card, if available, for anyone who will receive care.

**What do I do when I have filled in all of the forms and have copies of documents?**
- You can take the application back to the place where you picked it up or mail it to the place where you picked it up. When do I know if I qualify?
- It can take from 2 weeks up to 2 months to let you know if you qualify. We will send you a letter telling you if you are qualified and for which program. It is possible one child may qualify for Medicaid and another for CHP+. If you do not qualify, we will send you a letter telling you why not.

**Colorado Indigent Care Program (CICP)**
- If you are not eligible for Medicaid or CHP+, you may be able to receive limited services through a CICP provider. To find a CICP provider near you, go to the Department of Health Care Policy and Financing’s website at www.chcpf.state.co.us and click on the CICP link.