

Section I: PATIENT/APPLICANT

Today's Date: _____

Homeless: _____

Emergency Application: _____

Last Name _____ **First Name** _____ **Middle Initial** _____

Address _____ **City** _____ **Zip Code** _____ **County** _____ **Phone Number** _____

Relationship to Patient _____ **Date of Birth** _____ **Health First CO Number** _____ **Social Security Number (CICP Only)** _____ **Health First CO/CHP + Ineligibility Codes (CICP Only)** _____ **Selected Program for Household Member (CICP, HDC, or)** _____

1. _____ PATIENT/APPLICANT

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

13. _____

14. _____

15. _____

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 _____ **FPG Percentage:** _____ **Household Size:** _____
(Line 6 times .10): \$ _____ **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 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
Patient was contacted by phone email other: _____ and documentation of contact is attached in lieu of signature.

Applicant Signature and Date

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: _____ 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 payments from STD) \$ _____ \$ _____

Unemployment Income (weekly amount multiplied by 52 to ensure correct 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 _____



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 March 2024

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



Worksheet 3 - Allowable Deductions

<u>Type of Deduction</u>	<u>Amount</u>	<u>Frequency</u>	<u>Annualized Amount</u>
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
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_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____

Household declares they have no deductions

Grand Total \$ _____

 Eligibility Technician Signature

 Date

 Facility

 Phone

Revised March 2024

If your facility includes deductions, this worksheet must be signed and included with all client applications.