COLORADO INDIGENT CARE PROGRAM
CLIENT APPLICATION

CALCULATING EQUITY IN RESOURCES		Value	Amount Owed	Equity	Minus Protected Portion	Amount to use for the CICP
7	Vehicle Equity	$____	$____	$____	$ [illegible]	$____
8	Real Property	$____	$____	$____		$____
9	Liquid Resources	$____	$____	$____		$____
10	Business Equity	$____	$____	$____	$ [illegible]	$____

11.	Total Equity in Resources (Lines 7+8+9+10)	Total Resources	$____
12	Less Family Size Deduction Family Size____	$ [illegible]	
13.	Equity in Resources for the CICP (Line 11 minus Line 12, cannot be a negative number)		$____
14.	Total Family Financial Status (Lines 6+13)		$____
15.	Minus Allowable Deductions		$____
16.	Net CICP Income and Equity in Resources (Line 14 minus Line 15)	GRAND TOTAL	$____

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 and shall be punished as provided in section 18-1-105, C.R.S.. I authorize the Department of Health Care Policy and Financing to use any information contained in the application to verify my eligibility for 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 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 the CICP that this provider has the right to be included in the claims process! **I also realize that I have the right to appeal the rate I was given within 15 days of the date I sign this application at the facility where I completed this application.**

YOU HAVE 15 DAYS TO APPEAL YOUR RATE
(Ask your eligibility technician for more information on the appeal process)

CICP Rate:________ **Prenatal Pricing Program?**_____ **Date:** ___/___/___

Client Copayment Annual Cap (Line 16 times 0.10): _______

Inpatient Facility Copayment: _______

Inpatient Physician Copayment: _____

Outpatient Copayment: _______

Prescription Copayment: ______

Prenatal Pricing Copayment: _______

____
Print or Type Applicant Name

____
Applicant Signature and Date

____
Print or Type Eligibility Technician Name

____
Eligibility Technician Signature and Date

Sterling Regional Med Center
Print or Type Facility Name

522-0122
Facility Phone Number

COLORADO INDIGENT CARE PROGRAM

Worksheet 1 - Employment Income and Unearned Income

Record all income and cash from other sources on this page and attach it to the Application

Payment Sources	*Monthly Amount*		*Annualized Amount*
Employment income	________	X 12	________
Old Age Pension	________	X 12	________
Supplemental Security Income (SSI SSDI)	________	X 12	________
Aid to Needy & Disabled	________	X 12	________
Pension plans (name plans):	________	X 12	________
________			
________			
Commissions, bonuses, & tips	________	X 12	________
Alimony received	________	X 12	________
Rental income	________	X 12	________
Interest income	________	X 12	________
Monetary gains	________	X 12	________
Trust accounts	________	X 12	________
Settlements (do not annualize, show total amount received)	________		________
Other income (list source)			
________	________	X 12	________
________	________	X 12	________
________	________	X 12	________

Total ________

(use this figure on line 1 or 2 of Section V of the application)

____
Applicant Signature *Date*

____
Eligibility Technician Signature *Date*

____
Facility *Phone*

COLORADO INDIGENT CARE PROGRAM

Worksheet 2 - Net Self-Employment Income

Record all monthly business expenses for the applicant on this page and attach it to the Application. Obtain documentation to support these expenses. Do not use tax forms for determining income.

If a self-employed person can document that they are paying themselves, do not complete this worksheet. Show their income on Worksheet 1.

	Monthly Amount		*Annualized Amount*
Gross Business Deposits	________	X 12	________
Business Expenses			
Insurance	________	X 12	________
Labor	________	X 12	________
Laundry	________	X 12	________
Merchandise/wholesale cost of inventory	________	X 12	________
Mortgage interest	________	X 12	________
Rent	________	X 12	________
Taxes	________	X 12	________
Upkeep of equipment & upkeep labor	________	X 12	________
Utilities	________	X 12	________
Supplies	________	X 12	________
Professional services	________	X 12	________
Education/Licensing/Certification	________	X 12	________
Business-related travel	________	X 12	________

Total Business Expenses ________

***Net Profit** (Gross Business Deposits minus Total Business Expenses)* ________

(use this figure on line 3 of Section V of the application)

____
Applicant Signature *Date*

____
Eligibility Technician Signature *Date*

____
Facility *Phone*

COLORADO INDIGENT CARE PROGRAM

Worksheet 3 - Monthly Expense

DO NOT COMPLETE THIS FORM IF THE CLIENT RECEIVES EMPLOYMENT INCOME AND/OR UNEARNED INCOME

Record all monthly expenses for the applicant on this page and attach it to the Application. Obtain documentation to support monthly expenses.

Expense	*Monthly Amount*	*Expense*	*Monthly Amount*
Auto insurance	$ ________	Eye exam & lenses	$ ________
Auto loan	$ ________	Groceries (food & toiletries)**	$ ________
Auto maintenance & gas	$ ________	Loans	$ ________
Child & elderly care	$ ________	Pharmacy	$ ________
Alimony (paid)	$ ________	Physicians	$ ________
Child support (paid)	$ ________	Rent/mortgage	$ ________
Credit cards	$ ________	Telephone	$ ________
Dental	$ ________	Gas, electricity, water, sewer, trash (all utilities)	$ ________
Diapers & baby formula	$ ________	Other expenses (list)	$ ________

***Do not include the value of Food Stamps or WIC*

Total $__________ X 12 months = $__________ yearly income
(use this figure on line 4 of Section V of the application)

____
Applicant Signature *Date*

____
Eligibility Technician Signature *Date*

____
Facility *Phone*

COLORADO INDIGENT CARE PROGRAM

Worksheet 4 - Allowable Deductions

Self Declared Deductions	Amount per month		Annualized Amount
Elderly Care	________	X 12	________
Day Care	________	X 12	________
Paid Alimony	________	X 12	________
Child Support	________	X 12	________
Health Insurance Premium(s)	________	X 12	________
		Sub-total	________

Paid or Outstanding Medical Bills from non-CICP provider (attach receipts) (Must be Documented)	Date paid	Amount
________	________	________
________	________	________
________	________	________
________	________	________
	Sub-total	________

Paid or Outstanding Medical Bills from CICP Provider that incurred prior to 90 days of application date (attach receipts) (Must be Documented)	Date Paid	Amount
________	________	________
________	________	________
________	________	________
________	________	________
	Sub-total	________

Grand Total ________

(use this figure on line 15 of Section V of the application)

____
Applicant Signature *Date*

____
Eligibility Technician Signature *Date*

____
Facility *Phone*

COLORADO INDIGENT CARE PROGRAM

Worksheet 5 – Check List to Screen for Child Health Plan Plus (CHP+) and Medicaid

Please complete and attach this check list to the CICP application as an explanation of not placing the child on CHP+ or the family on Medicaid.

Ineligible for CHP+ because:	Yes	No
• The child had coverage under an employer plan with at least a 50% employer contribution during the past **three** months.	___	___
• The child has other primary health insurance coverage	___	___
• The child is eligible for Medicaid	___	___
• A member of the family is eligible for health benefits coverage under a State health benefits plan or public agency in the State (i.e., employed by State Government)	___	___
• Other ______________________________		

Ineligible for Medicaid because:	Yes	No
• Have received Medicaid denial letter	___	___
• Does not meet Medicaid standard of assistance of resource level	___	___
• Individual no longer receiving SSI or SSDI	___	___
• Does not meet age requirements	___	___
• Does not meet Medicaid's definition of disability or incapacity	___	___
• Applicant is no longer pregnant	___	___
• Transitional Medicaid benefits have been discontinued	___	___
• Other ______________________________		

Use this area if additional explanation is necessary: ______________________________

____

____

______________________________ ______________________________
Applicant Signature *Date*

______________________________ ______________________________
Eligibility Technician Signature *Date*

______________________________ ______________________________
Facility *Phone*

Calculating Equity in Assets Worksheet

Vehicle Equity Table

Vehicle*	Payment	Value	Balance
Total			

*Vehicles Include: Cars, Trucks, Motorcycles, Boats, RV's

Comments: ____________________

Liquid Assets

Liquid Asset*	Value	Protected Portion	Amount Available
Checking Acct.		*************	
Savings Acct.			
CD's			
Total			

*Other Liquid Assets Include: Partnership Earnings kept in reserve, Cash Value on Life Insurance, IRA and Tax Shelter Annuities, if the applicant can withdraw funds without a penalty.

Comments: ____________________

Business Equity

Name/Source	Assets	Liabilities
Total		

Comments: ______________________________