New Medical Assistance Application Desk Aid

This desk aid explains the changes that were recently made to the Medical Assistance Application.

April 2018

Application for Health Insurance & Help Paying Costs

CONNECT for HEALTH COLORADO

COLORADO Department of Health Care Policy & Financing

Colorado.gov/PEAK

ConnectforHealthCO.com

Table of Contents added

See inside

The glossary can help better explain terms an applicant may not be familiar with

- Free or low-cost public health insurance from Health First Colorado (Colorado's Medicaid Program) or the Child Health Plan *Plus* (CHP+) program administered by the Colorado Department of Health Care Policy and Financing ⓘ
- Affordable private health insurance plans that offer comprehensive coverage available through Connect for Health Colorado ⓘ (the Marketplace), or
- A tax credit that can help lower your premiums for health coverage.

You may qualify for free or low-cost health insurance if you earn as much as $46,500 a year for an individual, or $95,000 a year for a family of 4. Filling out this application does not mean you have to buy health insurance.

Who can use this application?

Anyone can use this application. Applying will not affect your immigration status or chances of becoming a permanent resident or citizen.

Call us to get connected to free help in other languages

If someone is helping you fill out this application, you may need to complete **Worksheet A** ✎ (pages 18 - 19).

For a list of languages we can assist in, see **Things to Know**. If you need help in a language other than English, call and tell the customer service representative the language you need.

Llame a nuestro centro de servicio gratis para ayuda o para obtener una copia de esta formulario en Español.

Department of Health Care Policy & Financing's Member Contact Center

Symbols used in application explained on front page

Symbols used in this application

Worksheets are marked with the symbol ✎ in this application (starting on page 18). Terms marked with an ⓘ in the application can be found in the **Glossary** (starting on page 41).

Things to Know

Call us to get connected to free help in other languages

Español - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-221-3943 (State Relay: 711).

Tiếng Việt - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-221-3943 (State Relay: 711).

繁體中文 - 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-221-3943（State Relay: 711）。

한국어 - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-221-3943 (State Relay: 711) 번으로 전화해 주십시오.

Русский - Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Звоните 1-800-221-3943 (State relay: 711).

አማርኛ - ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ በቋ ሚከተለው ቁጥር ይደውሉ 1-800-221-3943 (መስማት ለተሳናቸው: 711).

العربية - ملحوظة: إذا كنت تتحدث اذكر فلك، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1-800-221-3943 ورقم هاتف الصم والبكم 711.

Deutsch - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-221-3943 (State Relay: 711).

Français - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-221-3943 (ATS : 711).

नेपाली - ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-221-3943 (टिटिविडी: 711).

Tagalog - PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-221-3943 (State Relay: 711).

日本語 - 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます. 1-800-221-3943（State Relay: 711）まで、お電話にてご連絡ください.

Oroomiffa - XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-221-3943 (State Relay: 711).

Polski - UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-221-3943 (State Relay: 711).

What an applicant may need to apply is listed on the application. This should be reviewed prior to starting the application

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants) for everyone in your household who needs insurance
- Employer and income information for everyone in your household
- Current health insurance information, including policy number for each member of your household
- Information about any job-related health insurance available to your household

Things to Know continued on next page

Things to Know (continued)

Why do we ask for this information?

We may ask about income and other information to find what health coverage you may qualify for and if you can get help paying for it. We keep all the information you provide us private and secure, as required by law.

What happens next?

- Send or drop off your completed, signed application to one of the addresses in **Addendum A.**
- If you do not have all the information we ask for, sign and submit your application anyway. We will contact you and tell you what you need to do next.
- If you do not hear from us, please contact the agency you sent your application to (a list of agencies can be found in **Addendum A**).
- Please note:
  - It may take up to 45 days — or up to 90 days if the application requires a disability determination — from the date your application was received for a case number to be assigned to you.
  - You can check your status and benefits online through Colorado PEAK. Get more information about your case number and where to find it at: https://www.healthfirstcolorado.com/health-first-colorado/glossary/case-number-find/

Where can you find additional information or help with this application?

	Health First Colorado and CHP+	Connect for Health Colorado
Online:	Colorado.gov/PEAK	ConnectforHealthCO.com
Phone:	1-800-221-3942	1-855-PLANS-4-YOU (1-855-752-6749)
TTY/TDD:	State Relay: 711	1-855-346-3432
In Person:	Find a [illegible] at Colorado.gov/hcpfmap	[illegible] Counselors, and Agents/Brokers in your area.

For more detailed instruction please see the separate Frequently Asked Questions: Applying for Coverage

For additional information, please see the separate **Frequently Asked Questions: Applying For Coverage** available at Colorado.gov/HCPF/Apply and ConnectforHealthCO.com/resources/the-basics/customer-resources/.

Application starts on next page

Start application here

Clearly states where application starts

Step 1: Tell us about your household

Write each member of your household in the Household Relationship Table on the next page. Use the Household Relationship Table Example below as a guide. Your income and household size help us decide what programs you qualify for.

DO include the following people on your application:

- Yourself
- Your spouse*
- Your children under 19 who live with you
- Anyone on your federal income tax return
  - This could include children over 19, even if they do not live with you
- Your unmarried partner* who needs health coverage
- Anyone else under 19 who you take care of and lives with you

If you are claimed as a dependent* on someone else's federal tax return, also include:

- The person(s) who claims you
- All members of that federal tax filing household claimed as dependents
- Any family member living with you

★ Note: If someone in your household has passed away this year, you should still include them on your application. This will help us better determine what benefits you may qualify for.

★ **You DO NOT have to include other unrelated roommates.**

*Find the definitions of these words in the **Glossary** (starting on page 41).

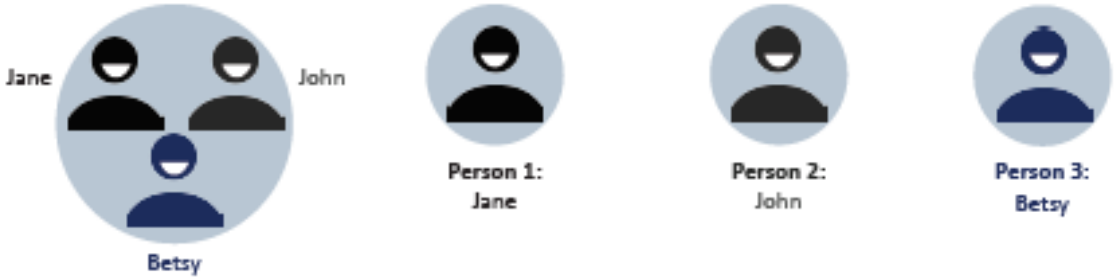
Household R… Table Example

This information is needed to get an accurate eligibility decision.

In **Step 1**, we are asking how each person in your household is related to each other.
Use the example table on the next page to help you fill out the Household Relationship Table.
When you're ready, list each person in your household on the next page.

- **Person 1 is the main contact person for this application.**
- Start with **Person 1**, and fill in the relationship that **Person 1** has to each member of the household.
- Repeat this step for **each person** listed in the household.
- **Only use the terms husband, wife, or spouse when describing people who are legally married** ("legally married" includes common law and common law registered, but does not include civil unions).

1. This household is made up of Jane, John, and Betsy.
2. Jane is the person filling out this application and is known as **Person 1.**
3. Jane and John are married to each other.
4. Betsy is Jane's daughter from a previous relationship.



Step 1 continued on next page

Worksheet A must be completed if anyone is helping the applicant complete the application (i.e., authorized representative, CAAS, brokers, etc.)

Is someone helping you fill out the application? If yes, remember to complete **Worksheet A** (pages 18 - 19).

Step 2: Person 1 (Start with yourself)

Complete Step 2 for each person in your household. Start with yourself, then add other adults and children in your household. If you have more than 2 people in your household, you can fill out **Worksheet I** (pages 31 - 34) and make copies of the pages if needed.

You do not need to provide immigration status or Social Security Number (SSN) for household members who are not applying for health coverage.

It may be necessary for the applicant to make copies of certain Worksheets in order to accurately report necessary information for all household members. It's a good idea to have extra copies of all Worksheets available at your site/office.

1. Legal Na

2. Date of Birth (mm/dd/yyyy)

4. Home A

City	State	Zip Code	County

5. Mailing Address (if different from Home Address) Apartment/Suite #

6. In Care Of (If applicable):

City	State	Zip Code	County

7. Email Address

Tip: If you would like to receive notices electronically please visit Colorado.gov/PEAK to create an account.

Members can select to receive electronic notices in their PEAK account

8. Primary Phone

9. Secondary Phone Ext Phone Type: Cell Home Work

10. Preferred Spoken Language: ☐ English ☐ Spanish Other (Please Specify):

11. Preferred Written Language: ☐ English ☐ Spanish Other (Please Specify):

Note: Information we send you in writing, including letters and emails, can only be sent in English and Spanish.

12. Are you temporarily living outside of Colorado? ☐ Yes ☐ No

13. If you are temporarily living outside of Colorado, where will you be living in Colorado when you return?

City	Zip Code	County

Step 2, Person 1 continues on next page

Step 2: Person 1 (continue with yourself)

14. Social Security Number (or Taxpayer ID):

A box for the applicant's Social Security Number has been added

If you are applying for Health First Colorado or C[illegible] and have a SSN [illegible]: we need this information. If you are applying for [illegible] the Marketplace, providing your SSN will help us t[illegible] to check income and other information to see wh[illegible]

If you do not have a SSN, and you are applying for health coverage, tell us why you do not have a SSN. If you are not eligible to receive a SSN, do you have a Taxpayer Identification Number (TIN), such as an Individual Taxpayer Identification Number (ITIN) or an Adoption Taxpayer Identification Number (ATIN)? If so, enter it above. **If you do not have a Social Security Number**, please visit http://www.ssa.gov/ssnumber/ for information on how to apply for a Social Security Number, or call the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778) for assistance.

[illegible] a SSN for valid non-work reason

- ☐ Not eligible to receive a SSN
- ☐ Refuses to obtain due to well established religious objection

15. Do you plan to file a federal income tax return next year? ☐ Yes ☐ No

Tax filer information has moved to this page

You can still apply for Health First Colo[illegible] file a federal income tax return. However, you must plan to file federal [illegible] its (APTC) or Cost Sharing Reductions (CSR) through the Marketplace.

If you selected Yes, answer questions a - f. If you selected No, skip to question 2.

a. What is your current federal income tax filing status? ☐ Single ☐ Married Filing Jointly ☐ Head of Household ☐ Married Filing Separately ☐ Qualifying Widow(er) with Dependent Child

b. If you selected "Head of Household" or "Married Filing Separately", do exceptional circumstances apply to your case? ☐ Yes ☐ No

c. If you are "Married Filing Jointly", please name your spouse:

d. Will you claim dependents on your tax return? ☐ Yes ☐ No

If Yes, list the legal name(s) of your dependents:

e. If you are a tax dependent, list who claims you as a dependent:

Is this person listed on the application? ☐ Yes ☐ No

Is this person a non-custodial parent? ☐ Yes ☐ No

f. Are you living with both parents, but your parents do not expect to file a joint federal income tax return? ☐ Yes ☐ No

Attention: On the following pages the answers to questions marked with an asterisk (*) cannot be used to determine the availability or cost of premiums for any health insurance purchased through the Marketplace. This information is necessary to ensure you and your family receive a correct determination for the program you may qualify for.

Step 2, Person 1 continues on next page

Step 2: Person 1 (continue with yourself)

50. Employer Phone	51. City	52. State	53. Zip Code

54. Wages/tips (before taxes) $	Pay Period:	☐ Daily	☐ Weekly	☐ Every 2 Weeks
		☐ Monthly	☐ Twice a Month	☐ Yearly

55. Average Hours Worked Each Week:

56. Tell us the total gross pay that you got or will get this month as a one-time payment from this employer (this could be a bonus or other extra pay you got).

57. Does your income from this job change month to month? ☐ Yes ☐ No

If Yes, fill out the Current Wages/Tips AND Expected Annual Income for this job. If No, only fill out the Current Wages/Tips in number 54 above. You do not need to fill out the Expected Annual Income.

58. Expected Annual income from this job:

59 a. Is this income from seasonal employment? ☐ Yes ☐ No

59 b. Is this income from commission-based employment (including tip based employment)? ☐ Yes ☐ No

60. Will the expected annual income from this job be the same or lower in the next calendar year? ☐ Yes ☐ No

61. **DEDUCTIONS:** Check all that apply, and give the amount and how often you pay it. Telling us about these deductions could make the cost of your health insurance lower. You should not include a cost that you already considered in your answer to job income and net self-employment.

62. Do your deductions change month to month? ☐ Yes ☐ No

If Yes, for each deduction that changes, fill out the Current Amount AND the Expected Annual Amount columns.

If you are not paying the deduction at this time, but expect to claim it on your tax return, fill out $0 for the Current Amount, and write the amount you will include on your tax return for the Expected Annual Amount.

If No, only fill out the Current Amount column. You do not need to fill out the Expected Annual Amount column.

Deduction Types:

- Alimony Paid
- Student Loan Interest
- Capital Losses
- Certain Business Expenses of Reservists, Performing Artists, or Fee-Based Government Officials
- Penalty of Early Withdrawal of Savings
- Domestic Production Activities
- Contributions to a Traditional IRA

In addition to the current amount the member must also report frequency

Type of Deduction	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only	☐ Twice Monthly
				☐ Weekly	☐ Monthly
				☐ Every 2 Weeks	☐ Yearly
Type of Deduction	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only	☐ Twice Monthly
				☐ Weekly	☐ Monthly
				☐ Every 2 Weeks	☐ Yearly
Type of Deduction	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only	☐ Twice Monthly
				☐ Weekly	☐ Monthly
				☐ Every 2 Weeks	☐ Yearly

63. Tell us the total amount of income you plan to report on your tax return that you have NOT yet included in this application and its Worksheets. Include incomes such as past employment, or benefits that you received in past months.

64. After you submit this application, we will verify your income. Please tell us if any of the following have happened to you in the past two years to help us with this verification process. Check the box and enter the date this change occurred for all reasons that apply showing why your income has changed.

- ☐ Stopped working at a job
- ☐ Hours changed at a job
- ☐ Change in Employment
- ☐ Married, Legal Separation, or Divorce
- ☐ Other:

Date the change occurred? (mm/dd/yyyy)

End of Step 2, Person 1

If the applicant is applying for more than two people they will need to complete Worksheet I for each additional household member.

Step 2: Person 2 (continue with Person 2)

Make copies of these pages if necessary.

15. Social Security Number (or Taxpayer ID):

If Person 2 is applying for Health First Colorado or Child Health Plan *Plus* (CHP+), and has a SSN, we need this information. If they are applying for help paying for health insurance costs through the Marketplace, providing their SSN will help us to quickly process their application. We use SSNs to check income and other information to see what type of health coverage they may qualify for. If Person 2 does not have a SSN, and they are applying for health coverage, tell us why they do not have a SSN. If they are not eligible to receive a SSN, do they have a Taxpayer Identification Number (TIN), such as an Individual Taxpayer Identification Number (ITIN) or an Adoption Taxpayer Identification Number (ATIN)? If so, enter it above. *If they do not have a Social Security Number, please visit http://www.ssa.gov/ssnumber/ for information on how to apply for a Social Security Number, or call the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778) for assistance.

Please answer the following:

- ☐ Have applied for a SSN*
- ☐ Only eligible to receive a SSN for valid non-work reason
- ☐ Not eligible to receive a SSN
- ☐ Refuses to obtain due to well established religious objection

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16. **Does Person 2 plan to file a federal income tax return next year?** ☐ Yes ☐ No

They can still apply for Health First Colorado, CHP+, or other health insurance even if they do not file a federal income tax return. However, they must plan to file federal taxes every year you receive Advance Premium Tax Credits (APTC) or Cost Sharing Reductions (CSR) through the Marketplace.

If they selected **Yes**, answer questions a - f. If you selected **No**, skip to question e.

a. What is Person 2's current federal income tax filing status? ☐ Single ☐ Married Filing Jointly ☐ Head of Household ☐ Married Filing Separately ☐ Qualifying Widow(er) with Dependent Child

b. If Person 2 selected "Head of Household" or "Married Filing Separately", do exceptional circumstances ⓘ apply to their case? ☐ Yes ☐ No

c. If Person 2 is "Married Filing Jointly", please name his or her spouse:

d. Will Person 2 claim dependents on their tax return? ☐ Yes ☐ No

If Yes, list the legal name(s) of their dependents:

e. If Person 2 is a tax dependent, list who claims them as a dependent:

Is this person listed on the application? ☐ Yes ☐ No

Is this person a non-custodial parent? ☐ Yes ☐ No

f. Is Person 2 living with both parents, but their parents do not expect to file a joint federal income tax return?

☐ Yes ☐ No

Attention: On the **following pages** the answers to questions marked with an asterisk (*) cannot be used to determine the availability or cost of premiums for any health insurance purchased through the Marketplace. This information is necessary to ensure you and your family receive a correct determination for the program you may qualify for.

***Step 2, Person 2** continues on next page* ⏩

Step 3: What I Should Know

Step 2 Note (page 12): If you have more than two people in your household to include, go to Worksheet I (pages 31 - 34) make additional copies as needed, and complete.

1. I know I or another applicant may be automatically provided enrollment into Health First Colorado (Colorado's Medicaid Program) or Child Health Plan *Plus* (CHP+) if we are eligible. I can visit the Health First Colorado website at Colorado.gov/PEAK for more information. I will immediately notify the State of any medical 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 Health First Colorado and receive money for the same medical bills that the State has paid, I will give the money to the State. I give the State all rights to payment for me[illegible] I also assign my right to appeal a denial of benefits by another party responsible for payment for services the state has paid. If there is an absent parent(s) from my home, I agree to seek medical support for Health First Colorado, I must seek medical support from the absent parent(s). I may contact Child Support Enforcement for assistance.

2. Federal and Colorado state law require the Department of Health Care Policy and Financing to recover all medical assistance benefits, including capitation payments, paid on behalf of Health First Colorado clients from the estates of deceased Health First Colorado clients who were permanently institutionalized. For Health First Colorado clients who were over the age of 55 when benefits were provided, the Department recovers payments for nursing facility services, home and community-based services, and related hospital and prescription drug services. There are certain exemptions to estate recovery. For further information, please contact your county and request the "Medical Assistance Estate Recovery Program" brochure.

3. If I am eligible for Advance Premium Tax Credit ("APTC"), these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC may impact my annual tax liability. I will be given the option to apply all, some or none of the APTC amount I may be eligible for to my monthly premium.

4. If I am receiving financial assistance, I know that I must tell the organization providing the assistance if information I listed on this application changes. I am aware I have 10 calendar days to report any changes if I am enrolled in Health First Colorado or Child Health Plan *Plus* (CHP+). Changes are to be reported to my local county office for Health First Colorado or to CHP+. I am responsible for paying fees, premiums and co-payments for myself and my family if they are required for Medical Assistance benefits. I know I have 30 calendar days to report any change to Connect for Health Colorado if I am receiving Advance Premium Tax Credits, Reduced Co-Pays or Deductibles, or I am enrolled in a Qualified Health Plan. If my family is enrolled in multiple insurance affordability programs, I must report changes to each organization in the appropriate time frame. I understand [illegible] could affect my eligibility and [illegible] household.

The applicants Rights and Responsibilities are listed on this page and continued on the next page. This information should be reviewed with the applicant

[illegible]s, together with any supplements [illegible]sis for the health insurance [illegible]t no insurance of financial [illegible]ctive until the date specified by [illegible]nization providing the certificate, policy, or notice. I understand that I may request a copy of the Application. I agree that a photographic copy of this application shall be as valid as the original. A legible copy signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

6. To make it easier to determine my eligibility for help paying for health coverage in future years, if I am enrolled in a Qualified Health Plan, I agree to allow Connect for Health Colorado to use income data, including information from tax returns for the next coverage year. Connect for Health Colorado will send me a notice, let me make changes, and I can opt out at any time. I can visit the Connect for Health Colorado website at ConnectforHealthCO.com for more information.

7. I understand that if I am eligible for the Advance Premium Tax Credit (APTC) and/or Reduced Co-pays and Deductibles these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or Reduced Co-pays and Deductibles may impact my coverage year(s) tax liability. I will be given the option to apply all, some, or none of any APTC amount I may be eligible for to my monthly premium.

Step 3 continues on next page

Step 3: What I Should Know (continued)

8. The Department of Health Care Policy and Financing and Connect for Health Colorado do not discriminate on the basis of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, disability, or marital status in any of its programs, services and activities. For further information about the Department's policy, to request free disability and/or language aids and services, or to file a discrimination complaint, contact: 504/ADA Coordinator, 1570 Grant St, Denver, CO 80203, Phone: 303-866-6010, Fax: 303-866-2828, State Relay: 711, Email: hcpf504ada@state.co.us. For information about Connect for Health Colorado's policy, aids and services or to file a discrimination complaint, contact: General Counsel, 3773 Cherry Creek N. Dr., Suite 1005, Phone: 303-590-9640, Fax: 303-322-4217. Complaints can also be filed with the U.S. Department of Health and Human Services Office for Civil Rights at http://www.hhs.gov/ocr/filing-with-ocr/index.html.

9. I know that it is unlawful to receive APTC and CSR from two state Marketplaces at the same time. I have agreed to submit this application for myself and/or my family. By signing this application, I certify that I have reviewed this application; that I understand and agree to the Rights, Responsibilities, and Penalties; and that under the penalty of perjury, I certify the information I have given is true including the information concerning citizenship and alien status. This means I have provided true answers to all the questions on this form to the best of my knowledge. This certification extends to Producers or other persons filing out an application on behalf of an applicant. I know that if I am not truthful, there may be a penalty. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purposes of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance.

My right to appeal:

10. If I think Health First Colorado/Child Health Plan *Plus* (CHP+) or Connect for Health Colorado has made a mistake, I can appeal the decision. To appeal means to tell someone at Health First Colorado/CHP+ or Connect for Health Colorado that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting Health First Colorado at 1-800-221-3943, or I can contact the Marketplace at 1-855-PLANS-4-YOU or by visiting their website at ConnectforHealthCO.com. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Additional Information

Domestic violence information and services are available to me. If I ever feel I am in immediate danger I will call 911. If I would like to receive information regarding safety and services in Colorado, I will call the Colorado Coalition Against Domestic Violence at 303-831-9632 or toll free at 1-888-778-7091. I may also find the location of services near me by going to http://www.colorado.gov/cdhs/dvp. The National Domestic Violence Hotline at 1-800-799-SAFE (7233) or TTY 1-800-787-3224 or

When assisting an applicant make sure that they check this box so we can verify their information electronically

Acknowledge (check box below)

☐ **By checking this box,** I agree to allow my information to be used and collected from the data sources for this application, including information from federal tax returns. I have consent from all people I list on the application allowing collection of information about them from data sources for this application. (See full **Privacy Statement** on page 17.)

Instructions on how to appeal an eligibility decision are located on this page

Step 3 continues on next page

Step 3: What I Should Know (continued)

This is a new question that will allow Connect for Health Colorado to verify the household's information, and is important that applicant read it.

☐ I do not give Connect for Health Colorado permission to validate my income data against federal sources.

Sign Here

The application MUST be signed to be valid

Sign this application. The person who filled out STEP 1 should sign this application. If you are an authorized representative, you may sign here as long as you have provided the information required in **Worksheet A** (pages 18 - 19).

Person 1 signature or Authorized Representative	**Date** (mm/dd/yyyy)

If you are signing this application outside of Open Enrollment make sure you review **Worksheet H** (page 30). Open Enrollment begins November 1 and ends January 31.

The next two (2) questions are used to figure out if you qualify for services from the Healthy Communities Program through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions of Health First Colorado (Colorado's Medicaid Program). These questions are optional.

1. Special services may be available to children and pregnant women. Please check the health services that any pregnant women or children ☐ Medical Services ☐ Prescriptions ☐ Mental or Behavioral Health Services ☐ School or Health Services

This is a reminder that it may be necessary to fill out additional Worksheets based off of information reported in the main body of the application

2. Has any child in the doctor ☐ Yes ☐ No

Attention: You may not be done

- Did you get help with this application? Fill out **Worksheet A** (pages 18 - 19).
- Does one of the following apply to anyone on the application? If yes, fill out **Worksheet B** **to find out if you qualify for additional services** (pages 20 - 24).
  - A person on the application has a medical or developmental condition that has lasted, or is expected to last, more than 12 months, including blindness.
  - A person on the application needs help with some or all of his/her self-care activities (bathing, dressing, eating, or using the bathroom).
  - A person on the application is in, or has been in a medical facility (such as a nursing home, hospital, mental health institution, or a group home) within the last 90 days.
  - Qualify for or enrolled in Medicare.
- Qualifies for or is enrolled in: Medicare, TRICARE, Peace Corp, Other State or Federal Health Benefit Program, VA Health Care Benefits, or Other Coverage fill out **Worksheet C** (page 25).
- Qualifies for or is enrolled in insurance from an employer: fill out **Worksheet D** (page 26).
- American Indian/Alaska Native? Fill out **Worksheet E** (page 27).
- Self-employed? Fill out **Worksheet F** (page 28).
- Other income that is not from a job or self-employment? Fill out **Worksheet G** (page 29).
- Applying outside of Open Enrollment and had a life change event in the past 60 days? Fill out **Worksheet H** (page 30).
- More than two people in the household? Fill out **Worksheet I** (pages 31 - 34) for each additional person.

End of Step 3

Person 1 Name: | Date of Birth:

Worksheet A Tell Us About Who Is Helping You With Your Application

If anyone helped the applicant complete the application (i.e., authorized representative, CAAS, brokers, etc.) Worksheet A must be completed.

Section A: Authorized Representative or Organization

You can choose an Authorized Representative. An Authorized Representative is a trusted person or organization who you choose to help you with your application. We need your permission so that your Authorized Representative can talk with us about this application, see your information, and act for you on all issues related to your health coverage. If you ever want to change your Authorized Representative, or no longer want an Authorized Representative, contact Health First Colorado & CHP+ or Connect for Health Colorado.

1. Is your authorized representative an: ☐ Individual ☐ Organization

2. Authorized Representative First Name: | Middle Name: | Last Name:

3. Organization/Company Name (if applicable) | 4. Organization/Company ID (if applicable)

5. How is the Authorized Representative related to you? (if applicable)

6. Authorized Representative's address (leave blank if you don't have one) | Apartment/Suite #

7. In Care Of (if applicable):

8. City | 9. State | 10. Zip Code | 11. County

12. Email Address

13. Phone | Ext.

14. Do you want your Authorized Representative to receive copies of your notices/communications? ☐ Yes ☐ No

By signing, you allow the Authorized Representative to sign your application, get information about this application, and act for you on all future matters with this agency and/or Connect for Health Colorado.

Applicant's Signature | Date (mm/dd/yyyy)

Worksheet A continues on next page

Person 1 Name: | Date of Birth:

Worksheet B Aged, Blind, Disabled, & Long Term Care

If an applicant meets one of the following: 65+, have a disability, blind, need Long Term Services and Supports, have Medicare (or eligible) or receive SSI or SSDI Worksheet B must be completed

The information in Worksheet B is needed to find out if individuals that are 65 years of age or older, have a disability, blind, need Long Term Services and Supports, have Medicare (or eligible) or receive SSI or SSDI are for medical assistance or a medical facility or need help with activities of daily living, you have the option to complete Worksheet B. Worksheet B must be completed for individuals that are 65 and older, and/or who are blind, have a disability, need Long Term Services and Supports, have Medicare (or eligible) or receive SSI or SSDI. The Department of Human and Social Services (see a list in Addendum A) reserves the right to request additional information if we need to add more information please make a copy of this worksheet.

Additional Income

1. Your Name (First, Middle, Last): | Date of Birth:

2. Tell us about **Additional Income** you or your spouse received this month or last month. **Do not repeat** income that may have already been listed on earlier income pages.

☐ No Additional Income.

Examples of **Additional Income** include:

- Public Cash Assistance
- Railroad Retirement
- Rental Income
- Survivor Benefit
- Retirement/Pension
- Social Security Benefit
- Supplemental Security Income
- Social Security Disability Insurance
- Veterans Benefit
- Veteran Widow Benefit
- Child Support
- Dividends/Interest
- Alimony
- Unemployment
- Worker's Compensation
- Disability Benefit
- Financial Aid
- Other Cash Received Monthly
- Employment Income

Type of income	Month received	Who it is for?	Monthly amount before taxes and deductions

3. Tell us about **Expenses** you or your spouse have this month or last month. **Do not repeat** expenses that may have already been listed on earlier pages.

☐ No Expenses.

Examples of **Expenses** include:

- Child Care
- Dependent Elder Care
- Medical Expenses
- Health Insurance Premiums
- Mortgages(1st, 2nd, 3rd)
- Heating
- Cooking
- Child Support
- Alimony
- Facility
- Medical
- HOA Fees
- Phone/Cell
- Prescriptions
- Rent
- Water
- Sewer
- Trash
- Electricity
- Care Provider

Type of expense	Who pays this expense?	Who is it for?	Month	Amount

Worksheet B continues on next page

Person 1 Name: | Date of Birth:

Worksheet C Tell Us About Household Member(s) With Other Health Coverage

Part 1

If anyone in the household has access to health insurance, even if not currently enrolled Worksheet C must be completed .

If you or anyone in your household are currently enrolled in any of the following types of coverage, please fill out the table below. If there are more than four individuals in your household that are enrolled in this coverage, please make a copy of this Worksheet.

- TRICARE
- Peace Corps
- Other State or Federal Health Benefit Program

Name of Person Enrolled	Type of Coverage From List Above	Insurance Company Name	Policy Number

Part 2

If you or anyone in your household are currently enrolled in any of the following types of coverage, please fill out the table below. If there are more than four individuals in your household that are enrolled in this coverage, please make a copy of this Worksheet.

- VA Health Care Benefits
- COBRA
- Retired Health Plan

Name of Person Enrolled	Type of Coverage From List Above	Insurance Company Name	Policy Number

End of Worksheet C

Person 1 Name: | Date of Birth:

Worksheet D — Tell us About Household Member(s) Who Can Get Health Insurance from an Employer

If anyone in the household has access to health insurance, even if not currently enrolled Worksheet D must be completed.

First and La[st Name of Employee Offered Co]verage | Date of Birth (mm/dd/yyyy)

Who else in your household has access to this coverage? If there are more than four individuals in your household that have access to coverage, please make a copy of this Worksheet.

Household Member's Name	Is this person eligible but not enrolled, or is this person enrolled? Check the box that applies.	Date your insurance could have started (mm/yyyy)
	☐ Eligible but not enrolled ☐ Enrolled	
	☐ Eligible but not enrolled ☐ Enrolled	
	☐ Eligible but not enrolled ☐ Enrolled	
	☐ Eligible but not enrolled ☐ Enrolled	

Employer Name

Employer Phone | Employer Identification Number (EID) ☐☐—☐☐☐☐☐☐☐

Employer Address | City | State | Zip Code

A health plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. In other words, in most cases a plan that meets minimum value will cover 60% of covered medical costs. You'd pay 40%. Most job-based plans meet the minimum value standards. **Do you have access to an employee-only health plan that meets the minimum value standard health plan?** ☐ Yes ☐ No

If yes, what is the name of the lowest-cost plan offered only to the employee (do not include family plans):

☐ I don't know.

How much would you pay in premiums for this plan?

How often do you pay this premium? ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly ☐ I don't know ☐ Other:

Does your employer offer wellness programs to the employee (do not include family plans)? ☐ Yes ☐ No

If yes, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs: $

What change, if any, will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan that meets the minimum value standard and is available to the employee only. (Premium should reflect the discount for the wellness program).

How much will the employee have to pay in premiums for that plan? $

Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly ☐ Twice a Month ☐ I don't know

Date of change (mm/dd/yyyy):

End of Worksheet D

Person 1 Name: | Date of Birth:

Worksheet E

Tell us About Household Member(s) Who Are American Indian or Alaska Native

To qualify for American Indian/Alaska Native Cost-Sharing benefits, and the Special Enrollment Periods, this Worksheet must be filled out.

Complete this Worksheet for each person in your household who is American Indian or Alaska Native (AI/AN). Submit this Worksheet with your application. We may request proof of your status. American Indians and Alaska Natives may get services from the Indian Health Services, Tribal Health Programs, or Urban Indian Health Programs or through a referral from one of these programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

Certain money you receive may not count as income for determining if you qualify for Health First Colorado or CHP+. List any income (type, amount, and how often) reported on your application that includes money from these sources:

- Per capita payments from a Tribe that come from natural resources, usage rights, leases or royalties.
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).
- Money from selling things that have cultural significance.

AI/AN Person A Name and Income from above sources:

(Print Name) First | Middle | Last | Suffix

Income Type:	Amount	How often?

Member of a federally recognized Tribe? ☐ Yes ☐ No	If Yes, Tribe name:	State Tribe is located in?

AI/AN Person B Name and Income from above sources:

(Print Name) First | Middle | Last | Suffix

Income Type:	Amount	How often?

Member of a federally recognized Tribe? ☐ Yes ☐ No	If Yes, Tribe name:	State Tribe is located in?

AI/AN Person C Name and Income from above sources:

(Print Name) First | Middle | Last | Suffix

Income Type:	Amount	How often?

Member of a federally recognized Tribe? ☐ Yes ☐ No	If Yes, Tribe name:	State Tribe is located in?

AI/AN Person D Name and Income from above sources:

(Print Name) First | Middle | Last | Suffix

Income Type:	Amount	How often?

Member of a federally recognized Tribe? ☐ Yes ☐ No	If Yes, Tribe name:	State Tribe is located in?

Indian Health Services	Check all that apply
1. Who in the household has received a service from the Indian Health Service, a Tribal Health Program, or Urban Indian Health Program or through a referral from one of these programs?	☐ Person A ☐ Person C ☐ Person B ☐ Person D
2. If none, who in the household is eligible to receive services from the Indian Health Service, a Tribal Health Program, or Urban Indian Health Program or through a referral from one of these programs?	☐ Person A ☐ Person C ☐ Person B ☐ Person D

End of Worksheet E

This Worksheet must be completed for each household member that is self-employed. If a household member has more than one business a separate Worksheet must be completed for each business.

Person 1 Name: Birth:

Worksheet F
Tell us About Household Member(s) Who Have Self-Employment

Make copies of these pages if necessary.

1. First and Last Name

2. Date of Birth (mm/dd/yyyy)

3. What type of self-employment do you have? ☐ Day Care ☐ Self-Employment Farming ☐ Sale of Crops ☐ Sale of Livestock/Poultry ☐ Other:

4. What is the name of your self-employment business?

5. Are you the only owner of the business? ☐ Yes ☐ No

If no, please answer the questions at right. If yes, please skip to question 6.

How many owners are there (including yourself)?

What percent of the business do you own?

6. How much money does your self-employment business make? Give us the amount the business earns before any taxes, deductions, or expenses are taken out. If your income changes from month to month, tell us your Current Gross Monthly Amount (6a) AND your Expected Annual Amount (6b) AND if you expect your Expected Annual Amount will be the same or lower for the next calendar year (6c). If your income is the same each month, then only tell us your Current Gross Monthly Amount (6a).

6a. Current Gross Monthly Amount:

6b. Expected Annual Amount:

6c. Will the Expected Annual Amount from this self employment be the same or lower in the next calendar year? ☐ Yes ☐ No

7. Do you have any monthly self-employment expenses? ☐ Yes ☐ No
If yes, list all of your self-employment expenses below.
If you need more space to report all of your expenses make a copy of this page. For a more extensive list [illegible] available at Colorado.gov/HCPF/Apply and ConnectforHealthCO.com/resources/the-basics/customer-resources/. If your self-employment expenses change month to month, fill out [illegible] self-employment expenses do not change month to month, you only need to fill out the Current Amount.

It is best for the applicant to report <u>all</u> possible information on income and expenses, and let the system do the income calculations.

Types of Expenses can include but are not limited to:

- Business rent
- Labor/employee salaries
- Certain business taxes paid
- Business interest paid
- Cost of goods sold
- Utility costs for your business
- Business equipment costs
- Other business costs

Type of Expense	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only ☐ Twice Monthly ☐ Weekly ☐ Monthly ☐ Every 2 Weeks ☐ Yearly
Type of Expense	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only ☐ Twice Monthly ☐ Weekly ☐ Monthly ☐ Every 2 Weeks ☐ Yearly
Type of Expense	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only ☐ Twice Monthly ☐ Weekly ☐ Monthly ☐ Every 2 Weeks ☐ Yearly
Type of Expense	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only ☐ Twice Monthly ☐ Weekly ☐ Monthly ☐ Every 2 Weeks ☐ Yearly
Type of Expense	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only ☐ Twice Monthly ☐ Weekly ☐ Monthly ☐ Every 2 Weeks ☐ Yearly

End of Worksheet F ✖

Person 1 Name:	Date of Birth:

Worksheet G
Tell us About Your Household Member(s) Who Have Other Income

1. First and Last Name	2. Date of Birth (mm/dd/yyyy)

If anyone in the household has Unearned Income Worksheet G must be completed

Section A: Grants, Scholarships, or Work Study

2. Does this person have any income from Grants, Scholarships, or Work Study?

☐ Yes ☐ No If yes, answer questions 3 and 4 below.
If no, skip to Section B.

3. What is the amount ($) of Grants, Scholarships, and/or Work Study this person used for living expenses this month? ______

4. What is the taxable amount ($) of Grants, Scholarships, and/or Work Study this person received for the year? ______

Section B: Other Income

Please list all your other income below.

5. Does your other income type change month-to-month? ☐ Yes ☐ No

If yes, fill out the Current Amount AND Expected Annual Amount columns for each type of other income that applies to you. If no, you do not need to fill out the Expected Annual Amount column.

You do not need to report any money from the following types because they are not considered income: Supplemental Security Income (SSI), Veterans Benefits, Child Support Payments, Adoption Assistance Program, Workers Compensation, or Gifts.

Types of Other Income can include but are not limited to:
- Unemployment
- Social Security
- Spousal maintenance/alimony
- Net Capital Gains
- Retirement/Pensions
- Dividends/Interest
- Net Farming/Fishing
- Net Rental/Royalty
- Other

Type of Income	Current Amount	Expected Annual Amount	Frequency		
				☐ One Time Only ☐ Weekly ☐ Every 2 Weeks	☐ Twice Monthly ☐ Monthly ☐ Yearly
Type of Income	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only ☐ Weekly ☐ Every 2 Weeks	☐ Twice Monthly ☐ Monthly ☐ Yearly
Type of Income	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only ☐ Weekly ☐ Every 2 Weeks	☐ Twice Monthly ☐ Monthly ☐ Yearly
Type of Income	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only ☐ Weekly ☐ Every 2 Weeks	☐ Twice Monthly ☐ Monthly ☐ Yearly
Type of Income	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only ☐ Weekly ☐ Every 2 Weeks	☐ Twice Monthly ☐ Monthly ☐ Yearly

End of Worksheet G ⊗

Person 1 Name: | Date of Birth:

Worksheet H — Tell us About Household Member(s) Who Have a Life Change Event

For applicants applying outside of the Open Enrollment Period, they must have a Qualified Life Change Event to enroll through a Special Enrollment Period with Connect for Health Colorado. If this worksheet is not completed, the applicant may not be able to enroll.

If you need more space to fill in the names of the [illegible] who experienced the Life Change Event you are reporting, make a copy of this Worksheet before filling in this page.

Note: The loss of other health insurance can be reported up to 60 days before you lose the other insurance. Members of federally recognized tribes and Alaska Natives can enroll in coverage through Connect for Health Colorado any time of the year.

1. Someone lost health insurance in the last 60 days, or expects to lose health insurance in the next 60 days.

Name(s)	Date coverage ended or will end (mm/dd/yyyy)

2. Someone got married in the last 60 days.

Name(s)	Date of marriage (mm/dd/yyyy)

3. Someone was released from incarceration, detention, or jail in the last 60 days.

Name(s)	Date of release (mm/dd/yyyy)

4. Someone gained eligible immigration status within the last 60 days.

Name(s)	Date status changed (mm/dd/yyyy)

5. Someone was born, adopted, placed for adoption, or placed for foster care in the last 60 days.

Name(s)	Date (mm/dd/yyyy)

6. Someone moved in the last 60 days.

Name(s)	Date of move (mm/dd/yyyy)	Zip code of previous address

7. Someone became a member of a federally recognized American Indian or Alaska Native Tribe.

Name(s)	Date of membership (mm/dd/yyyy)

The Qualified Life Change Event must fall within the time period listed for each option. For example, if the customer is applying outside of the Open Enrollment Period, and he/she moved to Colorado from another state, to qualify for a Special Enrollment Period they had to have moved here within the last 60 days. Individuals have 60 days from their Qualified Life Change Event to apply and enroll in a plan.

End of Worksheet H

Person 1 Name: | Date of Birth:

Worksheet I — Tell us About Household Member(s)

Make copies of these pages if necessary.

Person #

Use this Worksheet for additional household members by filling in the number of the person each page applies to (example, PERSON 3, PERSON 4, etc.). Make additional copies and attach if necessary.

1. Legal Name (First) (Middle) (Last) Suffix

If a household has more than two members Worksheet I must be completed for each additional household member

City | State | Zip Code | County

5. If this person is 18 years or older, would they like to receive their own mail about their health coverage? If yes, please fill out mailing address below. ☐ Yes ☐ No

6. Mailing Address (if different from Home Address) Apartment/Suite #

7. In Care Of (if applicable):

City | State | Zip Code | County

8. Email Address

9. Primary Phone | Ext | Phone Type: ☐ Cell ☐ Home ☐ Work

10. Secondary Phone | Ext | Phone Type: ☐ Cell ☐ Home ☐ Work

11. Preferred Spoken Language: ☐ English ☐ Spanish | Other (Please Specify):

12. Preferred Written Language: ☐ English ☐ Spanish | Other (Please Specify):

13. Is this person temporarily living outside of Colorado? ☐ Yes ☐ No

14. If this person is temporarily living outside of Colorado, where in Colorado will they be living when they return?

City | Zip Code | County

15. Social Security Number (SSN)

If THIS PERSON is applying for Health First Colorado or Child Health Plan *Plus* (CHP+), ⓘ and have a SSN, we need this information. If they are applying for help paying for health insurance costs through the Marketplace, providing their SSN will help us to quickly process THIS PERSON's application.

Worksheet I continues on next page ⏩

This section includes contact information for county offices. Applications can be returned to the applicants county of residence or to Connect for Health Colorado

Addendum A — Connect for Health Colorado and County Mailing Addresses

Connect for Health Colorado - Individual Applications
P.O. Box 35681
Colorado Springs, CO 80935
Phone: 1-855-752-6749; Fax: 1-855-346-3175
Write your Marketplace Account number on each page if you have one.

Adams - Department of Human Services
7190 Colorado Boulevard
Commerce City, CO 80022
Phone: 303-227-2800; Fax: 303-227-2380

Alamosa - Department of Human Services
P.O. Box 1310
Alamosa, CO 81101
Phone: 719-589-2581; Fax: 719-589-9794

Arapahoe - Department of Human Services
14980 East Alameda Drive
Aurora, CO 80012
Phone: 303-636-1170; Fax:

Archuleta - Department of Human Services
P.O. Box 240
Pagosa Springs, CO 81147
Phone: 970-264-2182; Fax: 303-636-1426

Baca - Department of Public Welfare
772 Colorado Street
Springfield, CO 81073
Phone: 719-523-4131; Fax: 719-523-4820

Bent County - Department of Social Services
215 2nd Street
Las Animas, CO 81054
Phone: 719-456-2620; Fax: 719-456-2640

Boulder - Department of Housing and Human Services
P.O. Box 471
Boulder, CO 80306
Phone: 303-441-1000; Fax: 303-441-1523

Broomfield - Department of Health and Human Services
#6 Garden Center
Broomfield, CO 80020
Phone: 720-887-2200; Fax: 303-469-2110

Chaffee - Department of Human Services
P.O. Box 1007
Salida, CO 81201
Phone: 719-530-2500; Fax: 719-539-6430

Cheyenne - Department of Human Services
560 West 6th North
P.O. Box 146
Cheyenne Wells, CO 80810
Phone: 719-767-5629; Fax: 719-767-5101

Clear Creek - Department of Health and Human Services

The Addendum contains additional information for the client. It should be detached and given to the client.

Conejos - Department of Social Services
P.O. Box 68
Conejos, CO 81129
Phone: 719-367-5455; Fax: 719-376-2389

Costilla - Department of Social Services
233 Main Street, Suite A
San Luis, CO 81152
Phone: 719-672-4136; Fax: 719-672-4141

Crowley - Department of Human Services
631 Main Street, Suite 100
Ordway, CO 81063
Phone: 719-267-3456; Fax: 719-267-5296

Custer - Department of Human Services
P.O. Box 929
Westcliffe, CO 81252
Phone: 719-783-2371; Fax: 719-783-0163

Questions?

Thank You!