Colorado Indigent Care Program Manual

Fiscal Year 2020-21

Section IV: Application

Effective July 1, 2020

CICP
Colorado Indigent Care Program

Table of Contents

CICP
Colorado Indigent Care Program

CLIENT APPLICATION
Hospitals and Hospital Based Clinics

Section I: APPLICANT

Homeless: _____

Today's Date: _____ Emergency Application: _____

Last Name | **First Name** | **Middle Initial**

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

List Household Members	Dependent Code	Date of Birth	Health First CO Number	Social Security Number	Residency Code	Health First CO/CHP+ Ineligibility Codes
1. APPLICANT						
2.						
3.						
4.						
5.						
6.						
7.						

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. Total Liquid Resources	$	
6. Household Size Protected Amount	Household Size: _____ X _____ =	$
7. Available Resources (cannot be negative)	$	

8. Total Household Financial Status (Lines 4 + 7)	$
9. Allowable Deductions **(See Worksheet 3)**	$
10. Net Household Financial Status (Lines 8 - 9)	$
11. Liquid Asset Spend Down	$
12. **Grand Total** Net CICP Income (Lines 10 - 11)	$

FPL Percentage: _____ **Client Copayment Annual Cap (Line 12 times percentage chosen):** $_____

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. In addition, misrepresenting my eligibility for assistance under this program is a Class 2 Misdemeanor (26-15-112, C.R.S.). I authorize the provider to use any information contained in the application to verify my eligibility for assistance under 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 assistance under this program that the provider has the right to be included in the claims process. If applicable, I understand that legal immigrants receiving assistance under this program shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997. **I understand it is my responsibility to notify the provider of an income or household change that may influence the rating on this application and failure to do so voids this application.**

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

Print Applicant Name	Applicant Signature and Date
Print Eligibility Technician Name	Eligibility Technician Signature and Date
Print Facility Name	Facility Phone Number

Application Notes:

Section 1.02 Ineligibility Code Legend

Dependent Codes

1. Self
2. Spouse/Civil Union Partner
3. Minor
4. Senior
5. Adult Student
6. Other

Residency Codes

1. Colorado Resident & U.S. Citizen
2. Colorado Resident & Lawfully Present
3. Migrant Farm Worker & U.S. Citizen
4. Migrant Farm Worker & Lawfully Present
5. Counted in Household Size Only

Medicaid/CHP+ Ineligibility Codes

A. Has the Applicant Received a Medicaid/CHP+ Denial Letter?

B. Applicant is not a U.S. Citizen, has been lawfully present for less than 5 years, and does not have refugee status

C. Transitional Medical Benefits have been discontinued

D. Over Income for Medicaid and is:

   a. NOT A CHILD

   b. NOT PREGNANT

   c. NOT DISABLED

E. Has Primary Insurance - NOT Eligible for CHP+

F. **Other - Provide a brief Explanation**

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Colorado Indigent Care Program

Worksheet 1 - Earned and Unearned Income

Payment Sources	Monthly Income	Annualized Income		
Earned Income:				
Employment Income	$	$		
Monthly Unearned Income Sources:			Documented	Self-Declared
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐

Annual or One Time Income Sources:

			Documented	Self-Declared
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
Earned Income Total	$ _____	$ _____		
Unearned Income Total	$ _____	$ _____		
Total Income	$ _____	$ _____		

_____

Applicant Signature Date

_____

Eligibility Technician Signature Date

_____

Facility Phone

Revised 2020-21

This worksheet must be signed and included with all client applications.

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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: _____

	Monthly	Annualized
Revenue:		
Gross Business Income	$	$
Business Property Expenses:		
Mortgage/Rent of Business Property	$	$
Utilities	$	$
_____	$	$
_____	$	$
Other Expenses:		
Advertising	$	$
Businees 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	$	$

_____	$ _____	$ _____
_____	$ _____	$ _____
Day Care Provider Reductions (if applicable)	$ _____	$ _____
Total Expenses:	$ _____	$ _____
Total Expenses Attributed to Business:	$ _____	$ _____
Net Profit	$ _____	$ _____ (use this figure on line 3, Section II of the CICP Application)

Applicant Signature _____ Date _____

Eligibility Technician Signature _____ Date _____

Facility _____ Date _____

Revised 2020-21

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

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Worksheet 3 - Allowable Deductions

Type of Deduction	Amount	Frequency	Annualized Amount
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
		Grand Total	$

Applicant Signature Date

Eligibility Technician Signature Date

Facility Phone

Revised 2020-21

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

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Worksheet 4 - Liquid Resources - HOSPITAL AND HOSPITAL BASED CLINIC USE ONLY

Type of Liquid Resource	Value
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
Total Value	$

Applicant Signature Date

Eligibility Technician Signature Date

Facility Date

Revised 2020-21

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

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CLIENT APPLICATION
Clinics

Section I: APPLICANT

Homeless: _____

Today's Date:

Emergency Application:

Last Name | **First Name** | **Middle Initial**

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

List Household Members	Dependent Code	Date of Birth	Health First CO Number	Social Security Number	Residency Code	Health First CO/CHP+ Ineligibility Codes
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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	$	

FPL Percentage: _____ **Client Copayment Annual Cap (Line 6 times percentage chosen):** $ _____

Revised 2020-21

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. In addition, misrepresenting my eligibility for assistance under this program is a Class 2 Misdemeanor (26-15-112, C.R.S.). I authorize the provider to use any information contained in the application to verify my eligibility for assistance under 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 assistance under this program that the provider has the right to be included in the claims process. If applicable, I understand that legal immigrants receiving assistance under this program shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997. **I understand it is my responsibility to notify the provider of an income or household change that may influence the rating on this application and failure to do so voids this application.**

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

Print Applicant Name	Applicant Signature and Date
Print Eligibility Technician Name	Eligibility Technician Signature and Date
Print Facility Name	Facility Phone Number

Application Notes:

Section 2.02 Ineligibility Code Legend

Dependent Codes

1. Self
2. Spouse/Civil Union Partner
3. Minor
4. Senior
5. Adult Student
6. Other

Residency Codes

1. Colorado Resident & U.S. Citizen
2. Colorado Resident & Lawfully Present
3. Migrant Farm Worker & U.S. Citizen
4. Migrant Farm Worker & Lawfully Present
5. Counted in Household Size Only

Medicaid/CHP+ Ineligibility Codes

A. Has the Applicant Received a Medicaid/CHP+ Denial Letter?

B. Applicant is not a U.S. Citizen, has been lawfully present for less than 5 years, and does not have refugee status

C. Transitional Medical Benefits have been discontinued

D. Over Income for Medicaid and is:

   d. NOT A CHILD

   e. NOT PREGNANT

   f. NOT DISABLED

E. Has Primary Insurance - NOT Eligible for CHP+

F. **Other - Provide a brief explanation**

Annual or One Time Income Sources:

			Documented	Self-Declared
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
Earned Income Total	$ _____	$ _____		
Unearned Income Total	$ _____	$ _____		
Total Income	$ _____	$ _____		

Applicant Signature Date

Eligibility Technician Signature Date

Facility Phone

Revised 2020-21

This worksheet must be signed and included with all client applications.

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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: _____

	Monthly	Annualized
Revenue:		
Gross Business Income	$	$
Business Property Expenses:		
Mortgage/Rent of Business Property	$	$
Utilities	$	$
_____	$	$
_____	$	$
Other Expenses:		
Advertising	$	$
Businees 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	$	$

_____	$ _____	$ _____
_____	$ _____	$ _____
Day Care Provider Reductions (if applicable)	$ _____	$ _____
Total Expenses:	$ _____	$ _____
Total Expenses Attributed to Business:	$ _____	$ _____
Net Profit	$ _____	$ _____ (use this figure on line 3, Section II of the CICP Application)

Applicant Signature _____ Date _____

Eligibility Technician Signature _____ Date _____

Facility _____ Date _____

Revised 2020-21

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

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Colorado Indigent Care Program

Worksheet 3 - Allowable Deductions

Type of Deduction	Amount	Frequency	Annualized Amount
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
		Grand Total	$

Applicant Signature | Date

Eligibility Technician Signature | Date

Facility | Phone

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

AFFIDAVIT FOR LAWFUL PRESENCE
Colorado Indigent Care Program

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.
- ☐ I am not a United States citizen, but I am a Permanent Resident of the United States.
- ☐ I am not a United States citizen, but 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 "state public benefit", as that term is defined under section 24-76.5-102(3), C.R.S. (2016). I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this state 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 section 18-8-503, C.R.S. (2016) and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

_____

Applicant Signature **Date**

FOR INTERNAL USE ONLY

Please mark the box that indicates which document was verified for lawful presence and keep a photocopy of the document presented in the applicant's file.

- ☐ A current, valid Colorado driver's license or a Colorado identification card, issued pursuant to article 2 of title 42, C.R.S., unless the applicant holds a license or card that states, "Not Valid for Federal Identification, Voting, or Public Benefit Purposes", or
- ☐ Any out-of-state driver's license or state issued identification if that state requires that the Applicant prove lawful presence prior to issuance of the license or identification card, or
- ☐ A United States military card or a military dependent's identification card, or
- ☐ A United States Coast Guard Merchant Mariner card, or
- ☐ A Native American tribal document, or
- ☐ Other documentation pulled from SAVE or found on a Federal list of acceptable documentation for establishing lawful presence (see 1 CCR 204-30 sections 2.1.4 and 2.1.6)
  Name of doucment accepted (include document number):

  _____

Date verified in SAVE (if applicable): _____

Please Note: If the applicant is a United States citizen or non-citizen national and is unable to present any of the documents listed on this form they may submit a written declaration or a third-party written declaration. These options should be used with caution.

SELF DECLARATION

I, _____, self-declare and swear or affirm under penalty of perjury, and possibly subject to later verification of status, that I am a United States citizen or non-citizen national.

_____

Signature Date

THIRD-PARTY DECLARATION

I, _____, swear or affirm under penalty of perjury, and possibly subject to later verification of status, that I have personal knowledge that the Applicant is a United States citizen or non-citizen national.

_____

Signature Date

For Colorado Department of Revenue's Lawful Presence Rule, see 1 CCR 204-30 Rule 5: http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=6860&fileName=1%20CCR%20204-30

States that require Applicants to prove lawful presence prior to issuing a driver's license or identification card are also called REAL ID compliant states. A list of REAL ID compliant states can be found at:
https://www.dhs.gov/real-id

Declaración Jurada de Presencia Legal
Programa de Atención para Indigentes de Colorado

Yo, _____, juro o afirmo bajo pena de perjurio según las leyes del estado de Colorado queque (marque un opción):

- ☐ Soy ciudadano de los Estados Unidos, O
- ☐ No soy un ciudadano de Estados Unidos pero soy residente permanente de los Estados Unidos
- ☐ No soy un ciudadano de Estados Unidos pero estoy legalmente presente en Estados Unidos bajo de la Ley Federal

Entiendo que esta declaración jurada es requerida por la ley porque he solicitado una "prestación pública estatal", como ese término se define en la sección 24-76.5-102(3), C.R.S. (2016). Entiendo que la ley estatal requiere que demuestren que estoy legalmente presente en Estados Unidos antes de recibir este beneficio público del estado. Además, reconozco hacer una declaración falsa, ficticia o fraudulenta o representación en esta declaración jurada jurada está penado por las leyes penales de Colorado como perjurio en el segundo grado en la sección 18-8-503, C.R.S. (2016) y constituirá un delito separado cada vez que fraudulentamente se recibe un beneficio público.

_____

Firma del Solicitante **Fecha**

SÓLO PARA USO INTERNO

Por favor marque la casilla que indica que documento se verificó presencia legal y fotocopia del documento en el archivo del solicitante.

- ☐ Un válido y corriente licencia de conductor de Colorado o un Colorado tarjeta de identificación, emitido de conformidad con el artículo 2 del título 42, C.R.S.., a menos que el solicitante es titular de una licencia o tarjeta que dice, "no son válidos para identificación federal, votar o beneficio público", o
- ☐ Un licencia de cualquier conducir fuera del estado o estado emitido identificación si ese estado requiere que el solicitante probar presencia legal antes de la expedición de la licencia o tarjeta de identificación, o
- ☐ Una tarjeta militar de Estados Unidos o tarjeta de identificación de dependiente militar o
- ☐ Una tarjeta de Estados Unidos guardacostas Merchant Mariner, o
- ☐ Un documento tribal americano nativo, o
- ☐ Otra documentación tirado de SAVE o se encuentran en una lista Federal de documentación aceptable para establecer presencia legal (véase 1 CCR 204-30 secciones 2.1.4 y 2.1.6)
  Nombre de doucment aceptado (incluir número):
  _____

Fecha verificado en SAVE (si corresponde): _____

Por favor nota: Si el solicitante es un ciudadano o no ciudadano nacional y es incapaz de presentar cualquiera de los documentos listado en este formulario puede enviar una declaración escrita o un declaración por escrito del tercero. Estas opciones deben usarse con precaución. El solicitante debe firmar abajo.

Declaración del uno mismo

Yo, _____ mismo-declara y juro o afirmo bajo pena de perjurio y posiblemente sujeta a verificación posterior de la situación, que yo soy un ciudadano o no ciudadano nacional.

_____

Firma del Solicitante Fecha

Tercero Declaración

Yo, _____ juro o afirmo bajo pena de perjurio y posiblemente sujeta a verificación posterior de la situación, que tengo conocimiento personal que el solicitante es un ciudadano o no ciudadano nacional.

_____

Firma del Solicitante Fecha

Estado de presencia legal del Departamento de ingresos de Colorado, véase 1 CCR 204-30 regla 5:

http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=6860&fileName=1%20CCR%20204-30

Estados que requieren los aspirantes probar presencia legal antes de la expedición de licencia de conducir o tarjeta de identificación también se llaman Estados compatibles con ID REAL. Una lista de Estados conformes ID REAL puede encontrarse en:

https://www.dhs.gov/real-id

ARTICLE IV. Other

Section 4.01 Optional CICP ID Card Template

For homeless applicants put their rate on the “Rate” line and add an “H” after the rate to signify the applicant is homeless.

Example: 34 H

Colorado Indigent Care Program (CICP)
This is not Health Insurance

Name:_____

Rate:_____ SSN:_____

Copay Cap:_____ County Code:_____

Begin Date_____

End Date:_____

_____
Technician's Signature Phone

The following family members are covered under the FPL on the front of this card. (Family members eligible for Medicaid or CHP+ are not listed)

Name_____ SSN_____

Name_____ SSN_____

Name_____ SSN_____

Name_____ SSN_____

Name_____ SSN_____

Name_____ SSN_____

Present card each time you receive services at a CICP Provider

Section 4.02 County Codes

01 Adams
02 Alamosa
03 Arapahoe
04 Archuleta
05 Baca
06 Bent
07 Boulder
08 Chaffee
09 Cheyenne
10 Clear Creek
11 Conejos
12 Costilla
13 Crowley
14 Custer
15 Delta
16 Denver
17 Dolores
18 Douglas
19 Eagle
20 Elbert
21 El Paso
22 Fremont
23 Garfield
24 Gilpin
25 Grand
26 Gunnison
27 Hinsdale
28 Huerfano
29 Jackson
30 Jefferson
31 Kiowa
32 Kit Carson
33 Lake
34 La Plata
35 Larimer
36 Las Animas
37 Lincoln
38 Logan
39 Mesa
40 Mineral
41 Moffat
42 Montezuma
43 Montrose
44 Morgan
45 Otero
46 Ouray
47 Park
48 Phillips
49 Pitkin
50 Prowers
51 Pueblo
52 Rio Blanco
53 Rio Grande
54 Routt
55 Saguache
56 San Juan
57 San Miguel
58 Sedgwick
59 Summit
60 Teller
61 Washington
62 Weld
63 Yuma
64 Broomfield

Section 4.03 Client Statement of Responsibilities in English

Clients applying for or receiving discounted CICP services shall:

1. Acknowledge that the CICP is not health insurance, does not offer a specific benefit package, is not an entitlement to medical benefits and that there are limitations to services discounted;
2. Acknowledge that discounted CICP health care services vary by provider location;
3. Give the CICP provider all the necessary financial information and documentation needed to complete the application;
4. Not give false information with the intent to commit fraud;
5. Tell the CICP provider if a CICP financial rating was issued by another provider and notify the CICP provider within 15 days if the CICP rating is disputed;
6. Be responsible for paying any money owed on time, and as required, or work with the CICP provider to make payment arrangements;
7. Notify the CICP provider promptly of changes in resources, income and all other household changes that may affect the CICP rating;
8. Communicate any information, concerns and/or questions related to the financial screening to the appropriate representative;
9. Keep track of all copayments made to CICP providers for services discounted by CICP and inform the provider once the household copayment cap has been met;
10. Respect the property of the CICP provider, fellow clients and others; and
11. Follow all other rules and regulations of the CICP provider's location relating to respectful treatment and rights of other clients and provider staff.

Section 4.04 Client Statement of Responsibilities in Spanish

Los clientes que soliciten o reciban servicios CICP con descuento deberán:

1. Reconocer que el CICP no es un seguro de salud, no ofrece un paquete de beneficios específico, no es un derecho a los beneficios médicos y que hay limitaciones a los servicios descontados;
2. Reconocer que los servicios de atención médica con descuento en CICP varían según la ubicación del proveedor;
3. Dar al proveedor de CICP toda la información financiera necesaria y documentación necesaria para completar la solicitud;
4. No dará información falsa con la intención de cometer fraude;
5. Informe al proveedor de CICP si se ha emitido una calificación financiera CICP por otro proveedor y notificar al proveedor de CICP en un plazo de 15 días si se disputa la calificación CICP;
6. Ser responsable de pagar el dinero adeudado a tiempo, y según sea necesario, o trabajar con el proveedor de CICP para hacer arreglos de pago;
7. Notifique al proveedor de CICP con prontitud de los cambios en los recursos, los ingresos y todos los demás cambios del hogar que puedan afectar la calificación de CICP;
8. Comunicar cualquier información, inquietud y/o pregunta relacionada con el control financiero al representante correspondiente;
9. Mantener un seguimiento de todos los copagos realizados a los proveedores de CICP por servicios descontados por el CICP e informar al proveedor una vez que se haya cumplido el límite de copago del hogar;
10. Respete la propiedad del proveedor de CICP, sus compañeros de clientes y otros; y
11. Siga todas las demás reglas y reglamentos de la ubicación del proveedor de CICP en relación con el trato respetuoso y los derechos de otros clientes y el personal del proveedor.

Section 4.05 Copay Category

Percent of FPL	0 - 40% and Homeless	0 - 40%	41 - 62%	63 - 81%	82 - 100%	101 - 117%	118 - 133%	134 - 159%	160 - 185%	186 - 200%	201 - 250%
Ambulatory Surgery	$0	$15	$65	$105	$155	$220	$300	$390	$535	$600	$630
Inpatient Facility	$0	$15	$65	$105	$155	$220	$300	$390	$535	$600	$630
Hospital Physician	$0	$7	$35	$55	$80	$110	$150	$195	$270	$300	$315
Emergency Room	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45	$50
Emergency Transportation	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45	$50
Outpatient Hospital Services	$0	$7	$15	$15	$20	$20	$25	$25	$35	$35	$40
Clinic Services	$0	$7	$15	$15	$20	$20	$25	$25	$35	$35	$40
Specialty Outpatient	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45	$50
Outpatient Pharmacy	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30	$35
Laboratory	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30	$35
Basic Radiology & Imaging	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30	$35
High-Level Radiology & Imaging	$0	$30	$90	$130	$185	$250	$335	$425	$580	$645	$680

The following information explains the different types of medical care charges:

- **Ambulatory Surgery** charges are for all non-physician (facility) Ambulatory Surgery operative procedures received by a Client who is admitted to and discharged from the hospital setting on the same day. The Client is also responsible for the corresponding Hospital Physician charges.
- **Inpatient Facility** charges are for all non-physician (facility) services received by a Client while receiving care in the hospital setting for a continuous stay of 24 hours or longer.
- **Hospital Physician** charges are for services provided directly by a physician in the hospital setting, including inpatient, ambulatory surgery, and emergency room care.
- **Emergency Room** charges are for all non-physician (facility) services received by a Client while receiving Emergency Care or Urgent Care in the hospital setting for a continuous stay less than 24 hours (i.e., emergency room care).
- **Emergency Transportation** charges are for transportation provided by an ambulance.
- **Outpatient Hospital Service** charges are for all non-physician (facility) and physician services received by a Client while receiving non-Emergency Care or non-Urgent Care in the outpatient clinic setting. Charge includes primary and preventive medical care; does not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.
- **Clinic Services** charges are for all non-physician (facility) and physician services received by a Client while receiving care in the outpatient clinic setting. Charges include primary and preventive medical care. Charge does not include radiology or laboratory services performed at the clinic.
- **Specialty Outpatient** charges are for all non-physician (facility) and physician services received by a Client while receiving care in the specialty outpatient setting. These services can be provided in standalone clinics and outpatient hospital settings. Specialty Outpatient charges include distinctive medical care (i.e., oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventive medical care. Charges do not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.
- **Outpatient Pharmacy** charges are for prescription drugs received by a Client at a Qualified Health Care Provider's pharmacy as an outpatient service.
- **Laboratory Service** charges are for all laboratory tests received by a Client while receiving care in the outpatient hospital or clinic setting. Laboratory Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.
- **Basic Radiology and Imaging Service** charges are for all radiology and imaging services received by a Client while receiving care in the outpatient hospital or clinic setting. Basic Radiology and Imaging Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.
- **High-Level Radiology and Imaging Service** charges are for Clients receiving a Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Positron Emission Tomography (PET) or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory (cath lab) in the outpatient hospital, emergency room, or clinic setting. This copayment already includes the outpatient facility charge and therefore MAY NOT be combined with any other outpatient facility charge (i.e. Emergency Room, Specialty Outpatient Clinic).

Clients who are seen in the hospital setting in an observation bed should be charged the emergency room copay if their stay is less than 24 hours and the inpatient facility copay if their stay is 24 hours or longer.

Section 4.06 Annual Income Ranges for Each FPL Range

Family Size	Effective April 1, 2020 – March 31, 2021				
1	$0 - $5,104	$5,105 - $7,911	$7,912 - $10,336	$10,337 - $12,760	$12,761 - $14,929
2	$0 - $6,896	$6,897 - $10,689	$10,690 - $13,964	$13,965 - $17,240	$17,241 - $20,171
3	$0 - $8,688	$8,689 - $13,466	$13,467 - $17,593	$17,594 - $21,720	$21,721 - $25,412
4	$0 - $10,480	$10,481 - $16,244	$16,245 - $21,222	$21,223 - $26,200	$26,201 - $30,654
5	$0 - $12,272	$12,273 - $19,022	$19,023 - $24,851	$24,852 - $30,680	$30,681 - $35,896
6	$0 - $14,064	$14,065 - $21,799	$21,800 - $28,480	$28,481 - $35,160	$35,161 - $41,137
7	$0 - $15,856	$15,857 - $24,577	$24,578 - $32,108	$32,109 - $39,640	$39,641 - $46,379
8	$0 - $17,648	$17,649 - $27,354	$27,355 - $35,737	$35,738 - $44,120	$44,121 - $51,620
9	$0 - $19,440	$19,441 - $30,132	$30,133 - $39,366	$39,367 - $48,600	$48,601 - $56,862
10	$0 - $21,232	$21,233 - $32,910	$32,911 - $42,995	$42,996 - $53,080	$53,081 - $62,104
11	$0 - $23,024	$23,025 - $35,687	$35,688 - $46,624	$46,625 - $57,560	$57,561 - $67,345
12	$0 - $24,816	$24,817 - $38,465	$38,466 - $50,252	$50,253 - $62,040	$62,041 - $72,587
13	$0 - $26,608	$26,609 - $41,242	$41,243 - $53,881	$53,882 - $66,520	$66,521 - $77,828
14	$0 - $28,400	$28,401 - $44,020	$44,021 - $57,510	$57,511 - $71,000	$71,001 - $83,070
15	$0 - $30,192	$30,193 - $46,798	$46,799 - $61,139	$61,140 - $75,480	$75,481 - $88,312
16	$0 - $31,984	$31,985 - $49,575	$49,576 - $64,768	$64,769 - $79,960	$79,961 - $93,553
Poverty Level	**0 - 40%**	**41 - 62%**	**63 - 81%**	**82 - 100%**	**101 -117%**

Family Size	Effective April 1, 2020 – March 31, 2021				
1	$14,930 - $16,971	$16,972 - $20,288	$20,289 - $23,606	$23,607 - $25,520	$25,521 - $31,900
2	$20,172 - $22,929	$22,930 - $27,412	$27,413 - $31,894	$31,895 - $34,480	$34,481 - $43,100
3	$25,413 - $28,888	$28,889 - $34,535	$34,536 - $40,182	$40,183 - $43,440	$43,441 - $54,300
4	$30,655 - $34,846	$34,847 - $41,658	$41,659 - $48,470	$48,471 - $52,400	$52,401 - $65,500
5	$35,897 - $40,804	$40,805 - $48,781	$48,782 - $56,758	$56,759 - $61,360	$61,361 - $76,700
6	$41,138 - $46,763	$46,764 - $55,904	$55,905 - $65,046	$65,047 - $70,320	$70,321 - $87,900
7	$46,380 - $52,721	$52,722 - $63,028	$63,029 - $73,334	$73,335 - $79,280	$79,281 - $99,100
8	$51,621 - $58,680	$58,681 - $70,151	$70,152 - $81,622	$81,623 - $88,240	$88,241 - $110,300
9	$56,863 - $64,638	$64,639 - $77,274	$77,275 - $89,910	$89,911 - $97,200	$97,201 - $121,500
10	$62,105 - $70,596	$70,597 - $84,397	$84,398 - $98,198	$98,199 - $106,160	$106,161 - $132,700
11	$67,346 - $76,555	$76,556 - $91,520	$91,521 - $106,486	$106,487 - $115,120	$115,121 - $143,900
12	$72,588 - $82,513	$82,514 - $98,644	$98,645 - $114,774	$114,775 - $124,080	$124,081 - $155,100
13	$77,829 - $88,472	$88,473 - $105,767	$105,768 - $123,062	$123,063 - $133,040	$133,041 - $166,300
14	$83,071 - $94,430	$94,431 - $112,890	$112,891 - $131,350	$131,351 - $142,000	$142,001 - $177,500
15	$88,313 - $100,388	$100,389 - $120,013	$120,014 - $139,638	$139,639 - $150,960	$150,961 - $188,700
16	$93,554 - $106,347	$106,348 - $127,136	$127,137 - $147,926	$147,927 - $159,920	$159,921 - $199,900
Poverty Level	**118 - 133%**	**134 - 159%**	**160 - 185%**	**186 - 200%**	**201 - 250%**

Poverty Level refers to the percent of Federal Poverty Level.

Revised 3/2020

CICP
Colorado Indigent Care Program

Welcome to the Colorado Indigent Care Program (CICP)

The Colorado Indigent Care Program (CICP) is a discounted health care program for residents of Colorado. Health care providers who participate in the CICP offer discounted health care services to people who qualify for the program.

The CICP health care provider has assigned you a rating based on your financial resources. Your rating determined what your CICP copayment is. The copayment is the portion of your medical bills under the CICP that you will be responsible for. Payment of the copayment is expected at the time of service, unless you have made other payment arrangements with the CICP provider.

The CICP is not health insurance and the CICP cannot guarantee benefits. Services must be received by a qualified CICP provider. Available discounted services and copayments may be different from provider to provider. If your CICP provider refers you to a non-CICP health care provider for care, you may be responsible for the bill without a discount. Please check with your health care provider before receiving care so that you understand what CICP will cover and what it will not cover.

Please discuss questions about your medical bills and medical care directly with your CICP provider at the following phone number:

_____

If you need more information about CICP, or have concerns that have not been resolved with your CICP provider, call:

Colorado Department of Health Care Policy and Financing
Customer Contact Center
1-800-221-3943

Information about CICP is also available on the Department of Health Care Policy and Financing's Website, including a Provider Directory: Go to www.colorado.gov/hcpf and click the link "Explore Programs and Benefits", "Adults", Colorado Indigent Care Program (CICP), then select "Program Information Page", and then "CICP Provider Directory" at the bottom of the page.

Your CICP provider can enter your copayment amount for health care services in the table below. Copayments are different for different types of medical care, and your CICP provider may not offer all types of services. The copayments listed below may only be valid at the issuing facility. You should ask your CICP provider about what health care services are available at a discount and which copayment applies.

Your household rating: _____

CICP Copayment Information for Clients based on rating:

Service	**Copayment per Visit**
Ambulatory Surgery	$_____
Inpatient Facility	$_____
Hospital Physician (while in the hospital or emergency room)	$_____
Emergency Room	$_____
Emergency Transportation	$_____
Outpatient Hospital Services	$_____
Clinic Services	$_____
Specialty Outpatient	$_____
Prescription	$_____
Laboratory	$_____
Basic Radiology & Imaging	$_____
High-Level Radiology Imaging*	$_____

*High-Level Radiology and Imaging includes Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Positron Emission Tomography (PET) or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory (cath lab) in the outpatient hospital, emergency room, or clinic setting. Some providers may charge a lower copay amount for certain High-Level Radiology and Imaging services.

CICP
Colorado Indigent Care Program

Bienvenidos al Programa de Atención de Indigentes de Colorado (CICP)

Programa de atención de indigentes de Colorado (CICP) es un programa de salud con descuento para residentes de Colorado. Proveedores médicos quienes participan en CICP ofrecen servicios médicos a bajo costo a gente que califica para el programa.

El proveedor de atención médica del CICP le ha asignado una calificación basada en sus recursos financieros. Su calificación determinó cuál es su copago de CICP. El copago es la porción de sus gastos médicos en el centro que usted será responsable. Pago de los copagos se espera que en el momento del servicio, a menos que hayan hecho otros arreglos de pago con el proveedor de CICP.

El CICP no es seguro de salud y el centro no puede garantizar beneficios. Servicios deben ser recibidas por un proveedor calificado del CICP. Servicios y copagos con descuento disponibles pueden variar de proveedor a proveedor. Si su proveedor de CICP refiere un centro no médico para el cuidado, usted puede ser responsable de la cuenta sin un descuento. Por favor compruebe con su médico antes de recibir atención para que entiendas lo que cubrirá centro y lo que no cubrirá.

Por favor discutir preguntas acerca de sus gastos médicos y atención médica directamente con su proveedor CICP en el siguiente número de teléfono:

_____

Si usted necesita más información sobre el programa, o tiene preocupaciones que no han sido resueltas con su proveedor de CICP, llame al:

Departamento de Colorado de Salud Política y Financiamiento
Centro de contacto al cliente
1-800-221-3943

Información sobre CICP también esta disponible en el sitio web del Departamento de Colorado de Salud Política y Financiamiento, incluyendo un directorio de proveedores visite www.colorado.gov/hcpf y haga clic en el enlace "Explore Programs and Benefits", "Adults", Programa de Atención para Indigentes de Colorado (CICP), seleccione "Programa de Información de la página", y luego "CICP Provider Directory" en la parte inferior de la página

Su proveedor de CICP puede ingresar el monto de su copago para servicios de salud en la tabla debajo de. Los copagos son diferentes para diferentes tipos de atención médica y médico del centro no puede ofrecer todo tipo de servicios. Los co-pagos puesto en la lista abajo puede ser válida solo en el centro de expedición. Usted debe pedir a su proveedor de CICP acerca de qué servicios de atención médica están disponibles con un descuento y que el copago se aplica.

Su calificación familiar: _____CICP Copago Información de Clientes Basada en su Clasificación:

Servicio	**Copago por Visita**
Cirugía Ambulatorial	$_____
Hospitalizados	$_____
Servicios Médicos (Mientras que en el hospital o sala de emergencia)	$_____
Carga de Servicio Urgencias	$_____
Transporte de Emergencia	$_____
Servicios Externa de Hospital	$_____
Servicios de la Clínica	$_____
Consulta Externa de Especialidad	$_____
Medicamentos Con Receta	$_____
Prueba de Laboratorio	$_____
Básico de Radiología y Imaging	$_____
Nivel alto de Radiología y Imaging*	$_____

*La Radiología e Imágenes de Alto Nivel incluye Imágenes por Resonancia Magnética (RM), Tomografía Computarizada (TC), Tomografía por Emisión de Positrones (PET) u otros servicios de Medicina Nuclear, Estudios del Sueño o Laboratorio de Cateterismo (laboratorio de cateterismo) en el hospital ambulatorio, sala de emergencias, o el entorno de la clínica. Algunos proveedores pueden cobrar una cantidad de copago más baja por ciertos servicios de Radiología e Imagen de Alto Nivel