~~Form to Opt Out of~~ Screening for Public Health Coverage and

Prior to completing this form, you should have read "Hospital Discounted Care,~~ Are You Eligible for Discounted Care?,~~ Your Rights as a Patient ~~Under Hospital Discounted Care~~". By completing this form, you are telling the hospital if you do or do not want to be screened~~knowingly deciding to opt out of screening~~ for public health insurance programs and ~~h~~Hospital ~~d~~Discounted ~~c~~Care.

I _____ (patient's name) have received the following information from _____ (hospital name) in the language in which I feel most comfortable. I understand the purpose of this form.

By signing below, I am indicating that I understand and agree to the following:

- The hospital told me about public health coverage programs (Medicaid, Emergency Medicaid, Child Health Plan Plus (CHP+), Medicare, and financial help for private insurance) and discounted care and payment plans (Hospital Discounted Care). See next page for more information on these programs.
    - For more information on discounted care and payment plans, visit: https://hcpf.colorado.gov/colorado-hospital-discounted-care
    - For more information about your right to be screened for ~~h~~Hospital ~~d~~Discounted ~~c~~Care, see Colorado Revised Statute §25.5-3-501
- I understand that:
    - Public health coverage programs can help pay my medical bills with little or no cost to me.
    - Discounted care and payment plans may reduce the cost of my care received in a hospital.
    - Choosing not to be checked for eligibility for these programs means I will not find out if I may qualify for these programs at this time.
    - If I choose not to be checked, I may lose the right to take legal action against the hospital for not checking me.
    - If I choose not to be checked today, I can ask to be checked later. If I ask within ~~45~~181 days of the date I received services, the hospital must check my eligibility.

~~If you want to opt out of screening, p~~Please read and initial the appropriate box ~~or~~ boxes below indicating your screening choice.

____I **do want** my eligibility to be checked for public health insurance programs and discounted health care and payment plans.

____I **do not want** my eligibility to be checked for public health insurance programs or discounted health care and payment plans today.

~~____I **do not want** my eligibility to be checked for discounted health care and payment plans today.~~

First and Last Names of Patient: _____

Signature of Patient: _____

First and Last Name of Legal Guardian or Parent (if needed): _____

Signature of Legal Guardian or Parent (if needed): _____

Today's Date: _____ Date of Hospital Service: _____

Signature of Staff Member: _____ Date: _____