COLORADO
Department of Health Care Policy & Financing

303 E. 17th Ave. Suite 1100
Denver, CO 80203

Provider Stabilization Fund Attestation Form

This attestation must be completed and signed by an authorized representative of your organization.

By signing this form, you confirm the following:

1. CONSENT TO USE DATA: You acknowledge and consent to the Department of Health Care Policy & Financing (HCPF) using data provided in your agency's 2025-26 Primary Care Fund application for purposes of the Provider Stabilization Fund application.

2. INCOME THRESHOLD for PATIENT COUNT: By applying to the Provider Stabilization Fund using the patient count from your Primary Care Fund 2025-26 application, you acknowledge and agree that this patient count will include only patients whose family income is below 200% of the Federal Poverty Guidelines.

3. ACCURACY OF INFORMATION: You affirm that all information submitted in your Primary Care Fund grant application is true, accurate, and complete to the best of your knowledge.

Grantee Information

Organization Name: _____

Name of Authorized Representative: _____

Title: _____

Email Address: _____

Phone Number: _____

Attestation Statement

I hereby attest that the information provided in our 2025-26 Primary Care Fund grant application to the Colorado Department of Health Care Policy and Financing is accurate and complete to the best of my knowledge. I authorize the use of this information for the purpose of applying to the Provider Stabilization Fund.

Signature

I understand that this attestation is a requirement of the Provider Stabilization Fund application process and by signing below, I affirm the truth of the above statement.

Signature: _____
Printed Name: _____
Date _____