COLORADO
Department of Health Care Policy & Financing

**Eligibility Application Partner (EAP)**
**Medical Assistance Site (MA)**
**Mapping Tool Update Form**

Please complete this form for **each** of your existing sites when the following changes occur: agency information, contact information, and agency status of Presumptive Eligibility (PE) and Certified Application Assistance Site (CAAS).
To ensure the information in the mapping tool is accurate, current, and updated timely, submit the completed form to the below address within five business days of the change.

Site Name in Mapping Tool: _____

| **Site Information Change:** | |
|---|---|
| Site Name: | |
| Address: | |
| City, State, Zip: | |
| Site County: | |
| Site Telephone w/EXT: | |
| Site Fax: | |
| Site Website: | |
| Site Email: | |
| **Contact Information Change:** | |
| Contact Name: | |
| Contact Email: | |
| Contact Telephone w/EXT: | |
| Contact Fax: | |

**Site Status Change:**

- Site no longer a PE site? ☐ No CAAS? ☐ No EAP/MA? Satellite ☐ No
- Termination Date_____

**Other** (Please explain)

| **Name & Title (print):** | |
|---|---|
| **Signature or e-signature:** | |
| **Date:** | |

**Please submit this form to:** Department of Health Care Policy and Financing
E-mail: **Monica.Owens@state.co.us** OR Fax: **303-866-4517**

**DEPARTMENT USE ONLY:** Approval By: _____ Updated: _____