



Essential Community Provider (ECP) Application

An Essential Community Provider is a health care provider that: (a) has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population or, in the case of a sole community provider, serves the medically indigent patients within its medical capability; and (b) waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a client’s financial limitations. Section 25.5-5-403 C.R.S. (2006). Designation will apply to Medicaid / CHP+, and the Colorado Health Benefit Exchange (COHBE).

The following application must be completed to obtain an ECP designation:

Name of organization			
Street Address			
Mailing Address (if different)			
City	State	Zip	County
Telephone ()	Fax ()		Email
Contact Person		Title	Medicaid ID

Please check the box that best represents your health care system:

*Health Care Providers meeting requirements 1-3 automatically qualify as ECPs.

- 1. **Disproportionate share hospitals***: An acute care facility that meets the inpatient utilization rate of at least one standard deviation above the established Colorado mean for Medicaid inpatient utilization rate.
- 2. **Local county and district health departments, county nursing services and regional health departments***: Operates pursuant to Sections 25-1-501 through 25-1-518, C.R.S. (2008)
- 3. **Federally qualified health centers***: Qualifies under the federal law pursuant to the Social Security Act, Section 1905(1)(2)(B). This includes those providers that meet the requirements of the Public Health Service Act, Section 330.
- 4. **School based health centers**: Must be able to verify that 25% of students enrolled in the school are at or below 250% of the Federal Poverty Level (FPL), and that services are offered to the entire student population without regard to the patient’s ability to pay.
- 5. **Family Medicine Residency Training Programs**: Operates pursuant to Section 25-1-901, C.R.S. (2008). This includes all medical services received at a Family Medicine Residency practice site that can verify that 25% of the individuals served are at or below 250% of the FPL.



- 6. **Rural Health Clinics:** Qualifies under the federal law, Social Security Act, Section 1861 (aa)(2) and can verify that 25% of the individual served are at or below 250% of the FPL.
- 7. **State certified Title X family planning agencies:** Must be able to verify that 25% of individuals served are at or below 250% of the FPL.
- 8. **Sole community providers:** Located outside metropolitan statistical areas (MSA) as designated by the US Office of Management and Budget, for which there is no other similar type of health care. The provider must be able to verify that it provides health care services to individuals below 250% of the FPL, within its medical capability.
- 9. **Health care providers:** Must be able to verify that 25% of the individuals served are at or below 250% of the FPL
- 10. **Mental Health and Substance Abuse Provider**
- 11. **New health care providers:** Operates under a sponsoring or participating agency or center that exists as an entity that has historically served low income and medically indigent populations.
- 12. **Other**, as defined by the Affordable Care Act (ACA): _____

Please provide the following information:

- a. Total Number of non-Medicaid/CHP+ patients serviced at your facility in the past 12 months _____
- b. Number of patients counted in (a) above that are under 250% of the FPL _____
- c. A copy of your current sliding fee scale, if applicable

As a participating ECP provider, you must agree to the following terms and conditions:

To furnish the Department of Health Care Policy and Financing or its designee, with such information as it may request regarding services to medically indigent and low-income patients who are not eligible for Medicaid or CHP+. Records shall verify that 25% of the individuals served are at or below 250% of the Federal Poverty Level (this does not apply to sole community providers).

To make such disclosure of ownership and provide access to medical records and billing information as is requested.

If, at any time from the date of this agreement, the Department of Health Care Policy and Financing determines that I failed to maintain compliance with any state and/or federal rules and regulations, I understand that I may be suspended from participating as an Essential Community Provider.

I certify that the above and foregoing is true, complete and correct.

Provider Name		
Authorized Signature and Title		Date:
Approved by the Department of Health Care Policy & Financing		Date:

Submit application to: Health Care Policy and Financing Medicaid Division, ECP Applications
 1570 Grant Street
 Denver, CO 80203-1818

