



Health First
COLORADO™

Colorado's Medicaid Program



CHP+

Child Health Plan Plus

Case Number:

How Do I Complete This Form?

- Review the current information we have for all members of your household. You must take action whether or not you have changes to report.
- If you **do have changes** to your information: Provide updates, **SIGN (on page 4)** the Renewal Form Signature Page, and return the entire form by .
 - **To maintain your health coverage, you are required to report changes.** If you have changes and do not report them, you may have to pay back medical payments paid by Health First Colorado.
- If you **do not have changes** to your information: **SIGN (on page 4)** and return the Renewal Form Signature Page by . **If you do not return the signature form by the deadline, you may lose your health care coverage.**

What Happens Next?

- We will check to see if you and your household still qualify for Health First Colorado.
- We will contact you if we need anything else from you to help us make our decision, including letters requesting information or verifications about your reported changes. Please make sure to complete all requests for information we send.
- After , we will send you another letter to tell you if you still qualify for Health First Colorado.



Visit CO.gov/PEAK to
manage your account

What I Should Know - Rights & Responsibilities

- I am signing this renewal form under penalty of perjury. That means that I have provided true answers to all the questions on this form to the best of my knowledge. Also, I understand that I may receive penalties under federal law if I provide false or untrue information.
- Federal and Colorado state law require the Department of Health Care Policy and Financing to recover all medical assistance benefits, including capitation payments, paid on behalf of Health First Colorado clients from the estates of deceased Health First Colorado clients who were permanently institutionalized. For Health First Colorado clients who were over the age of 55 when benefits were provided, the Department recovers payments for nursing facility services, home and community-based services, and related hospital and prescription drug services. There are certain exemptions to estate recovery. Please contact your county or coestater recovery@hms.com for additional information.
- I know I am responsible for keeping my information up to date. I understand I must report any changes to the information I have provided within 10 days of the change. I understand changes I report might affect whether someone in my household qualifies for health care coverage. I can report changes online at CO.gov/PEAK or through my county office or organization that assists me.
- I understand the Department is authorized to collect and process my household information and confirm that information through federal databases that verify information. Everyone on my form has given me permission to share and submit their information and to receive communications about their eligibility and enrollment.
- The information the Department collects, and processes will be used to decide if I and members of my household qualify for health care coverage. The Department's authority to collect, process and verify my information comes from the Patient Protection and Affordable Care Act and the Social Security Act. I understand that if I do not qualify for Medicaid or Child Health Plan Plus, the Department will share my information with Connect for Health Colorado so they can see if I qualify.
- I know that under federal law and state law, discrimination is not permitted on the basis of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, disability, or marital status. I can file a complaint of discrimination by visiting: <https://hcpf.colorado.gov/nondiscrimination-policy> and <https://www.hhs.gov/ocr/filing-with-ocr/index.html>.
- If I think Health First Colorado/Child Health Plan Plus (CHP+) has made a mistake, I can appeal the decision. Appeal means I tell a county or state office that I disagree with a decision and I want a hearing. I have the right to represent myself at my appeal hearing. I may also choose a lawyer, relative, friend or any other person to act as my authorized representative. The Department will tell me in writing (Notice of Action) how to make an appeal.



Renewal Form Signature Page

Read and sign this attachment (This page MUST be returned)

Health First Colorado

Case Number:

Please refer to What I Should Know - Rights & Responsibilities before signing. **Read and sign this attachment (This page MUST be returned).**

1

Check the box that applies:

- I have read all parts of the Renewal Form and Rights and Responsibilities for Health First Colorado/CHP+. All information in the Renewal Form is correct. **I do not need to make any changes or corrections** to the information.
- I have read all parts of the Renewal Form and Rights and Responsibilities for Health First Colorado/CHP+. **I need to make changes or corrections** to the information. I will return the Renewal Form with the changes and corrections.

Signature of household contact or Authorized Representative

Date (MM/DD/YYYY):

✍

		/			/				
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- Check here if an authorized representative signed.

If you want to add, change or update an authorized representative, fill out the form that came with this letter.

- Check here if you want an authorized representative.

What We Need From You

Our records show that we need more information about the amount of income from self-employment you or someone else in your household receives and how often you receive it. With this packet, please provide proof of self-employment income.

You do not need to complete the resource section for your Medical Assistance redetermination. However, if you receive Medicare Savings Program benefits or want to apply for any Medical Assistance program that counts resources, you must complete the resource section every year.

Authorized Representative or Organization Form: Applicant Section

Health First Colorado

Case Number:

Complete this attachment if you need assistance with completing the Renewal Form.

An Authorized Representative is a trusted individual or organization you choose to help you with your Renewal Form. We need your permission so that your authorized representative can talk with us about the Renewal Form, to see your information, and act for you on all issues related to your health coverage. If you no longer want an authorized representative, you may go online at CO.gov/PEAK, or contact your county office, or organization or complete the form below.

If you have an authorized representative now, please answer these questions.

We show that you chose this individual as your authorized representative:

- Do you still want this individual to be your authorized representative? YES NO
- If "YES," has any of their information changed? YES NO

If you want to add, change or update an authorized representative's information please write the new information below:

Authorized Representative First Name <input type="text"/>	Authorized Representative Middle Name <input type="text"/>	Authorized Representative Last Name <input type="text"/>
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Organization/Company Name (if applicable) <input type="text"/>	Organization/Company ID (if applicable) <input type="text"/>
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Authorized Representative Street Address (leave blank if you don't have one) <input type="text"/>	Apartment/Suite # <input type="text"/>
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City <input type="text"/>	State <input type="text"/>	Zip Code <input type="text"/>	County <input type="text"/>
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Email Address <input type="text"/>	Phone Number (<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Phone Extension <input type="text"/>
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Do you want your new authorized representative to receive copies of notices/communications? YES NO

By signing, you allow the authorized representative to sign your Renewal Form, get information about this Renewal Form, and act for you on all future matters with this agency.

Applicant's Signature

Date (MM/DD/YYYY):

 / /

Authorized Representative or Organization Form: Authorized Representative or Organization Section

Health First Colorado

Case Number:

Ask the authorized representative to complete this section if you added or changed your authorized representative.

By signing, I agree to fulfill all responsibilities within the scope of the authorized representation that the individual who I represent is required to fulfill, which is different than having legal authority to act on behalf of the applicant or client. I agree to maintain the confidentiality of any information regarding the applicant or client provided by the agency in compliance with state, federal, and all other applicable laws. If an authorized representative is an organization, the signature of an organizational contact who is either a provider, staff member or volunteer of the organization is required. As a provider, staff member or volunteer of an organization which is an authorized representative, I affirm that I will adhere to the regulations in 42 CFR §431, Subpart F and to 45 CFR §155.260(f), and 42 CFR §447.10, as well as all other relevant state and federal laws concerning conflicts of interests and confidentiality of information.

Signature of Authorized Representative/Organizational Contact

Date (MM/DD/YYYY):

 / /

If you have been given the legal authority to act on behalf of the applicant or client through some means other than the assignment as an authorized representative through this form, such as the ability to make medical or financial decisions, you will need to affirm that you have that authority and provide the appropriate documents verifying that you have that authority.

- By checking this box, I affirm that I have legal authority to act on behalf of the applicant or client.(Please provide a copy of the following documents with this form when it is submitted: a power of attorney, court order establishing legal guardianship, or other legal document explicitly stating that you may legally act on behalf of the applicant or client.)

2 Has your contact information changed?

YES NO

If you marked "NO," please skip to question 3

If you update your address, it will be updated for every household member.
To add or remove someone from the household, go to **question 3**.

I am now homeless

Home Address (Currently On File)	
Mailing Address (Currently On File)	

2A If you have moved to a different home address, please provide updated information below: If your household has moved to a new home address, please also update your shelter expenses.

Street Address Apartment #

City State Zip Code What date did this address change? (MM/DD/YYYY)

/ /

2B If you have a different mailing address, please provide updated information below:

SAME AS NEW HOME ADDRESS? YES NO *If you marked "YES," do not enter a mailing address below*

Street Address Apartment #

City State Zip Code What date did this address change? (MM/DD/YYYY)

/ /

2C If you want to change how we contact you, please provide updated information below:

Primary Phone Number (Currently On File)	
Primary Phone Number (New)	(<input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>) <input style="width: 40px;" type="text"/> - <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Home

Email (Currently On File)		New Email Address?	
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Preferred method of contact:	<input type="checkbox"/> Call Home Phone	<input type="checkbox"/> Call Cell Phone	<input type="checkbox"/> Text Cell Phone
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We can send links that allow you to view electronic notices about your case. You may choose more than one option, but if you do not choose, you will receive paper notices by standard mail.

I want to receive communication by: Paper notices An email sent to the email address listed in **2C**

3 Do you need to add or remove anyone in the household?

YES NO *If you marked "NO," please skip to question 3B*

3A Mark in the table below if any members currently on file need to be removed from the household:

Current Benefits: MA = Medical Assistance, BHA = Behavioral Health Administration

Remove?	Full Name	Date of Birth	Current Benefits	Date they left the household
<input type="checkbox"/> REMOVE				<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

3B If any one in the household has changes to their name, please update below:

Full Name (Currently On File)	Date of Birth	What is their new first name?	What is their new middle name?	What is their new last name?	What date did this name change? (MM/DD/YYYY)
					<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

3C If anyone in the household's relationship to the Head of Household has changed, please update below:

Individual	Relationship to Head of Household (Currently On File)	What is the new relationship to Head of Household?	What date did this relationship change? (MM/DD/YYYY)
			<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

3D If anyone in the household's marital status has changed, please update below:

Individual	Marital Status (Currently On File)	What is the new marital status?	What date did this marital status change? (MM/DD/YYYY)
			<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

3E We do not have a Social Security Number (SSN) or Taxpayer ID on file for the following members of your household. Please update their information below:

If they are requesting Health First Colorado or Child Health Plan Plus (CHP+), and have a SSN, we need this information.

- If you provide their SSN, it will help us to quickly process their renewal. We use SSNs to check income and other information to see what type of health coverage they may qualify for. You do not need to provide immigration status or Social Security Number (SSN) for household members who are not requesting health coverage.

If they do not have a SSN, and they are requesting health coverage, tell us why they do not have a SSN.

- If they are not eligible to receive a SSN, do they have a Taxpayer Identification Number (TIN), such as an Individual Taxpayer Identification Number (ITIN) or an Adoption Taxpayer Identification Number (ATIN)? If so, enter it below.
- If they do not have a Social Security Number, please visit <http://www.ssa.gov/ssnumber/> for information on how to apply for a Social Security Number. You may also call the Social Security Administration at **1-800-772-1213** (TTY 1-800-325-0778).

Individual	Social Security Number (SSN) or Taxpayer ID	If they do not have an SSN, Please tell us why:
	<div style="border: 1px solid black; padding: 5px; display: flex; align-items: center; justify-content: center;"> - - </div>	<input type="checkbox"/> Have applied for SSN <input type="checkbox"/> Only eligible to receive a SSN for a valid non-work reason <input type="checkbox"/> Not eligible to receive a SSN <input type="checkbox"/> Refuses to obtain due to well established religious objection

3F If you have a new person in your household, please complete the remaining questions:

#1

First Name: Middle Name: Last Name: Suffix (Jr., Sr. I, II, III):

Date of Birth (MM/DD/YYYY): / / Date added to household (MM/DD/YYYY): / / How is this person related to Head of Household?

Gender(Optional): Male Female Other Marital Status: As of / / this person's marital status is

Does this new person want to apply for health coverage? YES NO If "NO," do they have other health coverage? YES NO

Help with past medical cost may be available during the 3 months before the month this renewal was submitted. If they need help paying for medical care received when they were not covered, when did they receive the care?
Please include proof of expenses for each month you request retroactive coverage.

Month One: (MM/YYYY)	<input type="text"/> / <input type="text"/>	Month Two: (MM/YYYY)	<input type="text"/> / <input type="text"/>	Month Three: (MM/YYYY)	<input type="text"/> / <input type="text"/>
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If they are requesting Health First Colorado or Child Health Plan Plus (CHP+), and have a SSN, we need this information.

- If you provide their SSN, it will help us to quickly process their renewal. We use SSNs to check income and other information to see what type of health coverage they may qualify for. You do not need to provide immigration status or Social Security Number (SSN) for household members who are not requesting health coverage.

If they do not have a SSN, and they are requesting health coverage, tell us why they do not have a SSN.

- If they are not eligible to receive a SSN, do they have a Taxpayer Identification Number (TIN), such as an Individual Taxpayer Identification Number (ITIN) or an Adoption Taxpayer Identification Number (ATIN)? If so, enter it below.
- If they do not have a Social Security Number, please visit <http://www.ssa.gov/ssnumber/> for information on how to apply for a Social Security Number. You may also call the Social Security Administration at **1-800-772-1213** (TTY 1-800-325-0778).

If they do have an SSN or Taxpayer ID, please provide it below:

SSN TaxPayer ID

- -

If they do not have an SSN, please tell us why:

- Have applied for SSN
- Only eligible to receive a SSN for a valid non-work reason
- Not eligible to receive a SSN
- Refuses to obtain due to well established religious objection

3G Please provide the information below for the new person in your household:

1. Does this person file federal taxes? YES NO

2. Is this person living with both parents, but the parents do not expect to file a joint tax return? YES NO

3. Does this person expect to be claimed as a tax dependent on someone else's tax return? YES NO

4. Does this person have a medical, physical, mental, or developmental condition that has lasted, or is expected to last, more than 12 months, including blindness? YES NO

5. Does this person expect to be claimed by a non-custodial parent?
(the parent the child **does not** live with most nights) YES NO

6. Does this person have a medical, physical, mental, or developmental condition that causes them to regularly need help with some or all of their self care activities
(such as bathing, dressing, eating, using the bathroom)? YES NO

7. Does this person need to move to a nursing home, acute care, hospital, group home, mental health institution or long-term care facility within the next 30 days, or do they need in-home health care to stay in their home? YES NO

8. Does this person want to apply for Emergency Medicaid and/or Reproductive Benefits?
Applicants who are not a U.S. citizen, or a legal resident for at least 5 years, cannot receive full Medicaid benefits, but they may qualify for Emergency Medicaid and Reproductive Benefits. Emergency Medicaid and Reproductive Benefits can cover life-threatening emergencies, labor and delivery for pregnant people, and birth control. YES NO

9. Does this person want to apply for Family Planning Benefits? Family planning provides health care and counseling for preventing, delaying or planning a pregnancy. YES NO

10. Is this person a U.S. citizen or U.S. national? YES NO

11. If this person is not a U.S. citizen or U.S. national, do they have an eligible immigration status?
If **Yes**, fill out the following table: YES NO

Non-Citizen Status:		Immigration Document Type:	
Alien or I-94 Number:		Card/Passport Number:	
Document Expiration Date:		Country of Issuance:	
Have you lived in the U.S. since 1996?			
Are you, your spouse, or parent an honorable discharged veteran or an active-duty member of the U.S. military?			

4 Do you have new details about people in the household? YES NO *If you marked "NO," please skip to question 5*

4A If anyone in the household is currently pregnant, please provide details below:

Who is pregnant?	When did this pregnancy begin? (MM/DD/YYYY)	Expected Due Date (MM/DD/YYYY)	Expected Number of Babies
	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	
	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	

If you have Colorado Works and have not provided this before, please send in a doctor's statement with a due date.

4B Help with past medical cost may be available during the 3 months before the month this renewal was submitted. If they need help paying for medical care received when they were not covered, when did they receive the care?
Please include proof of expenses for each month you request retroactive coverage.

Individual	Month One (MM/YYYY)	Month Two (MM/YYYY)	Month Three (MM/YYYY)
	<input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/>

4C Is the information we have on file correct?

Individual	Asking for Health First Colorado? (Yes or No)	If changed, What is the correct answer?	Files Federal Taxes? (Yes or No)	If changed, What is the correct answer?	Living with both parents, but parents do not expect to file a joint tax return? (Yes or No)	If changed, What is the correct answer?
		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

Individual	Expected to be claimed as a tax dependent on someone else's tax return? (Yes or No)	If changed, What is the correct answer?	Expected to be claimed by a non-custodial parents (the parent the child does not live with most nights)? (Yes or No)	If changed, What is the correct answer?	Is this person now a full-time student? (Yes or No)	If changed, What is the correct answer?
		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

4D If this person has **changes to their immigration status** currently on file, please update below

Individual	Immigration Status (Currently on file)	If changed, what is their new immigration status?	If changed, enter the Date of Change (MM/DD/YYYY)
			<input type="text"/> / <input type="text"/> / <input type="text"/>

4E If this person has **changes to their health insurance provider (other than Medicaid)** currently on file, please update below:

Individual	Other Health Insurance Provider (Currently on file)	If changed, what is their new health insurance provider?	If changed, enter their Coverage Start Date (MM/DD/YYYY)
			<input type="text"/> / <input type="text"/> / <input type="text"/>

4F **Does this person want to apply for Emergency Medicaid and/or Reproductive Benefits?** Applicants who are not a U.S. citizen, or a legal resident for at least 5 years, cannot receive full Medicaid benefits, but they may qualify for Emergency Medicaid and Reproductive Benefits. Emergency Medicaid and Reproductive Benefits can cover life-threatening emergencies, labor and delivery for pregnant people, and birth control.

Individual	Yes or No?
	<input type="checkbox"/> YES <input type="checkbox"/> NO

4G **Does this person want to apply for Family Planning Benefits?** Family planning provides health care and counseling for preventing, delaying or planning a pregnancy.

Individual	Yes or No?

Individual	Yes or No?
	<input type="checkbox"/> YES <input type="checkbox"/> NO

5 Please review the income information on file and report if you have any changes:
 To receive a quicker decision, proof of your income can be provided. Further information may be requested by the local office.

5A Update currently on-file information about income in your household:
 If anyone in the household has changes to their (job, self-employment or other income source), please update below:

Income Source #	[Individual]	[employer]
Income Type	Amount	How Often Paid?
<input type="checkbox"/> Job <input type="checkbox"/> Self-employment <input type="checkbox"/> Other Income		
Do they still receive income through this source? <input type="checkbox"/> YES <input type="checkbox"/> NO If "NO", when was their last day? (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>		How often are they paid now? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other: <input style="width: 100px;" type="text"/>
Gross amount of most recent payment \$ <input style="width: 100px;" type="text"/> Date of most recent paycheck (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>		
Is this a seasonal job? (Complete if job income) <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES," what is the annual gross income for this seasonal job? \$ <input style="width: 100px;" type="text"/>		Did this job start or stop paying them in commissions or tips? <input type="checkbox"/> YES <input type="checkbox"/> NO (Complete if job income)

5B Does anyone in the household have new income to report? YES NO *If you marked "NO," please skip this page*

If anyone in the household has new income to report, please add below. If you need additional space, use the blank page at the end of the packet.
For self-employment, submit proof of income from self-employment for this month or last month with this form. Make sure to submit self-employment expenses so we can assess net profit.
For other income, send proof of changes for new sources.

#1

Individual

Income type (select one):

Job Self-employment Other Income

Employer (if applicable):

Date Income Started (MM/DD/YYYY):

Received date of first payment (MM/DD/YYYY):

How often is this person paid?

One Time Weekly Every 2 Weeks Monthly Other:

What was the gross amount of their most recent payment?

\$

Do they expect this amount to stay roughly the same for the next year?

YES NO

If Job Income:

Type of income they earn:

Salary / Tips / Hourly Wages
 Other

Is this a job that pays commissions or tips?

YES NO

Is this a seasonal job?

YES NO

If "YES," what is the annual gross income for this seasonal job?

\$

If Other Income:

Income type:

Social Security Child Support Alimony/Spousal Support Unemployment Other:

#2

Individual

Income type (select one):

Job Self-employment Other Income

Employer (if applicable):

Date Income Started (MM/DD/YYYY):

Received date of first payment (MM/DD/YYYY):

How often is this person paid?

One Time Weekly Every 2 Weeks Monthly Other:

What was the gross amount of their most recent payment?

\$

Do they expect this amount to stay roughly the same for the next year?

YES NO

If Job Income:

Type of income they earn:

Salary / Tips / Hourly Wages
 Other

Is this a job that pays commissions or tips?

YES NO

Is this a seasonal job?

YES NO

If "YES," what is the annual gross income for this seasonal job?

\$

If Other Income:

Income type:

Social Security Child Support Alimony/Spousal Support Unemployment Other:

