Health First COLORADO™
Colorado's Medicaid Program

CHP+
Child Health Plan *Plus*

Case Number:

You must take action or you may lose your benefits.
It is time to renew your health coverage. We need to see if you and your household members still qualify for Health First Colorado (Colorado's Medicaid Program).

How Can I Submit My Renewal?

- **Online:** Go to CO.gov/PEAK. Log in to your account. Click "Manage my benefits."
  Then choose "Renew Benefits." If you do not have an account, you can create one at any time.
  Follow the instructions on CO.gov/PEAK to create an account.

- **Mobile app:** Download the Health First Colorado app and log in with your PEAK account or create an account on the mobile app to complete and electronically sign the renewal form. Use this app to:
  - See if your coverage is active
  - Complete your yearly renewal
  - Learn about your health coverage
  - Update your information
  - Find providers
  - View your member ID card

  Health First COLORADO™ Colorado's Medicaid Program — Download on App Store — GET IT ON Google Play

  Sign up to get helpful information about your Health First Colorado benefits by text! Text "JOIN" to 66596. Message and data rates may apply.

- **Paper:** Mail, fax, or bring the completed signature page and updated renewal form pages to your local county office:

- **Fax:**
- **Call:** at /State Relay: 711 and tell them you are calling about renewal of your health coverage.

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.

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 coestaterecovery@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): ☐☐ / ☐☐ / ☐☐☐☐

☐ 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

Authorized Representative Middle Name

Authorized Representative Last Name

Organization/Company Name (if applicable)

Organization/Company ID (if applicable)

Authorized Representative Street Address (leave blank if you don't have one)

Apartment/Suite #

City

State

Zip Code

County

Email Address

Phone Number ( ) -

Phone Extension

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): / /

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)	( ) -	☐ Cell ☐ Work ☐ Home

Email (Currently On File)		**New Email Address?**	

Preferred method of contact:	☐ Call Home Phone	☐ Call Cell Phone	☐ Text Cell Phone

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
☐ REMOVE				/ /

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)**
					/ /

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)
			/ /

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)
			/ /

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:
	☐☐☐ - ☐☐ - ☐☐☐☐	☐ 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

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)	__ __ / __ __ __ __	Month Two: (MM/YYYY)	__ __ / __ __ __ __	Month Three: (MM/YYYY)	__ __ / __ __ __ __

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
	/ /	/ /	
	/ /	/ /	

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)
	/	/	/

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?
		☐ YES ☐ NO		☐ YES ☐ NO		☐ YES ☐ 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?**
		☐ YES ☐ NO		☐ YES ☐ NO		☐ YES ☐ 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)
			☐☐/☐☐/☐☐☐☐

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)
			☐☐/☐☐/☐☐☐☐

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?**
	☐ YES ☐ 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?
	☐ YES ☐ 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?
☐ Job ☐ Self-employment ☐ Other Income		

Do they still receive income through this source? ☐ YES ☐ NO

If "NO", when was their last day? (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

How often are they paid now?

☐ Weekly ☐ Every 2 Weeks ☐ Monthly

☐ Other:

Gross amount of most recent payment $

Date of most recent paycheck (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

Is this a seasonal job? (Complete if job income) ☐ YES ☐ NO

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

Did this job start or stop paying them in commissions or tips? (Complete if job income) ☐ YES ☐ NO

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:

If you have any **additional information to help explain your renewal changes**, please do so below: