



Case Number:

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). You must take action or you may lose your benefits.

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



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.



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 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 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 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

Health First Colorado

Case Number:

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

Please refer to What I Should Know - Rights & Responsibilities before signing.

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.

If your household needs to **change its primary phone number**, please update here

Primary Phone Number (Currently On File)	XX	
Primary Phone Number (New)	(<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="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Home

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"/>
---	---

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"/>	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):

 / /

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.)

1. Is still in this household?

YES NO If "NO," please provide the date they left the household (MM/DD/YYYY): []/[]/[]

If you marked "NO" above, please skip the remaining questions for this person.

2. If this person has changes to their name, please update below:

Table with 5 columns: 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) []/[]/[]

3. If this person's relationship to has changed, please update below:

Table with 3 columns: Relationship to (Currently On File), What is the new relationship to ?, What date did this relationship change? (MM/DD/YYYY).

4. If this person has changes to their home address, please update below:

If your household has moved to a new home address, please also update shelter expenses for null null.

Table with 2 columns: Home Address (Currently On File), XXX

Street Address, Apartment #, City, State, Zip, What date did this address change? (MM/DD/YYYY)

5. If this person has changes to their mailing address, please update below:

Table with 2 columns: Mailing Address (Currently On File), XXX

SAME AS NEW HOME ADDRESS? YES NO

Street Address, Apartment #, City, State, Zip, What date did this address change? (MM/DD/YYYY)

6. Help with past medical costs may be available during the 3 months before the month you submit this renewal. If they **need help paying for medical care received when they were not covered**, when did they receive the care?

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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7. If this person is currently **pregnant**, please update below:

When did this pregnancy begin? (MM/DD/YYYY) Expected Due Date (MM/DD/YYYY): Expected Number of Babies:

/ / / /

8. If this person has **changes to their marital status**, please update below:

Marital Status On File	As of this person's marital status is
Updated Marital Status (MM/DD/YYYY)	As of <input type="text"/> / <input type="text"/> / <input type="text"/> this person's marital status is <input type="text"/>

9. If this individual has **changes to a job** currently on file, please update below:

Job #1 (Currently on File):		
Income Type	Amount	How Often Paid?
XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
Do they still work here? <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: 100%;" type="text"/>
Gross amount of most recent paycheck \$ <input style="width: 150px;" type="text"/> Date of most recent paycheck (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>		
Is this a seasonal job? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES," what is the annual gross income for this seasonal job? \$ <input style="width: 150px;" type="text"/>		Did this job start or stop paying them in commissions or tips? <input type="checkbox"/> YES <input type="checkbox"/> NO

11. If this person has a new job, please add below:

New Job #1:

Employer:

Date Started (MM/DD/YYYY): / /

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? \$

How Often Paid? One Time Weekly Every 2 Weeks
 Monthly Other:

When did they receive their **first** paycheck? (MM/DD/YYYY) / /

What was the gross amount of their **most recent** paycheck? \$

Do they expect this paycheck amount to stay roughly the same for the next year? YES NO

New Job #2:

Employer:

Date Started (MM/DD/YYYY): / /

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? \$

How Often Paid? One Time Weekly Every 2 Weeks
 Monthly Other:

When did they receive their **first** paycheck? (MM/DD/YYYY) / /

What was the gross amount of their **most recent** paycheck? \$

Do they expect this paycheck amount to stay roughly the same for the next year? YES NO

12. If this person has a **new source of self-employment income**, please add below:

New Self-Employment #1:

Employer:

Date Started (MM/DD/YYYY): / /

When did they receive their **first** paycheck? (MM/DD/YYYY) / /

What was the gross amount of their **most recent** paycheck? \$

Do they expect this paycheck amount to stay roughly the same for the next year? YES NO

Please submit proof of income from self-employment for this month or last month with this form, such as a copy of a profit and loss statement, a business ledger, a contract, or a bank statement. Make sure to submit self-employment expenses so we can assess net profit.

How Often Paid?
 One Time Weekly Every 2 Weeks
 Monthly Other:

New Self-Employment #2:

Employer:

Date Started (MM/DD/YYYY): / /

When did they receive their **first** paycheck? (MM/DD/YYYY) / /

What was the gross amount of their **most recent** paycheck? \$

Do they expect this paycheck amount to stay roughly the same for the next year? YES NO

Please submit proof of income from self-employment for this month or last month with this form, such as a copy of a profit and loss statement, a business ledger, a contract, or a bank statement. Make sure to submit self-employment expenses so we can assess net profit.

How Often Paid?
 One Time Weekly Every 2 Weeks
 Monthly Other:

13. If this person has changes to a source of unearned income (non-work income, such as child support or Social Security) currently on file, please update below. **Please send proof of changes to unearned income.**

Unearned Income (Currently on File)					
Income	Amount	How often is it received?	How often is it received now? (e.g., No Longer Receiving, Weekly, Every 2 Weeks, Monthly, etc.)	When did they last receive this income? (MM/DD/YYYY)	How much did they receive (gross amount)?
XXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXXXXXX		□□ / □□ / □□□□	\$
XXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXXXXXX		□□ / □□ / □□□□	\$
XXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXXXXXX		□□ / □□ / □□□□	\$
XXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXXXXXX		□□ / □□ / □□□□	\$
XXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXXXXXX		□□ / □□ / □□□□	\$
XXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXXXXXX		□□ / □□ / □□□□	\$

14. If this person has a new source of unearned income, please add below. Please send proof of changes if adding unearned income.

<p><u>New Unearned Income #1:</u></p> <p>Income Type:</p> <p><input type="checkbox"/> Social Security <input type="checkbox"/> Alimony or spousal support <input type="checkbox"/> Roomer/Boarder</p> <p><input type="checkbox"/> Unemployment <input type="checkbox"/> Other: <input type="text"/></p>		<p>Gross Amount:</p> <p>\$ <input type="text"/></p>	<p>When did they start receiving this income? (MM/DD/YYYY)</p> <p>□□ / □□ / □□□□</p>
		<p>How Often is it Received?</p> <p><input type="checkbox"/> One Time <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks</p> <p><input type="checkbox"/> Monthly <input type="checkbox"/> Other: <input type="text"/></p>	
<p><u>New Unearned Income #2:</u></p> <p>Income Type:</p> <p><input type="checkbox"/> Social Security <input type="checkbox"/> Alimony or spousal support <input type="checkbox"/> Roomer/Boarder</p> <p><input type="checkbox"/> Unemployment <input type="checkbox"/> Other: <input type="text"/></p>		<p>Gross Amount:</p> <p>\$ <input type="text"/></p>	<p>When did they start receiving this income? (MM/DD/YYYY)</p> <p>□□ / □□ / □□□□</p>
		<p>How Often is it Received?</p> <p><input type="checkbox"/> One Time <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks</p> <p><input type="checkbox"/> Monthly <input type="checkbox"/> Other: <input type="text"/></p>	

15. If this person has **changes to vehicles** currently on file, please update below. **Please send proof of changes to vehicles.**

Vehicles (Currently On File)					
Type	Year	Make	Model	Still Owned?	Date no longer owned (MM/DD/YYYY)
XXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	<input type="checkbox"/> No longer own	□□ / □□ / □□□□
XXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	<input type="checkbox"/> No longer own	□□ / □□ / □□□□
XXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	<input type="checkbox"/> No longer own	□□ / □□ / □□□□

16. If this person has a **new vehicle**, please add below. **Please send proof of changes if adding a vehicle.**

Adding New Vehicles						
Type	Year	Make	Model	Current Value	Are they the only owner of the vehicle?	When did they get this vehicle? (MM/DD/YYYY)
				\$	<input type="checkbox"/> YES <input type="checkbox"/> NO	□□ / □□ / □□□□
				\$	<input type="checkbox"/> YES <input type="checkbox"/> NO	□□ / □□ / □□□□

17. If this person has **changes to expenses** currently on file, please update below:

Expenses (Currently on File)						
Expense	Amount	How Often is it Paid?	How often is it paid now? (e.g., No Longer Paying, Weekly, Every 2 Weeks, Monthly, etc.)	How much was the last bill?	How much did they pay?	When did they pay? (MM/DD/YYYY)
XXXXXXXXXXXXXXXXXXXX	XXXXXXX	XXXXXXXXXXXX		\$	\$	
XXXXXXXXXXXXXXXXXXXX	XXXXXXX	XXXXXXXXXXXX		\$	\$	
XXXXXXXXXXXXXXXXXXXX	XXXXXXX	XXXXXXXXXXXX		\$	\$	
XXXXXXXXXXXXXXXXXXXX	XXXXXXX	XXXXXXXXXXXX		\$	\$	
XXXXXXXXXXXXXXXXXXXX	XXXXXXX	XXXXXXXXXXXX		\$	\$	
XXXXXXXXXXXXXXXXXXXX	XXXXXXX	XXXXXXXXXXXX		\$	\$	
XXXXXXXXXXXXXXXXXXXX	XXXXXXX	XXXXXXXXXXXX		\$	\$	

18. If this person has a new expense, please add below:

If additional expenses need to be added, please make a copy of this page, complete it, and send it in with the rest of the packet.

<p><u>New Expense #1:</u></p> <p>Expense Type: <input type="checkbox"/> Health Insurance Premiums <input type="checkbox"/> Shelter <input type="checkbox"/> Dependent Elder Care <input type="checkbox"/> Trust Fees <input type="checkbox"/> Prescriptions <input type="checkbox"/> Medical <input type="checkbox"/> Child Support <input type="checkbox"/> Child Care <input type="checkbox"/> Other: <input style="width:150px;" type="text"/></p>	<p>Expense Description (e.g., Rent, Deductibles, Dependent Name): <input style="width:100%; height:20px;" type="text"/></p> <p>Amount: \$ <input style="width:150px;" type="text"/> When did they start paying this expense? (MM/DD/YYYY) <input style="width:20px;" type="text"/> / <input style="width:20px;" type="text"/> / <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/></p> <p>How Often Paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other: <input style="width:100px;" type="text"/></p>
<p><u>New Expense #2:</u></p> <p>Expense Type: <input type="checkbox"/> Health Insurance Premiums <input type="checkbox"/> Shelter <input type="checkbox"/> Dependent Elder Care <input type="checkbox"/> Trust Fees <input type="checkbox"/> Prescriptions <input type="checkbox"/> Medical <input type="checkbox"/> Child Support <input type="checkbox"/> Child Care <input type="checkbox"/> Other: <input style="width:150px;" type="text"/></p>	<p>Expense Description (e.g., Rent, Deductibles, Dependent Name): <input style="width:100%; height:20px;" type="text"/></p> <p>Amount: \$ <input style="width:150px;" type="text"/> When did they start paying this expense? (MM/DD/YYYY) <input style="width:20px;" type="text"/> / <input style="width:20px;" type="text"/> / <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/></p> <p>How Often Paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other: <input style="width:100px;" type="text"/></p>
<p><u>New Expense #3:</u></p> <p>Expense Type: <input type="checkbox"/> Health Insurance Premiums <input type="checkbox"/> Shelter <input type="checkbox"/> Dependent Elder Care <input type="checkbox"/> Trust Fees <input type="checkbox"/> Prescriptions <input type="checkbox"/> Medical <input type="checkbox"/> Child Support <input type="checkbox"/> Child Care <input type="checkbox"/> Other: <input style="width:150px;" type="text"/></p>	<p>Expense Description (e.g., Rent, Deductibles, Dependent Name): <input style="width:100%; height:20px;" type="text"/></p> <p>Amount: \$ <input style="width:150px;" type="text"/> When did they start paying this expense? (MM/DD/YYYY) <input style="width:20px;" type="text"/> / <input style="width:20px;" type="text"/> / <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/></p> <p>How Often Paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other: <input style="width:100px;" type="text"/></p>
<p><u>New Expense #4:</u></p> <p>Expense Type: <input type="checkbox"/> Health Insurance Premiums <input type="checkbox"/> Shelter <input type="checkbox"/> Dependent Elder Care <input type="checkbox"/> Trust Fees <input type="checkbox"/> Prescriptions <input type="checkbox"/> Medical <input type="checkbox"/> Child Support <input type="checkbox"/> Child Care <input type="checkbox"/> Other: <input style="width:150px;" type="text"/></p>	<p>Expense Description (e.g., Rent, Deductibles, Dependent Name): <input style="width:100%; height:20px;" type="text"/></p> <p>Amount: \$ <input style="width:150px;" type="text"/> When did they start paying this expense? (MM/DD/YYYY) <input style="width:20px;" type="text"/> / <input style="width:20px;" type="text"/> / <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/></p> <p>How Often Paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other: <input style="width:100px;" type="text"/></p>

19. If this person has **changes to the value of their resources** or **no longer owns resources** currently on file, please update below.

Please send proof of changes to resources.

Resources (Currently on File)					
Resource	Value On File	If you no longer own this resource, fill out the below:		If they still own this resource and the value has changed, fill out the below:	
		Date no longer owned (MM/DD/YYYY)	If applicable, amount received for resource	Updated Value	When did the value of this resource change? (MM/DD/YYYY)
XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX		\$	\$	
XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX		\$	\$	
XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX		\$	\$	
XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX		\$	\$	
XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX		\$	\$	
XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX		\$	\$	

20. If this person has a **new resource**, please add below. **Please send proof of changes if adding a resource.**

<p>New Resource #1:</p> <p>Resource Type: <input type="checkbox"/> Bank Accounts <input type="checkbox"/> Properties <input type="checkbox"/> Trust Accounts <input type="checkbox"/> Life Insurance / Burial Policies <input type="checkbox"/> Stocks <input type="checkbox"/> Promissory Notes <input type="checkbox"/> Annuities <input type="checkbox"/> Other: <input style="width: 150px;" type="text"/></p>	<p>Resource Description: (e.g., Wells Fargo –Checking Account) <input style="width: 95%;" type="text"/></p> <p>When did they get this resource? (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Value: \$ <input style="width: 150px;" type="text"/></p>
<p>New Resource #2:</p> <p>Resource Type: <input type="checkbox"/> Bank Accounts <input type="checkbox"/> Properties <input type="checkbox"/> Trust Accounts <input type="checkbox"/> Life Insurance / Burial Policies <input type="checkbox"/> Stocks <input type="checkbox"/> Promissory Notes <input type="checkbox"/> Annuities <input type="checkbox"/> Other: <input style="width: 150px;" type="text"/></p>	<p>Resource Description: (e.g., Wells Fargo –Checking Account) <input style="width: 95%;" type="text"/></p> <p>When did they get this resource? (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Value: \$ <input style="width: 150px;" type="text"/></p>

21. If this person has **changes to the below information**, please update below:

	On File	New Value
Asking for Health First Colorado?	XXXXXXXXXX	<input type="checkbox"/> YES <input type="checkbox"/> NO
Files Federal Taxes?	XXXXXXXXXX	<input type="checkbox"/> YES <input type="checkbox"/> NO
Living with both parents, but parents do not expect to file a joint tax return?	XXXXXXXXXX	<input type="checkbox"/> YES <input type="checkbox"/> NO
Expects to be claimed by a non-custodial parent (the parent the child does not live with most nights)?	XXXXXXXXXX	<input type="checkbox"/> YES <input type="checkbox"/> NO
Expects to be claimed as a tax dependent on someone else's tax return?	XXXXXXXXXX	<input type="checkbox"/> YES <input type="checkbox"/> NO

22. If this person has **changes to their immigration status** currently on file, please update below:

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

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

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

24. Is this person now a **full-time student**? YES NO

4. 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 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

5. Does this person file federal taxes? YES NO

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

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

8. 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

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

10. 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

11. 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

12. If this person has a **new job**, please add below:

New Job #1:

Employer:

Date Started (MM/DD/YYYY): / /

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? \$

How Often Paid? One Time Weekly Every 2 Weeks Monthly Other:

When did they receive their **first** paycheck? (MM/DD/YYYY) / /

What was the gross amount of their **most recent** paycheck? \$

Do they expect this paycheck amount to stay roughly the same for the next year? YES NO

New Job #2:

Employer:

Date Started (MM/DD/YYYY): / /

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? \$

How Often Paid? One Time Weekly Every 2 Weeks Monthly Other:

When did they receive their **first** paycheck? (MM/DD/YYYY) / /

What was the gross amount of their **most recent** paycheck? \$

Do they expect this paycheck amount to stay roughly the same for the next year? YES NO

13. If this person has a **new source of self-employment income**, please add below:

New Self-Employment #1:

Employer:

Date Started (MM/DD/YYYY): / /

When did they receive their **first** paycheck? (MM/DD/YYYY) / /

What was the gross amount of their **most recent** paycheck? \$

Do they expect this paycheck amount to stay roughly the same for the next year? YES NO

Please submit proof of income from self-employment for this month or last month with this form, such as a copy of a profit and loss statement, a business ledger, a contract, or a bank statement. Make sure to submit self-employment expenses so we can assess net profit.

How Often Paid?

One Time Weekly Every 2 Weeks

Monthly Other:

New Self-Employment #2:

Employer:

Date Started (MM/DD/YYYY): / /

When did they receive their **first** paycheck? (MM/DD/YYYY) / /

What was the gross amount of their **most recent** paycheck? \$

Do they expect this paycheck amount to stay roughly the same for the next year? YES NO

Please submit proof of income from self-employment for this month or last month with this form, such as a copy of a profit and loss statement, a business ledger, a contract, or a bank statement. Make sure to submit self-employment expenses so we can assess net profit.

How Often Paid?

One Time Weekly Every 2 Weeks

Monthly Other:

14. If this person has a new source of unearned income, please add below. Please send proof of changes if adding unearned income.

<p><u>New Unearned Income #1:</u></p> <p>Income Type:</p> <p><input type="checkbox"/> Social Security <input type="checkbox"/> Alimony or spousal support <input type="checkbox"/> Roomer/Boarder</p> <p><input type="checkbox"/> Unemployment <input type="checkbox"/> Other: <input type="text"/></p>	<p>Gross Amount:</p> <p>\$ <input type="text"/></p> <p>How Often is it Received?</p> <p><input type="checkbox"/> One Time <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks</p> <p><input type="checkbox"/> Monthly <input type="checkbox"/> Other: <input type="text"/></p>	<p>When did they start receiving this income? (MM/DD/YYYY)</p> <p><input type="text"/> / <input type="text"/> / <input type="text"/></p>
<p><u>New Unearned Income #2:</u></p> <p>Income Type:</p> <p><input type="checkbox"/> Social Security <input type="checkbox"/> Alimony or spousal support <input type="checkbox"/> Roomer/Boarder</p> <p><input type="checkbox"/> Unemployment <input type="checkbox"/> Other: <input type="text"/></p>	<p>Gross Amount:</p> <p>\$ <input type="text"/></p> <p>How Often is it Received?</p> <p><input type="checkbox"/> One Time <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks</p> <p><input type="checkbox"/> Monthly <input type="checkbox"/> Other: <input type="text"/></p>	<p>When did they start receiving this income? (MM/DD/YYYY)</p> <p><input type="text"/> / <input type="text"/> / <input type="text"/></p>

