DATE

PATIENT NAME
PATIENT ADDRESS
CITY, STATE ZIP
PATIENT EMAIL ADDRESS(if available)

Dear (PATIENT NAME),

To be eligible under Colorado's Hospital Discounted Care law your gross household income must be at or below 250% of the Federal Poverty Guidelines (FPG). After reviewing your submitted application and supporting documentation, you are **not eligible** for financial assistance. Details below include household members that were used in household size only.

Household Member	Denied for
John Doe	Hospital Discounted Care/Internal Charity
Jane Doe	Hospital Discounted Care/Internal Charity
James Doe	Household size only (current CHP+/ Health First Colorado)

If your household size and/or income changes and you would like to re-apply for financial assistance, please contact us at (PHONE NUMBER) or (EMAIL ADDRESS IF APPLICABLE/AVAILABLE).

Your household was determined ineligible for Hospital Discounted Care due to (REASON[S]).

The determination covers the date(s) of service (DATE[S]).

The information we used to make the ineligible determination is:

- Household size -
- (ANNUAL/MONTHLY) Household income - $
- Household calculated FPG-

Members of your household may be potentially eligible for the following programs:

- Health First Colorado (Colorado's Medicaid Program) or Child Health Plan *Plus* (CHP+) or Emergency Medicaid - Apply by (DATE) to ensure coverage of (DATE OF SERVICE) at (COUNTY) Department of Human Services (PHONE NUMBER/WEBSITE) or online at healthfirstcolorado.com.
- Medicare - Apply at (COUNTY/LOCAL) Social Security Administration (ADDRESS AND/OR PHONE NUMBER) or online at medicare.gov.
- Subsidies through Connect for Health Colorado - More information on enrollment dates and special enrollment periods can be found on connectforhealthco.com.

If you do not agree with this determination, you have the right to appeal the decision:

- The patient/guardian has 30 calendar days from the date this determination letter was received to appeal (HOSPITAL NAME) ineligibility determination. The appeal must be submitted in writing:
    - By mail: (HOSPITAL APPEALS MAILING ADDRESS)
    - By email: (HOSPITAL APPEALS CONTACT EMAIL ADDRESS IF APPLICABLE/AVAILABLE)

(HOSPITAL NAME) has 15 calendar days from the date of the received appeal to complete a redetermination of eligibility and respond to the patient/guardian.

Patients may also file appeals or submit Hospital Discounted Care complaints to the Department of Health Care Policy and Financing at hcpf_HospDiscountCare@state.co.us or 303-866-2580.

Thank you,

Financial Counselor Signature