COLORADO
Department of Health Care Policy & Financing

Version 3

SCREENING:
Likely Eligibility for Public Health Insurance and Financial Assistance Programs

RESPONSES PROVIDED BY ELIGIBILITY TECHNICIAN	
What is the eligibility technician's full name?	
Hospital facility name?	
Facility phone number?	
What is today's date?	
Earliest date of service applying to cover?	

RESPONSES PROVIDED BY PATIENT	
Patient Contact Information	
Patient's Last Name	
Patient's First Name	
Patient's Middle Initial (OPTIONAL)	
Patient's street address	
Patient's city of residence	
Patient's zip code	
Patient's county	
Patient's primary phone number	
Patient's primary email address	
Patient's preferred method of contact	
Is the patient experiencing homelessness?	
Patient Demographic Information	
What is your birthday? [MM/DD/YYYY]	
Patient Residency	
Are you a resident of or currently living in Colorado? You can say "yes," "no," or "I don't want to answer."	
Pregnancy and Children (Optional)	
Are you currently pregnant? You can say "yes," "no," or "I don't want to answer." People who are pregnant sometimes qualify for some additional programs.	
Is anyone in your household under 19 years old? You can say "yes," "no," or "I don't want to answer." Children sometimes qualify for some programs that adults don't qualify for.	
Disabilities	
Do you have a disability? You can say "yes," "no," or "I don't want to answer." People with disabilities sometimes qualify for programs that people without disabilities don't qualify for.	
Do you receive federal disability income? You can say "yes," "no," or "I don't want to answer." People who receive federal disability income can automatically qualify for Medicare.	
Patient Insurance Status and Benefits	
Do you have insurance? You can say "yes," "no," or "I don't want to answer." *Health Sharing Ministries count as third party payers but not insurance.*	

Have you ever been covered under Medicaid or CHP+?	
If so, what is your Member ID if you have or know it?	
Do you have an unexpired Colorado Indigent Care Program rating?	

Household Size and Household Income

How many people live in your household, including yourself?	
Do you have any income? If so, about how much money do you receive each month?	$0.00
Is anyone in your household pregnant right now? If so, how many babies are expected? (Add unborn children as household members below) Some programs take pregnancy into account when counting how many people are in your household. When there are more children in your household, you may be more likely to qualify for some programs.	

Household Member 2

Name of Household Member 2 (OPTIONAL)	
What is the relationship to Household Member 2 to you?	
Does Household Member 2 have any income? If so, about how much money do they receive each month? If not, enter $0.	$0.00
Is this household member included in patient/guardian's taxes?	

Household Member 3

Name of Household Member 3 (OPTIONAL)	
What is the relationship to Household Member 3 to you?	
Does Household Member 3 have any income? If so, about how much money do they receive each month? If not, enter $0.	$0.00
Is this household member included in patient/guardian's taxes?	

Household Member 4

Name of Household Member 4 (OPTIONAL)	
What is the relationship to Household Member 4 to you?	
Does Household Member 4 have any income? If so, about how much money do they receive each month? If not, enter $0.	$0.00
Is this household member included in patient/guardian's taxes?	

Household Member 5

Name of Household Member 5 (OPTIONAL)	
What is the relationship to Household Member 5 to you?	
Does Household Member 5 have any income? If so, about how much money do they receive each month? If not, enter $0.	$0.00
Is this household member included in patient/guardian's taxes?	

Household Member 6

Name of Household Member 6 (OPTIONAL)	
What is the relationship to Household Member 6 to you?	
Does Household Member 6 have any income? If so, about how much money do they receive each month? If not, enter $0.	$0.00
Is this household member included in patient/guardian's taxes?	

Household Member 7

Name of Household Member 7 (OPTIONAL)	
What is the relationship to Household Member 7 to you?	
Does Household Member 7 have any income? If so, about how much money do they receive each month? If not, enter $0.	$0.00
Is this household member included in patient/guardian's taxes?	

Household Member 8

Name of Household Member 8 (OPTIONAL)	
What is the relationship to Household Member 8 to you?	

Does Household Member 8 have any income? If so, about how much money do they receive each month? If not, enter $0.	$0.00
Is this household member included in patient/guardian's taxes?	

Household Member 9

Name of Household Member 9 (OPTIONAL)	
What is the relationship to Household Member 9 to you?	
Does Household Member 9 have any income? If so, about how much money do they receive each month? If not, enter $0.	$0.00
Is this household member included in patient/guardian's taxes?	

Household Member 10

Name of Household Member 10 (OPTIONAL)	
What is the relationship to Household Member 10 to you?	
Does Household Member 10 have any income? If so, about how much money do they receive each month? If not, enter $0.	$0.00
Is this household member included in patient/guardian's taxes?	

Household Member 11

Name of Household Member 11 (OPTIONAL)	
What is the relationship to Household Member to you?	
Does Household Member 11 have any income? If so, about how much money do they receive each month? If not, enter $0.	$0.00
Is this household member included in patient/guardian's taxes?	

Household Member 12

Name of Household Member 12 (OPTIONAL)	
What is the relationship to Household Member 12 to you?	
Does Household Member 12 have any income? If so, about how much money do they receive each month? If not, enter $0.	$0.00
Is this household member included in patient/guardian's taxes?	

Household Member 13

Name of Household Member 13 (OPTIONAL)	
What is the relationship to Household Member 13 to you?	
Does Household Member 13 have any income? If so, about how much money do they receive each month? If not, enter $0.	$0.00
Is this household member included in patient/guardian's taxes?	

Household Member 14

Name of Household Member 14 (OPTIONAL)	
What is the relationship to Household Member 14 to you?	
Does Household Member 14 have any income? If so, about how much money do they receive each month? If not, enter $0.	$0.00
Is this household member included in patient/guardian's taxes?	

Household Member 15	
Name of Household Member 15 (OPTIONAL)	
What is the relationship to Household Member 15 to you?	
Does Household Member 15 have any income? If so, about how much money do they receive each month? If not, enter $0.	$0.00
Is this household member included in patient/guardian's taxes?	

Facility Deductions

Estimate of monthly deductions per Facility's deduction policies:

[Enter Deduction Type]	
[Enter Deduction Type]	
[Enter Deduction Type]	
[Enter Deduction Type]	
[Enter Deduction Type]	
[Enter Deduction Type]	
Total Monthly Deductions:	$0

AUTO-CALCULATE FEDERAL POVERTY GUIDELINES

Estimated household size as presented	1
Estimated annual household income as presented	$0.00
Estimated FPG as presented	0

HEALTH FIRST COLORADO, CHP+, EMERGENCY MEDICAID

Estimated household size	1
Estimated annual household income	$0.00
Estimated FPG	0

HOSPITAL DISCOUNTED CARE

Estimated household size	1
Estimated annual household income including deductions	$0.00
Estimated FPG	0

SCREENING RESULTS	
Note these are not official determinations of eligibility. For an official determination, the patient must apply for the program.	
Health First Colorado (Medicaid)	Likely eligible
CHP+ (Minors and Pregnant People only)	Likely not eligible
Medicare	Potentially eligible
Hospital Discounted Care	Could not determine residency
If the patient does not qualify for Health First Colorado due only to immigration status and they received emergency services, the patient should qualify for Emergency Medicaid	
If the patient does not qualify for Health First Colorado, CHP+, or Medicare, they may be eligible for financial assistance to purchase private health insurance through the Marketplace	

Assistance Mapping Tool: https://apps.colorado.gov/apps/maps/hcpf.map

Screening Notes

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Eligibility technician's full name	
Hospital facility name	
Facility phone number	
Today's date	
Earliest date of service applying to cover?	

Client Demographic Information

Patient's Last Name	
Patient's First Name	
Patient's Middle Initial	
Patient's Date of Birth	
Patient's street address	
Patient's city of residence	
Patient's zip code	
Patient's county	
Patient's primary phone number	
Patient's primary email address	
Patient's preferred method of contact	
Patient's Health First CO/CHP+ number (if applicable)	
Is the patient experiencing homelessness?	

Household Member 2

Household Member's Full Name	
Household Member's relationship to Patient	
Household Member's Birthday [MM/DD/YYYY]	
Household Member's Health First CO/CHP+ number (if applicable)	

Household Member 3

Household Member's Full Name	
Household Member's relationship to Patient	
Household Member's Birthday [MM/DD/YYYY]	
Household Member's Health First CO/CHP+ number (if applicable)	

Household Member 4

Household Member's Full Name	
Household Member's relationship to Patient	
Household Member's Birthday [MM/DD/YYYY]	
Household Member's Health First CO/CHP+ number (if applicable)	

Household Member 5

Household Member's Full Name	
Household Member's relationship to Patient	
Household Member's Birthday [MM/DD/YYYY]	
Household Member's Health First CO/CHP+ number (if applicable)	

Household Member 6

Household Member's Full Name	
Household Member's relationship to Patient	
Household Member's Birthday [MM/DD/YYYY]	
Household Member's Health First CO/CHP+ number (if applicable)	

Household Member 7

Household Member's Full Name	
Household Member's relationship to Patient	
Household Member's Birthday [MM/DD/YYYY]	
Household Member's Health First CO/CHP+ number (if applicable)	

Household Member 8

Household Member's Full Name	
Household Member's relationship to Patient	
Household Member's Birthday [MM/DD/YYYY]	
Household Member's Health First CO/CHP+ number (if applicable)	

Household Member 9

Household Member's Full Name	
Household Member's relationship to Patient	
Household Member's Birthday [MM/DD/YYYY]	
Household Member's Health First CO/CHP+ number (if applicable)	

Household Member 10

Household Member's Full Name	
Household Member's relationship to Patient	
Household Member's Birthday [MM/DD/YYYY]	
Household Member's Health First CO/CHP+ number (if applicable)	

Household Member 11

Household Member's Full Name	
Household Member's relationship to Patient	
Household Member's Birthday [MM/DD/YYYY]	
Household Member's Health First CO/CHP+ number (if applicable)	

Household Member 12

Household Member's Full Name	
Household Member's relationship to Patient	
Household Member's Birthday [MM/DD/YYYY]	
Household Member's Health First CO/CHP+ number (if applicable)	

Household Member 13

Household Member's Full Name	
Household Member's relationship to Patient	
Household Member's Birthday [MM/DD/YYYY]	
Household Member's Health First CO/CHP+ number (if applicable)	

Household Member 14

Household Member's Full Name	
Household Member's relationship to Patient	
Household Member's Birthday [MM/DD/YYYY]	
Household Member's Health First CO/CHP+ number (if applicable)	

Household Member 15

Household Member's Full Name	
Household Member's relationship to Patient	
Household Member's Birthday [MM/DD/YYYY]	
Household Member's Health First CO/CHP+ number (if applicable)	

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Worksheet 1 - Earned and Unearned Income

Payment Sources	Monthly Income	Documented	Self-Declared	Annualized Income
Earned Income:				
Employment Income	$0.00			$0.00
Monthly Unearned Income Sources:				
Social Security		☐	☐	$0.00
Social Security Disability Income (SSDI)		☐	☐	$0.00
Disbursement from Retirement Accounts		☐	☐	$0.00
Pension Payments		☐	☐	$0.00
Payments from Trust Funds		☐	☐	$0.00
Disbursement from Lottery Winnings		☐	☐	$0.00
Annual or One Time Income Sources:				
Bonuses (enter full amount of bonuses included on pay stubs)				$0.00
Short Term Disability (enter full amount of remaining payments from STD)				$0.00
Unemployment Income (use calculator to right)	$0.00			$0.00
Tips and Commissions (only if not normal on pay stub)				$0.00
Infrequent Overtime				$0.00
Earned Income Total	$0.00			$0.00
Unearned Income Total	$0.00			$0.00
Total Income:				$0.00

Eligibility Technician Signature

Date

Facility

Phone

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This worksheet must be signed and included with all applications.

Combined Earned Monthly Gross Income	
Patient/Guardian	
Total Household Gross Income	$0.00

Year-to-Date Methodology	
Cumulative Year-to-Date Earnings	
Pay Period Type	
Number of Paychecks Received Year-to-Date	
Number of Annual Pay Periods	0
Gross Monthly Income	$0.00

Average Pay Methodology		
Pay Period Type		
Pay Stubs		Gross Earnings
	1	
	2	
	3	
	4	
	5	
Paystub TOTAL		$0.00
Number of Paystubs		0
Monthly Income		$0.00

Unemployment Income	
Amount in Unemployment Bank at check/validate date	
Total Weekly Payment	
Date Unemployment Bank checked/validated	
Date of last received payment	
Date of last expected payment	
Total amount to include in application	$0.00

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Worksheet 2 - Net Self-Employment Income

	Business #1		Business #2		
Does the self-employed household member operate their business from their home?	Yes		Yes		
Square footage of household's home:					
Square footage used for household member's home business:					
Hours per week household member works out of their home:					
	Monthly	Business #1 Annualized	Monthly	Business #2 Annualized	Total Annualized
Revenue:					
Gross Business Income		$0.00		$0.00	$0.00
Business Property Expenses:					
Mortgage/Rent of Business Property		$0.00		$0.00	$0.00
Utilities		$0.00		$0.00	$0.00
		$0.00		$0.00	$0.00
		$0.00		$0.00	$0.00
Total Business Property Expenses:	$0.00	$0.00	$0.00	$0.00	$0.00
Other Expenses:					
Advertising		$0.00		$0.00	$0.00
Business Phone		$0.00		$0.00	$0.00
Business Taxes (non-personal)		$0.00		$0.00	$0.00
Fuel for Business-related Travel		$0.00		$0.00	$0.00
Gross Wages		$0.00		$0.00	$0.00
Insurance		$0.00		$0.00	$0.00
Legal Fees		$0.00		$0.00	$0.00
License/Certification Fees Paid		$0.00		$0.00	$0.00
Merchandise/Cost of goods		$0.00		$0.00	$0.00
Office Supplies		$0.00		$0.00	$0.00
Repairs/Upkeep of Equipment		$0.00		$0.00	$0.00
Tools/Equipment		$0.00		$0.00	$0.00
		$0.00		$0.00	$0.00
		$0.00		$0.00	$0.00
		$0.00		$0.00	$0.00
		$0.00		$0.00	$0.00
		$0.00		$0.00	$0.00
		$0.00		$0.00	$0.00
		$0.00		$0.00	$0.00
		$0.00		$0.00	$0.00
		$0.00		$0.00	$0.00
		$0.00		$0.00	$0.00
		$0.00		$0.00	$0.00
Total Other Expenses:	$0.00	$0.00	$0.00	$0.00	$0.00
Total Expenses:	$0.00	$0.00	$0.00	$0.00	$0.00
	Error in top four questions		Error in top four questions		
Net Profit	$0.00	$0.00	$0.00	$0.00	$0.00

Eligibility Technician Signature

Date

Facility

Phone

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This worksheet only needs to be signed and included if a household member owns their own business.

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Worksheet 3 - Deductions

Type of Deduction	Amount	Frequency	Annualized Amount
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
		Grand Total:	$0.00

Patient/Guardian declares they have no deductions ☐

Eligibility Technician Signature

Date

Facility

Phone

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PATIENT APPLICATION

Section I: PATIENT/APPLICANT

Experiencing Homelessness ☐

Today's Date: Effective Date: End Date:

First Name **Middle Initial** **Last Name**
Address **City**
Zip Code **County** **Phone Number**

	List Household Members	Relationship to Patient	Date of Birth	Health First CO/CHP+ Number	Household Member Approved for:
1.		PATIENT/APPLICANT			
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Section II: Calculating Income

Income Source	Monthly Income	Annualized Total
1. Gross Employment Income	**$0.00**	**$0.00**
2. Unearned Income	**$0.00**	**$0.00**
3. Self-Employment Income	**$0.00**	**$0.00**
4. Total Income (Lines 1 + 2 + 3)	**$0.00**	**$0.00**

5. Deductions **(See Worksheet 3)** **$0.00**

6. **Grand Total** Annual Income **$0.00**

FPG Percentage: **0** Household Size **1**

Facility Monthly Max.: **$0** **Physician Monthly Max.:** **$0**

PENALTY CLAUSE,CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the provider to use any information contained in the application to verify my eligibility for assistance under Hospital Discounted Care, and to obtain records pertaining to eligibility from a bank or other financial institution as defined in section 15-15-201(4), C.R.S., or from any insurance company.

YOU HAVE 30 CALENDAR DAYS TO APPEAL YOUR ELIGIBILITY DETERMINATION FOR HOSPITAL DISCOUNTED CARE
(Ask your eligibility technician for more information on the appeal process)

Print Patient/Guardian Name _____ Patient/Guardian Signature and Date _____

☐ Patient was contacted by ☐ phone ☐ email ☐ other: _____ and documentation of contact is attached in lieu of signature.

Print Eligibility Technician Name _____ Eligibility Technician Signature and Date _____

Print Hospital Name _____ Hospital Phone Number _____

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Application Notes