



Colorado Department of Health Care Policy and Financing administers a variety of Medical Assistance Programs for qualifying persons who live in Colorado and meet eligibility requirements.

# Application For Medical Assistance

**This application is to be used to apply for Colorado’s Medical Assistance Programs for yourself, your children, or for a family member.**

This application is for Medical Assistance Programs only. It is not for cash benefits or food assistance. To get an application for cash benefits or food assistance visit: [cdhs.state.co.us/servicebycounty.htm](http://cdhs.state.co.us/servicebycounty.htm) or your county department of human services. For online access visit: [Colorado.gov/PEAK](http://Colorado.gov/PEAK)

Please check the programs you are interested in:

- Medical Assistance Programs for Children, Families, and Pregnant Women:**  
For children under 19, families and pregnant women. This category includes Family Medicaid, Child Health Plan *Plus* (CHP+), and the Children’s Buy-In. Immediate, temporary coverage may be available for pregnant women and children through the Presumptive Eligibility Program.
- Medical Assistance Programs for Adults and Individuals with Disabilities:**  
For persons who are 19 and older, or have a disability, or are blind. This includes the programs for Adult Medicaid, Adults without Dependent Children, and the Adult Buy-In.
  - Please check if this is an application from a Women’s Wellness Connection (WWC) site for breast or cervical cancer.
- Long-Term Care (LTC) Services, such as Nursing Facility Care and Home and Community-Based Services (HCBS) Waivers for Adults and Children:**  
For persons needing help to pay for services received in their homes or a medical facility for more than 30 days. A medical and functional assessment is required.
  - Personal Needs Allowance (PNA):**  
For persons residing in a nursing facility who have income less than \$50 per month for personal needs—up to \$50 per month.
- Medicare Savings Programs (MSP):**  
For persons needing help to pay for some of their Medicare costs, such as premiums, deductibles and co-insurance.
- Emergency Medical Assistance:**  
For certain non-citizens who need help with an emergency medical expense and meet program eligibility criteria.

## some services that may be available are:

- Preventative Care
- Office Visits
- Prescriptions
- Hospital Care
- Dental Care
- Mental Health Care
- Nursing Facility Assistance
- Prenatal and Postpartum Care
- Immunizations (Shots)
- Medicare Part B Premiums
- Medicare Co-Pays and Deductibles
- Case Management for those under 21 years of age

## next steps

- **Check the “Not Applicable” box in the upper right hand corner of the page and the NA boxes within the application if there is a section that does not apply to you.**
- Pregnant women and children may be eligible for temporary coverage while their Family Medicaid or CHP+ application is being processed. Go to: [Colorado.gov/hcpf](https://Colorado.gov/hcpf) to find an approved Presumptive Eligibility (PE) location in your area.
- You can print the application and fill it out by hand OR you can enter your information online and print the application. Be sure to sign the printed application.
- If we have everything we need, your application will be reviewed and you will be sent a letter within 45 days. The letter will tell you if you qualify for Medical Assistance. If you need a disability determination, you will be sent a letter within 90 days.
- If we do not have everything we need, we will contact you. The processing of your application will be delayed.
- If you are applying for HCBS Children Waiver Services, complete the application with the child as the Head of Household. Parents' income and resources will not be considered for these programs.
- Never send original citizenship, identity or income documents with your application.
- If you need assistance in completing the application, visit an approved Application Assistance site or your local county department of human/social services. A directory of these locations can be found at [Colorado.gov/hcpf](https://Colorado.gov/hcpf)
- Complete and sign the application. Include copies of your certified citizenship and identification documents and other required verification, such as income and expenses.
- Take or mail your application to a Medical Assistance eligibility site or your county department of human/social services. Visit [Colorado.gov/hcpf](https://Colorado.gov/hcpf) for your local county contact information.
- You do not have to be a U.S. citizen to apply for assistance. Both U.S. citizens and qualified non-citizens may be eligible for Medical Assistance. Please do not let the fear about immigration status stop you from seeking benefits for your family. Receiving Medical Assistance will not stop you from gaining lawful permanent residence or U.S. citizenship.
- U.S. citizens who are applying for Medical Assistance Programs (except for MSP) may be asked to provide proof of citizenship and identity.
- **If applying for medical coverage for your family or children, you can mail the application to: Colorado Medical Assistance Program, PO Box 929, Denver, CO 80201-0929.**

**Tell us about the Head of Household or person completing this application who wants Medical Assistance for themselves, their family or the children in their care:**

Full Last Name	Maiden Name	First Name	Middle Initial
Physical Address	Apt #	City	State Zip Code
Mailing Address/PO Box	Apt #	City	State Zip Code
Phone (Home)	Phone (Work)	Phone (Cell/Message)	Email

What language(s) are spoken in the household? \_\_\_\_\_

**Tell us about all of the people living in your home.** (For Adult, LTC and MSP programs, be sure to include information about the applicant living outside of the home and information about the spouse.)

Full Last Name	First Name	Middle Initial	Birth Date (mm/dd/yyyy)	How Is This Person Related To You? (Self, Child, Step-Child, Spouse, Friend, etc.)	Does this person receive at least 50% support from the combined household? Yes/No	Is This Person Applying? Yes/No
				<b>SELF</b>		

1. Does anyone in the household who is applying for Medical Assistance have a physical or behavioral disability which has lasted or is expected to last more than 12 months? Yes  No   
 Person's Name \_\_\_\_\_  
 If yes, has the household member applied for SSI? Yes  No   
 Date of application? (mm/dd/yyyy) \_\_\_\_\_ What is the status of application? (pending, approved, denied) \_\_\_\_\_
2. Is anyone who is in the household or for whom you are applying currently in a medical facility, such as a nursing facility, hospital, a mental health institution or a group home (or has been within the last 90 days)? Yes  No  NA  If yes, complete the following:  
 Name of Person in Facility \_\_\_\_\_ Relationship \_\_\_\_\_ Date Entered \_\_\_\_\_  
 Name of Facility \_\_\_\_\_ Facility Address \_\_\_\_\_
3. Special services may be available to children and pregnant women. Please check any health services that any of your children get or use:  Medical Services  Mental or Behavioral Health Services  
 School Health Services  Prescriptions  Other \_\_\_\_\_
4. Has any child been to the emergency room for treatment since his or her last visit to the doctor? Yes  No
5. **Is anyone in the household pregnant?** Yes  No  If yes, what is her name? \_\_\_\_\_  
 When is her due date? \_\_\_\_\_ How many babies does she expect? \_\_\_\_\_  
 Name of father, if in the household \_\_\_\_\_

# tell us about anyone under 19 needing Medical Assistance

NOT APPLICABLE

One child/person under 19 per page. For more than 3 children, please attach an additional page(s).

This person is: Male  Female

Full Last Name	First Name	Middle Initial
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Social Security Number \_\_\_ / \_\_ / \_\_\_\_ Check here if this person does not have a social security number

Mother's name if living in the home: Last \_\_\_\_\_ Maiden \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Father's name if living in the home: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

1. Is this child a U.S. citizen? Yes  No  If yes, in which state was the child born? \_\_\_\_\_  
If no, is this child a legal permanent resident? Yes  No
2. Enter the child's alien registration number if he or she has one \_\_\_\_\_  
**Include a copy of the front and back of the U.S. Citizenship and Immigration Services card.**  
Does this child have an immigration sponsor? Yes  No
3. Does this child receive SSI or SSDI? Yes  No   
If no, has this adult ever received SSI/SSDI? Yes  No   
If yes, when did SSI/SSDI end? (mm/dd/yyyy) \_\_\_\_\_ Reason SSI/SSDI Ended: \_\_\_\_\_
4. Do you have any medical expenses for this child within the last 3 months? Yes  No   
If yes, what was the date(s) of care? \_\_\_\_\_ You **may** qualify for assistance with **some** of these expenses.
5. Is this child a full-time student? Yes  No  Name of school \_\_\_\_\_  
Last grade completed \_\_\_\_\_ Expected graduation date from high school, vocational or trade school (mm/dd/yyyy) \_\_\_\_\_
6. Does this child have an absent parent(s)? Yes  No  If yes, have there been steps taken to obtain medical support for the child's absent parent(s)? Yes  No
7. Please check the child's ethnic group(s). Certain groups may not have a CHP+ enrollment fee. This is not required but we want to make sure that all races and ethnicities are recognized and supported.  
 Caucasian     Hispanic/Latino     African American     Native American  
 Asian     Alaskan Native     Pacific Islander     Other: \_\_\_\_\_

**Proof of identification is also required for your child (for example, school ID with picture). Complete the information in the box below if your child is 15 or younger and no other identification is available at the time of application:**

## AFFIDAVIT TO ESTABLISH IDENTITY

I, (name of parent/guardian) \_\_\_\_\_, (relationship) \_\_\_\_\_ of  
(child's full name) \_\_\_\_\_ state under penalty of perjury that I have personal  
knowledge that (child's full name) \_\_\_\_\_ was born on (mm/dd/yyyy) \_\_\_\_\_,  
in (city, state, country of birth place) \_\_\_\_\_.

**I affirm and declare that the facts stated in this Affidavit are true and correct.**

Name of parent/guardian \_\_\_\_\_

Signature of parent or guardian \_\_\_\_\_ Date signed \_\_\_\_\_

# tell us about the next person under 19 needing Medical Assistance

NOT APPLICABLE

One child/person under 19 per page. For more than 3 children, please attach an additional page(s).

This person is: Male  Female

Full Last Name	First Name	Middle Initial
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Social Security Number \_\_\_ / \_\_\_ / \_\_\_\_\_ Check here if this person does not have a social security number

Mother's name if living in the home: Last \_\_\_\_\_ Maiden \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Father's name if living in the home: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

1. Is this child a U.S. citizen? Yes  No  If yes, in which state was the child born? \_\_\_\_\_  
If no, is this child a legal permanent resident? Yes  No
2. Enter the child's alien registration number if he or she has one \_\_\_\_\_  
**Include a copy of the front and back of the U.S. Citizenship and Immigration Services card.**  
Does this child have an immigration sponsor? Yes  No
3. Does this child receive SSI or SSDI? Yes  No   
If no, has this adult ever received SSI/SSDI? Yes  No   
If yes, when did SSI/SSDI end? (mm/dd/yyyy) \_\_\_\_\_ Reason SSI/SSDI Ended: \_\_\_\_\_
4. Do you have any medical expenses for this child within the last 3 months? Yes  No   
If yes, what was the date(s) of care? \_\_\_\_\_ You **may** qualify for assistance with **some** of these expenses.
5. Is this child a full-time student? Yes  No  Name of school \_\_\_\_\_  
Last grade completed \_\_\_\_\_ Expected graduation date from high school, vocational or trade school (mm/dd/yyyy) \_\_\_\_\_
6. Does this child have an absent parent(s)? Yes  No  If yes, have there been steps taken to obtain medical support for the child's absent parent(s)? Yes  No
7. Please check the child's ethnic group(s). Certain groups may not have a CHP+ enrollment fee. This is not required but we want to make sure that all races and ethnicities are recognized and supported.  
 Caucasian     Hispanic/Latino     African American     Native American  
 Asian     Alaskan Native     Pacific Islander     Other: \_\_\_\_\_

**Proof of identification is also required for your child (for example, school ID with picture). Complete the information in the box below if your child is 15 or younger and no other identification is available at the time of application:**

## AFFIDAVIT TO ESTABLISH IDENTITY

I, (name of parent/guardian) \_\_\_\_\_, (relationship) \_\_\_\_\_ of  
(child's full name) \_\_\_\_\_ state under penalty of perjury that I have personal  
knowledge that (child's full name) \_\_\_\_\_ was born on (mm/dd/yyyy) \_\_\_\_\_,  
in (city, state, country of birth place) \_\_\_\_\_.

**I affirm and declare that the facts stated in this Affidavit are true and correct.**

Name of parent/guardian \_\_\_\_\_

Signature of parent or guardian \_\_\_\_\_ Date signed \_\_\_\_\_

# tell us about the next person under 19 needing Medical Assistance

NOT APPLICABLE

One child/person under 19 per page. For more than 3 children, please attach an additional page(s).

This person is: Male  Female

Full Last Name	First Name	Middle Initial
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Social Security Number \_\_\_ / \_\_\_ / \_\_\_\_\_ Check here if this person does not have a social security number

Mother's name if living in the home: Last \_\_\_\_\_ Maiden \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Father's name if living in the home: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

1. Is this child a U.S. citizen? Yes  No  If yes, in which state was the child born? \_\_\_\_\_  
If no, is this child a legal permanent resident? Yes  No
2. Enter the child's alien registration number if he or she has one \_\_\_\_\_  
**Include a copy of the front and back of the U.S. Citizenship and Immigration Services card.**  
Does this child have an immigration sponsor? Yes  No
3. Does this child receive SSI or SSDI? Yes  No   
If no, has this adult ever received SSI/SSDI? Yes  No   
If yes, when did SSI/SSDI end? (mm/dd/yyyy) \_\_\_\_\_ Reason SSI/SSDI Ended: \_\_\_\_\_
4. Do you have any medical expenses for this child within the last 3 months? Yes  No   
If yes, what was the date(s) of care? \_\_\_\_\_ You **may** qualify for assistance with **some** of these expenses.
5. Is this child a full-time student? Yes  No  Name of school \_\_\_\_\_  
Last grade completed \_\_\_\_\_ Expected graduation date from high school, vocational or trade school (mm/dd/yyyy) \_\_\_\_\_
6. Does this child have an absent parent(s)? Yes  No  If yes, have there been steps taken to obtain medical support for the child's absent parent(s)? Yes  No
7. Please check the child's ethnic group(s). Certain groups may not have a CHP+ enrollment fee. This is not required but we want to make sure that all races and ethnicities are recognized and supported.  
 Caucasian     Hispanic/Latino     African American     Native American  
 Asian     Alaskan Native     Pacific Islander     Other: \_\_\_\_\_

**Proof of identification is also required for your child (for example, school ID with picture). Complete the information in the box below if your child is 15 or younger and no other identification is available at the time of application:**

## AFFIDAVIT TO ESTABLISH IDENTITY

I, (name of parent/guardian) \_\_\_\_\_, (relationship) \_\_\_\_\_ of  
(child's full name) \_\_\_\_\_ state under penalty of perjury that I have personal  
knowledge that (child's full name) \_\_\_\_\_ was born on (mm/dd/yyyy) \_\_\_\_\_,  
in (city, state, country of birth place) \_\_\_\_\_.

**I affirm and declare that the facts stated in this Affidavit are true and correct.**

Name of parent/guardian \_\_\_\_\_

Signature of parent or guardian \_\_\_\_\_ Date signed \_\_\_\_\_

# tell us about anyone 19 and over needing Medical Assistance

NOT APPLICABLE

This person is: Male  Female

Full Last Name	First Name	Middle Initial

Social Security Number \_\_\_ / \_\_\_ / \_\_\_\_

Check here if the adult does not have a social security number

1. Does this adult receive SSI or SSDI? Yes  No   
If no, has this adult ever received SSI/SSDI? Yes  No   
If yes, when did SSI/SSDI end? (mm/dd/yyyy) \_\_\_\_\_ Reason SSI/SSDI Ended: \_\_\_\_\_
2. Is this adult a U.S. citizen? Yes  No  If yes, in which state was the adult born? \_\_\_\_\_  
If no, is this adult a legal permanent resident? Yes  No
3. Enter this adult's alien registration numbers (if there is one) \_\_\_\_\_  
**Include a copy of the front and back of the U.S. Citizenship and Immigration Services card.**  
Does this adult have an immigration sponsor? Yes  No
4. Is the applicant or spouse a veteran? Yes  No
5. Has this adult had any medical expenses within the last 3 months? Yes  No   
If yes, what was the date(s) of care? (mm/dd/yyyy) \_\_\_\_\_ You **may** qualify for assistance with **some** of these expenses.
6. Does this adult need help on a regular basis with some or all of their daily self-care activities? (This means bathing, dressing, eating, getting around, and using the bathroom.) Yes  No
7. This adult's marital status is: Married  Single  Divorced  Separated  Widowed
8. Please check this adult's ethnic group(s). This is not required but we want to make sure that all races and ethnicities are recognized and supported.  
 Caucasian     Hispanic/Latino     African American     Native American  
 Asian     Alaskan Native     Pacific Islander     Other: \_\_\_\_\_

# tell us about the next person 19 and over needing Medical Assistance

NOT APPLICABLE

This person is: Male  Female

Full Last Name	First Name	Middle Initial

Social Security Number \_\_\_ / \_\_\_ / \_\_\_\_

Check here if the adult does not have a social security number

1. Does this adult receive SSI or SSDI? Yes  No   
If no, has this adult ever received SSI/SSDI? Yes  No   
If yes, when did SSI/SSDI end? (mm/dd/yyyy) \_\_\_\_\_ Reason SSI/SSDI Ended: \_\_\_\_\_
2. Is this adult a U.S. citizen? Yes  No  If yes, in which state was the adult born? \_\_\_\_\_  
If no, is this adult a legal permanent resident? Yes  No
3. Enter this adult's alien registration numbers (if there is one) \_\_\_\_\_  
**Include a copy of the front and back of the U.S. Citizenship and Immigration Services card.**  
Does this adult have an immigration sponsor? Yes  No
4. Is the applicant or spouse a veteran? Yes  No
5. Has this adult had any medical expenses within the last 3 months? Yes  No   
If yes, what was the date(s) of care? (mm/dd/yyyy) \_\_\_\_\_ You **may** qualify for assistance with **some** of these expenses.
6. Does this adult need help on a regular basis with some or all of their daily self-care activities? (This means bathing, dressing, eating, getting around, and using the bathroom.) Yes  No
7. This adult's marital status is: Married  Single  Divorced  Separated  Widowed
8. Please check this adult's ethnic group(s). This is not required but we want to make sure that all races and ethnicities are recognized and supported.  
 Caucasian     Hispanic/Latino     African American     Native American  
 Asian     Alaskan Native     Pacific Islander     Other: \_\_\_\_\_



# tell us about household income

COMPLETE FOR ALL PROGRAMS

1. If you or **anyone** in the household has **income from a job**, complete the following. Income must be from the same month and show a normal full month's pay. **If no one in the household has any income from a job, please check: NA**

All household income may need to be verified when applying for Medical Assistance. It is not required, but if you provide your Social Security Number (SSN)\*, we may be able to verify your income electronically through the Department of Labor's system. You may be asked for further information if needed.

Name of Person Working First and Last Name <b>SSN (Optional)*</b>	Employer Name and Phone	Month and Hours Worked	Paid Weekly, Every 2 Weeks, Twice a Month or Monthly?	Total Monthly Amount Before Taxes and Deductions
SSN:				\$
SSN:				\$
SSN:				\$
SSN:				\$

2. Has **anyone who is applying** received a lump sum payment? (lawsuit or insurance settlement, Social Security, SSI, SSDI, Veterans, inheritance, surrender of annuity or life insurance, other.)  
Yes  No  If yes, please complete the information below:

Name of Person Who Received Lump Sum	Type of Lump Sum	Amount Received	Date Received (mm/dd/yyyy)
		\$	
		\$	
		\$	
		\$	

# tell us about household income

COMPLETE FOR ALL PROGRAMS

(continued)

3. Tell us about **other income** anyone in your household received this or last month, even if they are not applying. Fill out a line for each item. **If no one in the household has other income, please check: NA**

Examples of **other income** include: • Public Assistance (cash) Benefits • Railroad Retirement • Rental Income • Survivor Benefits • Retirement/Pension • Social Security Benefits • SSI • SSDI • Veterans Benefits • Veteran Widow Benefits • Child Support • Dividends/Interest • Alimony • Unemployment • Worker's Compensation • Disability Benefits • Financial Aid • Other Cash Received Monthly

Type of Other Income	Month	Who is it for?	Monthly Amount Before Taxes and Deductions
			\$
			\$
			\$
			\$
			\$

4. Is anyone in your household **self-employed**? Yes  No  If **yes**, please **fill in** the following **chart(s)**. Include one full month of gross income. **Expenses must be for the same month as the gross income.** Complete one box for each self-employed person.

## SELF-EMPLOYMENT

Is the business in the home? Yes  No

Name:	Month:
<b>One Month's Gross Income</b>	<b>\$</b>
Business rent/mortgage expense	\$
Gross business labor costs	\$
Utilities paid for business	\$
Business taxes paid	\$
Interest paid for business	\$
Cost of merchandise for business	\$
Business equipment costs	\$
Other business costs	\$
<b>Net Income</b>	<b>\$</b>

Is the business in the home? Yes  No

Name:	Month:
<b>One Month's Gross Income</b>	<b>\$</b>
Business rent/mortgage expense	\$
Gross business labor costs	\$
Utilities paid for business	\$
Business taxes paid	\$
Interest paid for business	\$
Cost of merchandise for business	\$
Business equipment costs	\$
Other business costs	\$
<b>Net Income</b>	<b>\$</b>

Net income is your gross income minus expenses.

1. Is anyone who is applying for Medical Assistance receiving Medicare? Yes  No  If yes, please complete:

Name of person receiving Medicare \_\_\_\_\_ Medicare Number \_\_\_\_\_

Check for:  Part A  Part B  Part D

**Please include a copy of the front and back of the Medicare card if it is available.**

2. Has anyone who is applying had group health insurance **through an employer** within the last 3 months?  
Yes  No  **If no, go to question 3.**

Why did this insurance end?  It has not ended

The policyholder is no longer employed by company

The company no longer offers insurance

The employee voluntarily withdrew

Amount you pay/paid each month \$ \_\_\_\_\_ Amount employer pays/paid each month \$ \_\_\_\_\_

Name(s) of person(s) covered \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Name of Insurance Company \_\_\_\_\_

Insurance Company Phone Number ( ) \_\_\_\_\_ Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_ When did this insurance end? (mm/dd/yyyy) \_\_\_\_\_

3. Does anyone who is applying have any **other** type of medical health insurance? Yes  No   
**If no, go to question 4.**

Is this insurance COBRA? Yes  No

Name(s) of person(s) covered \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Name of Insurance Company \_\_\_\_\_

Policy/Group Number \_\_\_\_\_ Insurance Company phone number ( ) \_\_\_\_\_

**Please include a copy of the front and back of the insurance card if it is available.**

4. Do any members of this household have access to group health insurance and want help paying the monthly premium? Yes  No

Medical Assistance Programs use some of your expenses from your income when determining eligibility and benefits. All expenses must be paid from the same month of income reported on the income sections of this application.

Examples are included for each program.

- **Family Medicaid or CHP+:**

Family Medicaid and CHP+ do not need proof of expenses unless it is requested.

Examples of expenses that may be considered:

- Child Care • Dependent Elder Care • Medical Expenses • Child Support • Alimony
- Health Insurance Premiums • Prescriptions

- **Long-Term Care (LTC):**

LTC programs may need proof of expenses. Include the expenses for the applicant and for the applicant's spouse.

Examples of expenses that may be considered:

- Rent • Mortgages (first, second, third) • Heating • Cooling • Electricity • Water • Sewer • Trash
- Phone/Cell • HOA Fees • Facility • Care Provider • Medical

- **Medicare Savings Programs (MSP):**

MSP may need proof of expenses. Include the expenses for the applicant and for the applicant's spouse.

Examples of expenses that may be considered:

- Rent • Mortgages (first, second, third) • Heating • Cooling • Electricity • Water • Sewer • Trash • HOA Fees

Please list expenses:

Type of Expense	Who Pays this Expense	Who is it for	Month	Amount Paid
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$

# tell us about resources

**ONLY complete for Medical Assistance for adults, LTC and MSP programs**

**Do not complete for Family Medicaid or CHP+**

**NOT APPLICABLE**

**Adult Medical, LTC and MSP programs require proof of resources.**

1. Tell us about resources, such as • Cash • Checking and Saving Accounts • Certificates of Deposits (CD) • Annuities • Mutual Funds • Inheritance • PASS Accounts • Individual Development Accounts • Retirement Accounts • Stocks • Bonds • Trusts • Promissory Notes • College Funds • Education Accounts • Property (Land, Homes) • Proceeds from Sale of Home(s):

Type of Resource	Owner	Account Number	Amount	Name of Institution	Jointly Owned? Yes or No
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		

2. Does this applicant or spouse own or are they buying any land or property? (For example, house, rental property, timeshare, warehouse, or empty lot.) Yes  No  If yes, please complete:

Owner's Name	Jointly Owned? Yes or No	Full Address of Property	Type of Property	Value	Amount Owed
				\$	\$
				\$	\$
				\$	\$

# tell us about resources (continued)

**ONLY complete for Medical Assistance for adults, LTC and MSP programs**

**Do not complete for Family Medicaid or CHP+**

**NOT APPLICABLE**

3. Does this applicant or spouse have any vehicles? (car, van, truck, RV, boat, trailer) Yes  No   
If yes, please complete:

Owner(s)	Jointly Owned? Yes or No	Type of Vehicle	Year	Make/Model	Value	Amount Owed

4. Does this applicant or spouse have any life insurance policies? Yes  No  If yes, please list below:

Policy Owner	Policy Number	Individuals Covered	Insurance Company	Face Value	Cash Value

5. Does this applicant or spouse have a burial policy or any money set aside to be used for burial, cremation, or other funeral expenses? Yes  No  If yes, please complete:

Name of Applicant or Spouse	Amount	Is it Irrevocable? Yes or No	Name of Institution or Person Holding the Money

6. There may be help with funeral expenses for some recipients. If your family should need such help, what would the recipient prefer? Cremation  Burial  No Preference

7. Has the applicant or spouse given away anything of value within the last 5 years? For example, land, home, money, buildings, cars, boats. Yes  No  If yes, please complete the following:

Person Who Gave Item Away	Item Given Away	Date Given Away	Value of Item	Amount Owed

I know that when I sign this application, the State of Colorado can check to see if the information I gave is true and correct.

- To help you organize your documents, please check off the items you are sending with this application.
  - Proof of citizenship and identification for all applicants as requested. (Except MSP)
  - Copy of the front and back of U.S. Citizen and Immigration Services (INS) card, if you have one, for any non-citizen who will receive care and who is applying for Medical Assistance.
  - For each applicant that is pregnant, send a health care provider's note showing the due date with the number of babies expected.
  - Reported income **from a job** needs to be from this month or last month. The income must be from the same month and represent a full month's pay. If self-employed, complete the self-employment boxes in this application. Parents living in the household who are applying for Medical Assistance for their children must report all earned and unearned income.
  - If covered by health insurance, send a copy of the insurance card (front and back), if you have it.
  - If asking for **Medicaid** to cover old medical expenses, report the income for the month(s) of service(s) on page 9, question 1.
- How did you hear about Medical Assistance Programs?  county department of human/social services  community organization  Medicaid/Medical Assistance web site  media  other \_\_\_\_\_
- If you would like to register to vote you can go to: [sos.state.co.us](http://sos.state.co.us) → Voter Registration
- If we are in need of additional information regarding your application and are unable to contact you or the applicant, is there someone we may contact? Yes  No   
Name \_\_\_\_\_  
Phone (\_\_\_\_\_) \_\_\_\_\_ Address \_\_\_\_\_  
Relationship to Applicant \_\_\_\_\_

### SIGNATURE AND CERTIFICATION:

By signing this application I am giving my permission to the State of Colorado and its designees to make contacts to verify the information given on this application. I certify that I have read and understand the information on the "what I should know" insert and have been given a copy for my records. Under penalty of perjury I certify all information I have given is true and correct.

Print Name Here \_\_\_\_\_ Sign Here \_\_\_\_\_ Date \_\_\_\_\_

Authorized Representative, Conservator, Guardian, other contact: (please print) \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Print name of Agency Representative or Outreach Specialist who helped fill out the application \_\_\_\_\_

Signature of person who helped fill out the application \_\_\_\_\_

Date \_\_\_\_\_ Phone \_\_\_\_\_ Agency or Site Name \_\_\_\_\_

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## By signing the Medical Assistance Application I understand the following:

- The Department of Health Care Policy and Financing is the state agency responsible for Medical Assistance Programs in Colorado.
- If I receive **Medical Assistance, including Medicaid**, I must tell my county department of human/social services within 10 days about income or any other changes.
- The information given is confidential. However, it can be used or shared by the program(s) that each of my family members is enrolled in for purposes of treatment, payment, program operations, and other purposes permitted by law.
- I must tell the truth and answer all the questions on this application. If I do not tell the truth, I will lose my Medical Assistance, and I may have to pay the Department for the Medical Assistance received.
- My information will be checked with other federal and state agencies and that information received may affect my eligibility.
- It is a crime punished by fines and/or jail time to take benefits that I know my family is not eligible to receive.
- I must cooperate fully with state and federal staff if my case is reviewed.
- If there is an absent parent(s) from my home and I am applying for Medicaid, I must seek medical support from the absent parent(s). I may contact Child Support Enforcement for assistance.
- My information on this application may be reviewed and verified by my county department of human/social services, the Department, or its representatives.
- I am responsible for paying fees and copayments for myself and my family if they are required.
- If enrolled in **Medicaid** and other insurance is paying for medical care, **Medicaid** will pay last.
- I must give the needed proof and documents before qualifying for benefits.
- I will have to pay back any medical payments, including premium payments, which have been paid for by Medicaid if found ineligible during the time services were covered.
- The law says the Department must check the immigration status and citizenship for anyone who is applying for Medical Assistance. They will not check immigration status of family members who are not applying for Medical Assistance.
- The Department will review my application no matter what my race is, or my color, sex, age, disability, religion, national origin, or political beliefs.
- The Americans with Disabilities Act (ADA) of 1990 gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. If you would like more information please contact our Client/ADA Liaison at (303) 866-6010.
- If I think the **CHP+** program made a mistake, I can ask for an appeal. **CHP+** tells me about how to make an appeal in every letter that they send.
- I may request a Fair Hearing if I disagree with any action taken by Medical Assistance Programs, except for **CHP+**, when this application is processed. Information on how to ask for a Fair Hearing is printed on the back of all letters sent by Medical Assistance Programs (including **Medicaid**).
- I will immediately notify the State of any claim or lawsuit I have; I will cooperate with the State in collecting the medical bills the State has paid. The State may collect from any insurance company or court settlement for medical bills that the State has paid. If I am on Medicaid and receive money for the same medical bills that the State has paid, I will give the money to the State. I assign to the State all rights to payment for medical expenses and treatment. I also assign my right to appeal a denial of benefits by another party responsible for payment for the benefits to the State.
- The Medical Assistance Estate Recovery Program authorizes the Department to recover all Medical Assistance benefits paid on behalf of Medicaid clients, including capitation payments, from the estates of deceased Medicaid clients who were permanently institutionalized or were over the age of 55 when benefits were provided. The Federal and State laws governing estate recovery also provide for certain exemptions to the Medical Assistance Estate Recovery Program. For further information or questions please contact your county and request "The Medical Assistance Estate Recovery Program" brochure.
- I am allowing the agency to get records from financial institutions to show assets held for the person(s) named in this application. This includes banks, savings and loans, credit unions, insurance companies, and other financial institutions.

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