ASPEN VALLEY HOSPITAL

CICP/CHARITY Applicant,

Enclosed please find the application for the Colorado Indigent Care Program. This program is time sensitive. We request that you return this application to us within two weeks of your receiving it.

Please fill out and sign all pages of the application. If you feel that some pages of the application do not apply to you, please indicate on the page that it does not apply, **sign all pages** and return to me, either by mail or by taking it to the Front Desk at Aspen Valley Hospital. Please include the information requested in the "CICP/CHARITY Document Request Check List" attached to this application.

Would you also please include a note explaining your financial situation this year and how assistance could be of benefit to you? This should include what you expect to earn this year and how you have arrived at this figure.

Please call me if you have any questions.

Sincerely,

Lourdes Coombs
Financial Counseling Department
Aspen Valley Hospital
0401 Castle Creek Road
Aspen, CO 81611
Phone: (970) 544-1543
Fax: (970) 544-7365

ASPEN VALLEY HOSPITAL

FINANCIAL ASSISTANCE DOCUMENT REQUEST CHECK LIST

☐ **1. Financial Assistance Summary Application**
- Completed
- Signed (all pages)
- Provide a note explaining your financial situation.

☐ **2. Identification documents**
- Colorado Driver's License or Photo Identification
- Social Security Number and/or proof of immigration status

☐ **3. Household Income Verification**
- Two consecutive most recent pay stubs
- Unemployment award letter
- Award letter for Social Security, pension, disability and other sources
- If Self Employed or you receive Rent Income, year-to-date income & expense statement.

☐ **4. Signed Letter of Financial Support if you are receiving free room and board or other financial support from family, friends or others.**
- Use separate Letter of Financial Support for each source

☐ **5. Copy of most recent bank account statement:**
- Personal Checking
- Savings/Certificates of Deposit
- Business Checking
- Liquid assets held in trust

☐ **7. Tax return information:**
- Personal Tax Returns for most recent year or Form W-2 if taxes not yet filed
- Business Tax Returns for most recent year

☐ **8. Allowable deductions:**
- Elderly Care
- Day Care
- Paid Alimony
- Child Support
- Health Insurance Premium
- Medical bills statements and receipts of paid bills and/or proof you are on a payment plan.

☐ **9. Other Documentation requested by Hospital Staff to complete your application**.

_____

Please note:
1. *Please provide legible copies of all documents*
2. *Identification documents must be copied front and back*
3. *Letter of financial support signed.*

All applicable information must be returned in two weeks upon application received or your application for financial assistance will not be considered.

I understand that all of the information on my application and supporting documentation must be true to the best of my knowledge or my application will be denied.

_____ _____

AVH Authorized Signature Date Signature of Applicant Date

CICP
Colorado Indigent Care Program

CLIENT APPLICATION
Hospitals and Hospital Based Clinics

Section I: APPLICANT

Today's Date: Homeless: Emergency Application:

Last Name **First Name** **Middle Initial**

Address **City** **Zip Code** **County** **Phone Number**

List Household Members	Dependent Code	Date of Birth	Health First CO Number	Social Security Number	Residency Code	Health First CO/CHP+ Ineligibility Codes
1. APPLICANT						
2.						
3.						
4.						
5.						
6.						
7.						

Section II: Calculating Income

Income Source	Monthly Income	Annualized Total
1. Gross Employment Income	$	$
2. Unearned Income	$	$
3. Self-Employment Income	$	$
4. Total Income (Lines 1 + 2 + 3)	$	$
5. Total Liquid Resources	$	
6. Household Size Protected Amount	Household Size: X	= $
7. Available Resources (cannot be negative)	$	

8. Total Household Financial Status (Lines 4 + 7)	$
9. Allowable Deductions **(See Worksheet 3)**	$
10. Net Household Financial Status (Lines 8 - 9)	$
11. Liquid Asset Spend Down	$
12. **Grand Total** Net CICP Income (Lines 10 - 11)	$

FPL Percentage: _____ **Client Copayment Annual Cap (Line 12 times percentage chosen):** $ _____

PENALTY CLAUSE, CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the information provided to complete this application is true. I understand that if I make false statements on this application, I commit a Class 5 Felony. In addition, misrepresenting my eligibility for assistance under this program is a Class 2 Misdemeanor (26-15-112, C.R.S.). I authorize the provider to use any information contained in the application to verify my eligibility for assistance under this program, and to obtain records pertaining to eligibility from a financial institution as defined in section 15-15-201(4), C.R.S., or from any insurance company. I understand that the provider has a right to obtain any recovery or right of recovery for a patient who would have a right of recovery. This means that if I am found to have a claim for any benefits payable for any treatment, which is given, while I am eligible for assistance under this program that the provider has the right to be included in the claims process. If applicable, I understand that legal immigrants receiving assistance under this program shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997. **I understand it is my responsibility to notify the provider of an income or household change that may influence the rating on this application and failure to do so voids this application.**

YOU HAVE 15 DAYS TO APPEAL YOUR CICP ELIGIBILITY DETERMINATION
(Ask your eligibility technician for more information on the appeal process)

Print Applicant Name _____ Applicant Signature and Date _____

Print Eligibility Technician Name _____ Eligibility Technician Signature and Date _____

Print Facility Name _____ Facility Phone Number _____

Application Notes:

Section 1.02 Ineligibility Code Legend

Dependent Codes

1. Self
2. Spouse/Civil Union Partner
3. Minor
4. Senior
5. Adult Student
6. Other

Residency Codes

1. Colorado Resident & U.S. Citizen
2. Colorado Resident & Lawfully Present
3. Migrant Farm Worker & U.S. Citizen
4. Migrant Farm Worker & Lawfully Present
5. Counted in Household Size Only

Medicaid/CHP+ Ineligibility Codes

A. Has the Applicant Received a Medicaid/CHP+ Denial Letter?

B. Applicant is not a U.S. Citizen, has not been a legal resident for at least 5 years, or does not have refugee status

C. Transitional Medical Benefits have been discontinued

D. Over Income for Medicaid and is:

   a. **NOT A CHILD**

   b. **NOT PREGNANT**

   c. **NOT DISABLED**

E. Has Primary Insurance - NOT Eligible for CHP+

F. **Other - Provide a brief Explanation**

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Worksheet 1 - Earned and Unearned Income

Payment Sources	Monthly Income	Annualized Income		
Earned Income:				
Employment Income	$	$		
Monthly Unearned Income Sources:			Documented	Self-Declared
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐
	$	$	☐	☐

Annual or One Time Income Sources:

			Documented	Self-Declared
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
_____	$ _____	$ _____	☐	☐
Earned Income Total	$ _____	$ _____		
Unearned Income Total	$ _____	$ _____		
Total Income	$ _____	$ _____		

_____

Applicant Signature Date

_____

Eligibility Technician Signature Date

_____

Facility Phone

Rev July 2017

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Colorado Indigent Care Program

Worksheet 2 - Net Self-Employment Income

Does the client operate their business from their home? _____

Square footage of applicant's home: _____

Square footage used for applicant's home business: _____

Hours per week applicant works out of their home: _____

	Monthly	Annualized
Revenue:		
Gross Business Income	$	$
Business Property Expenses:		
Mortgage/Rent of Business Property	$	$
Utilities	$	$
_____	$	$
_____	$	$
Other Expenses:		
Advertising	$	$
Businees Phone	$	$
Business Taxes (non-personal)	$	$
Fuel for Business-related Travel	$	$
Gross Wages	$	$
Insurance	$	$
Legal Fees	$	$
License/Certification Fees Paid	$	$
Merchandise/Cost of goods	$	$
Office Supplies	$	$
Repairs/Upkeep of Equipment	$	$
Tools/Equipment	$	$

_____	$ _____	$ _____
_____	$ _____	$ _____
Day Care Provider Reductions (if applicable)	$ _____	$ _____
Total Expenses:	$ _____	$ _____
Total Expenses Attributed to Business:	$ _____	$ _____
Net Profit	$ _____	$ _____ (use this figure on line 3, Section II of the CICP Application)

Applicant Signature Date

Eligibility Technician Signature Date

Facility Date

Rev July 2017

CICP
Colorado Indigent Care Program

Worksheet 3 - Allowable Deductions

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

Applicant Signature Date

Eligibility Technician Signature Date

Facility Phone

CICP
Colorado Indigent Care Program

Worksheet 4 - Liquid Resources - HOSPITAL AND HOSPITAL BASED CLINIC USE ONLY

Liquid Resources

Type of Liquid Resource	Value
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
Total Value	$

Applicant Signature Date

Eligibility Technician Signature Date

Facility Date

AFFIDAVIT FOR LAWFUL PRESENCE
Colorado Indigent Care Program

I, _____, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check one):

- ☐ I am a United States citizen.
- ☐ I am not a United States citizen, but I am a Permanent Resident of the United States.
- ☐ I am not a United States citizen, but I am lawfully present in the United States pursuant to federal law.

I understand that this sworn statement is required by law because I have applied for a "state public benefit", as that term is defined under section 24-76.5-102(3), C.R.S. (2016). I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this state public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under section 18-8-503, C.R.S. (2016) and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

_____

Applicant Signature **Date**

FOR INTERNAL USE ONLY

Please mark the box that indicates which document was verified for lawful presence and keep a photocopy of the document presented in the applicant's file.

- ☐ A current, valid Colorado driver's license or a Colorado identification card, issued pursuant to article 2 of title 42, C.R.S., unless the applicant holds a license or card that states, "Not Valid for Federal Identification, Voting, or Public Benefit Purposes", or
- ☐ Any out-of-state driver's license or state issued identification if that state requires that the Applicant prove lawful presence prior to issuance of the license or identification card, or
- ☐ A United States military card or a military dependent's identification card, or
- ☐ A United States Coast Guard Merchant Mariner card, or
- ☐ A Native American tribal document, or
- ☐ Other documentation pulled from SAVE or found on a Federal list of acceptable documentation for establishing lawful presence (see 1 CCR 204-30 sections 2.1.4 and 2.1.6)
  Name of doucment accepted (include document number):
  _____

Date verified in SAVE (if applicable): _____

Please Note: If the applicant is a United States citizen or non-citizen national and is unable to present any of the documents listed on this form they may submit a written declaration or a third-party written declaration. These options should be used with caution.

SELF DECLARATION

I, _____, self-declare and swear or affirm under penalty of perjury, and possibly subject to later verification of status, that I am a United States citizen or non-citizen national.

_____

Signature Date

THIRD-PARTY DECLARATION

I, _____, swear or affirm under penalty of perjury, and possibly subject to later verification of status, that I have personal knowledge that the Applicant is a United States citizen or non-citizen national.

_____

Signature Date

For Colorado Department of Revenue's Lawful Presence Rule, see 1 CCR 204-30 Rule 5: http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=6860&fileName=1%20CCR%20204-30

States that require Applicants to prove lawful presence prior to issuing a driver's license or identification card are also called REAL ID compliant states. A list of REAL ID compliant states can be found at:
https://www.dhs.gov/current-status-states-territories