Dear Patient Community:

Thank you for considering HealthONE for your healthcare needs. We know medical bills can represent a financial hardship. Therefore, we would like to inform our patients that they may qualify for Colorado Hospital Discounted Care, also referred to as Hospital Discounted Care (HDC). HDC is a state law limiting the amounts certain patients can be billed for health care services. HDC defines qualifying patients as those whose household income is at or below 250% of the Federal Poverty Level. Household income is calculated using supporting income documents. For HDC consideration, please follow the instructions below.

To apply, please complete the screening and application, include one of the required supporting income documents, and return by fax to 804-381-4508 or by mail to the address below:

PO BOX 291569
NASHVILLE, TN 37229-1569

If you choose not to complete the screening or application, please complete the form to Opt Out of Screening for Public Health Insurance and HDC, included in this packet of forms and return by fax or mail.

***Supporting Income Documentation***

Please provide one of the following acceptable supporting income documents for each household member so that we can calculate and convert the most recent months' income to an annual household income.

**Employed Household Members**

- Most recent tax return
- Most recent months' paycheck stubs, payroll history, or other wage records
- Letter from employer stating the household member's salary or hourly wage and usual number of hours worked per pay period
- Short Term Disability payment information, if applicable

**Self-Employed Household Members**

- Most recent tax return
- Most recent months' paycheck stubs, payroll history, or other wage records if the household member pays themselves as an employee of the business
- Business financial records, including but not limited to profit and loss statements, ledgers, business bank accounts showing deposits and withdrawals, invoices and receipts, etc.

**Cash Salaried Household Members**

- Bank receipts showing cash deposits made
- Ledgers (account book, list of income and expenses, etc.) or other documentation of payments from clients
- Letters from employers stating how much the household member is normally paid for their services in a month

**Unemployed Household Members**

- Unemployment compensation documentation
- A letter attesting the household member has no income

After receiving all required forms and documentation, we will notify you of your HDC determination in writing. If you have any questions about completing and submitting the screening, application, or opt-out form, please contact 844-974-3800 8:00AM – 9:00PM ET M-F for assistance.

**COLORADO HOSPITAL DISCOUNTED CARE PRELIMINARY 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? _____
Date of service applying to cover? _____
Did patient receive a CICP-eligible service at a CICP provider, or is the patient scheduled to receive a CICP-eligible service? _____
Did patient receive care for a medical emergency? _____

**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? _____

**Patient Residency**
Are you a resident of or currently living in Colorado? _____

**Pregnancy and Children (Optional)**
Are you currently pregnant? _____
People who are pregnant sometimes qualify for some additional programs.
Is anyone in your household under 19 years old? _____
Children sometimes qualify for some programs that adults don't qualify for.

**Disabilities**
Do you have a disability? _____
People with disabilities sometimes qualify for programs that people without disabilities don't qualify for.

Do you receive federal disability income? _____
People who receive federal disability income can automatically qualify for Medicare.

**Patient Insurance Status and Benefits**
Are you uninsured *[or are you about to lose your health insurance]?* _____
*Health Sharing Ministries count as insurance.*
Have you ever been covered under Medicaid or CHP+? _____
If so, do you have or know your ID number? _____
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? _____
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. _____
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. _____
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. _____
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. _____
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. _____
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. _____
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. _____
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. _____
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. _____
Is this household member included in patient/guardian's taxes?_____

COLORADO
Department of Health Care Policy & Financing

**PATIENT APPLICATION**
**Hospitals and Hospital Based Clinics**

**Section I: PATIENT/APPLICANT**

Homeless: _____

Today's Date: _____ Emergency Application: _____

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

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

| | List Household Members | Relationship to Patient | Date of Birth | Health First CO Number | Social Security Number (CICP Only) | Health First CO/CHP+ Ineligibility Codes (CICP Only) | Selected Program for Household Member (CICP, HDC, or |
|---|---|---|---|---|---|---|---|
| 1. | | PATIENT/APPLICANT | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |
| 6. | | | | | | | |
| 7. | | | | | | | |
| 8. | | | | | | | |
| 9. | | | | | | | |
| 10. | | | | | | | |

**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)** | $ 0 | $ 0 |
| 5. Allowable Deductions **(See Worksheet 3)** | $ | |
| **6. Grand Total** Annual Income | $ | |

**CICP Annual Cap (Line 6 times .10):** $ _____

**FPG Percentage:** _____ Household Size: _____

**HDC Facility Monthly Max:** _____ **HDC Physician Monthly Max:** _____

## PENALTY CLAUSE,CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

**CICP ONLY:** I certify that the information provided to complete this application is true and correct to the best of my knowledge. I understand that any misrepresentations made with the intent to defraud the CICP program may result in criminal prosecution. Additionally, if I misrepresent my eligibility knowing that I am not eligible, I may be charged with a crime

I authorize the provider to use any information contained in the application to verify my eligibility for assistance under CICP or 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.

**CICP ONLY:** I understand that if I am a legal immigrant or legally present non-citizen, that while I am receiving assistance under the CICP, I agree to refrain from executing an affidavit of support for the purpose of sponsoring an immigrant.

**CICP ONLY: I understand it is my responsibility to notify the provider of an income or household change that may influence the rating on this application in relation to CICP and failure to do so voids this application for CICP.**

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

Print Patient/Applicant Name _____ Applicant 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 Facility Name _____ Facility Phone Number _____

**Application Notes:**

COLORADO
Department of Health Care Policy & Financing

## Worksheet 1 - Earned and Unearned Income

| Payment Sources | Monthly Income | Annualized Income | | |
|---|---|---|---|---|
| **Earned Income:** | | | | |
| Employment Income | $ | $ | | |
| **Monthly Unearned Income Sources:** | | | Documented | Self-Declared |
| Social Security Income (SSI) | $ | $ | ☐ | ☐ |
| Social Security Disability Income (SSDI) | $ | $ | ☐ | ☐ |
| Disbursement from Retirement Account | $ | $ | ☐ | ☐ |
| Pension Payments | $ | $ | ☐ | ☐ |
| Payments from Trust Funds | $ | $ | ☐ | ☐ |
| Disbursement from Lottery Winnings | $ | $ | ☐ | ☐ |
| **Annual or One Time Income Sources:** | | | Documented | Self-Declared |
| Bonuses (enter full amount of bonuses included on pay stubs) | $ | $ | ☐ | ☐ |
| Short Term Disability (enter full amount of payments from STD) | $ | $ | ☐ | ☐ |
| Unemployment Income (enter full amount of current UBI bank) | $ | $ | ☐ | ☐ |
| Tips and Commissions (only if not normal on paystub) | $ | $ | ☐ | ☐ |
| Infrequent Overtime | $ | $ | ☐ | ☐ |
| Earned Income Total | $ 0 | $ 0 | | |
| Unearned Income Total | $ 0 | $ 0 | | |
| **Total Income** | $ 0 | $ 0 | | |

Eligibility Technician Signature _____ Date _____

Facility _____ Phone _____

COLORADO
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## 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 | $ | $ |
| _____ | $ | $ |
| _____ | $ | $ |

| | | |
|---|---|---|
| Total Expenses: | $ | $ |
| Total Expenses Attributed to Business: | $ | $ |
| **Net Profit** | $ | $ (use this figure on line 3, Section II of the CICP Application) |

Eligibility Technician Signature Date

Facility Date

Revised August 2022

**This worksheet only needs to be signed and included if the applicant owns their own business.**

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## Worksheet 3 - Allowable Deductions

| Type of Deduction | Amount | Frequency | Annualized Amount |
|---|---|---|---|
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |
| | $ | | $ 0 |

Household declares they have no deductions ☐ **Grand Total** $ 0

Eligibility Technician Signature Date

Facility Phone

# Form to Opt Out of Screening for Public Health Coverage and Hospital Discounted Care

Prior to completing this form, you should have read "Are You Eligible for Discounted Care?, Your Rights as a Patient Under Hospital Discounted Care". By completing this form, you are knowingly deciding to opt out of screening for public health insurance programs and hospital discounted care.

I _____ (patient name) have received the following information from _____ (hospital name) in the language in which I feel most comfortable. I understand the purpose of this form.

**By signing below, I am indicating that I understand and agree to the following:**

- The hospital told me about public health coverage programs (Medicaid, Emergency Medicaid, Child Health Plan Plus (CHP+), Medicare, and financial help for private insurance) and discounted care and payment plans (Colorado Indigent Care Program and Hospital Discounted Care). See next page for more information on these programs.
    - For more information on discounted care and payment plans, visit: https://hcpf.colorado.gov/colorado-hospital-discounted-care
    - For more information about your right to be screened for hospital discounted care, see Colorado Revised Statute §25.5-3-501
- I understand that:
    - Public health coverage programs can help pay my medical bills with little or no cost to me.
    - Discounted care and payment plans may reduce the cost of my care received in a hospital.
    - Choosing not to be checked for eligibility for these programs means I will not find out if I may qualify for these programs at this time.
    - If I choose not to be checked, I may lose the right to take legal action against the hospital for not checking me.
    - If I choose not to be checked today, I can ask to be checked later. If I ask within 45 days of the date I received services, the hospital must check my eligibility.

If you want to opt out of screening, please read and initial the appropriate box or boxes below.

____I do not want my eligibility to be checked for public health insurance programs today.

____I do not want my eligibility to be checked for discounted health care and payment plans today.

First and Last Names of Patient: _____

Signature of Patient: _____

First and Last Name of Legal Guardian or Parent (if needed): _____

Signature of Legal Guardian or Parent (if needed): _____

Today's Date: _____ Date of Hospital Service: _____

Signature of Staff Member: _____ Date: _____

## PUBLIC HEALTH COVERAGE AND FINANCIAL HELP OPTIONS

**Health First Colorado (Colorado's Medicaid Program**) is a public health coverage program. It pays for health care services for low-income adults, children, older adults, and people with disabilities. People with Health First Colorado pay very little or nothing for health care services covered by the program. To qualify, you must be a resident of Colorado, and you must be a citizen or have a qualified immigration status. Medicaid can cover services that you received up to three months before you submitted your application.

- *Learn more and apply:* Visit CO.gov/PEAK or call 1-800-221-3943.

**Emergency Medicaid** is a public health coverage program that helps people pay for serious medical emergencies. It is for people in low-income households who are not eligible for Medicaid because of their immigration status, such as people who do not have a lawful immigration status. Emergency Medicaid only covers "life- or limb-threatening" emergencies, including severe cases of COVID-19, the birth of a baby, dialysis for End-Stage Renal Disease, and other life-threatening emergencies such as a heart attack. It does not cover routine (non-emergency) health care services. Emergency Medicaid can cover emergency services that you received up to three months before you submitted your application.

- *Learn more:* Visit http://www.healthfirstcolorado.com/emergency-medicaid to learn more.
    - Submit a paper application for Health First Colorado and write "Emergency Medicaid" on the top or call 1-800-221-3943.

**Child Health Plan Plus (CHP+)** is public low-cost health coverage for pregnant people and children aged 18 and under. It is for people who earn too much to get Health First Colorado (Medicaid) but not enough to pay for insurance. To qualify, you must be a resident of Colorado, and you must be a citizen or have a qualified immigration status.

- *Learn more and apply:* To learn more, visit hcpf.colorado.gov/child-health-plan-plus or call 1-800-359-1991. When you're ready to apply, visit CO.gov/PEAK.

**Medicare** is a federal health coverage program. It is for people aged 65 or older, people under 65 who get Social Security disability benefits, people with End-Stage Renal Disease, and people with Lou Gehrig's Disease (ALS). It helps with the cost of care, but it doesn't cover all medical costs. It also doesn't cover the cost of most long-term care.

- **Learn more and apply:** Visit www.medicare.gov/basics/get-started-with-medicare or call Medicare Customer Service at 1-800-633-4227.

**Connect for Health Colorado** is Colorado's official health insurance marketplace, where low- and middle-income people can get financial help with purchasing private health insurance. People with private health insurance typically pay more for health care, but financial help can help low- and middle-income people with those costs if they buy the insurance plan from Connect for Health Colorado. This financial help can lower the amount you have to pay for private health insurance each month and can sometimes lower the amount you have to pay for health care you receive.

- Learn more and apply: Visit connectforhealthco.com or call 855-752-6749