Application

COLORADO HEALTH CARE COVERAGE

Get the health care coverage your family needs at a price you can afford.

Use this form to apply for **Medicaid** and **Child Health Plan *Plus* (CHP+)**

Who can apply?

Someone can apply for **Medicaid** and **CHP+** if:

- They live in Colorado
- They are a U.S. citizen **or**
  - A legal permanent resident **or**
  - An asylee **or**
  - A refugee

What is Medicaid?

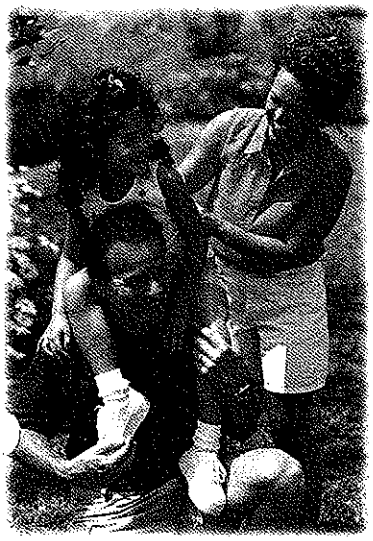
- **Medicaid** is health care insurance for families with children 18 and under, and pregnant women.
- There is no cost for children and pregnant women.
- Some adults may have to make small co-payments for each doctor visit or prescription medicine.

What is CHP+?

- **CHP+** is low-cost health insurance for children age 18 and under and pregnant women.
- Some families must pay a small fee each year. The most families will pay is $35 each year, no matter how many children they have.
- Some families may have to make small co-payments for each doctor visit or prescription medicine. Co-payments are between $1 and $5.

What health services do Medicaid and CHP+ cover?

- Regular checkups
- Doctor visits
- Medicine
- Hospital care
- Dental
- Mental health care
- Prenatal and postpartum care
- Immunizations (Shots)



What is the difference between Medicaid and CHP+?

- **Medicaid** and **CHP+** have different income limits. The program you or your children might qualify for depends on your income, family size, and expenses.

What documents do I need to apply?

- At least one paycheck stub from this month or last month for all working members of the family over age 18. If anyone applying is pregnant, a note from the doctor that says when the baby is due.
- Do you need **Medicaid** to pay for health care received in the last 3 months? If yes, send proof of income for those months and dates the services were received.
- A U.S. Citizen and Immigration Services (INS) card, if you have one, for anyone who is applying for health care coverage.
- Please look at the insert for other documents that you may need.

Tell us about your Household

1. Tell us how to call or write the head of the household.

Last name | Maiden name | First name | MI

Address # 1 (mailing address) | Apt. # | City/State/Zip

Address # 2 (fill in if you can't receive mail at address #1) | Apt. # | City/State/Zip

Phone (Home) | Phone (Work) | Phone (Message) | Email

2. What language do you use at home? _____

3. Tell us about all the people living in your home.

LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTH DATE (MONTH/DAY/YEAR)	HOW IS THIS PERSON RELATED TO YOU? (SELF, CHILD, STEP-CHILD, SPOUSE, FRIEND, ETC.)	FULL-TIME STUDENT? Yes/No	IS THIS PERSON APPLYING FOR HEALTH COVERAGE? Yes/No
				SELF		

4. Special services may be available to some children and pregnant women.
   Does your child get any of these health services now?
   - ☐ Medical services
   - ☐ Mental health services
   - ☐ School health services

Does your child use prescription medicine? Yes ☐ No ☐

Has your 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? _____

Tell us about the children who need health insurance

Write about one child on each page. For more than three (3) children, please attach a separate piece of paper.

This child is: Male ☐ Female ☐

_____
Child's last name Child's first name

Social Security #: ___ ___ ___ /___ ___ /___ ___ ___ ___ Check here if this child does not have a Social Security # ☐

Mother's name if living in the home: _____
Last name First name MI

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

1. Is this child a U.S. citizen? Yes ☐ No ☐
   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 (INS) card.)

3. Is this child a refugee, asylee or a certified victim of trafficking or deportee? Yes ☐ No ☐

4. If you qualify, do you want **Medicaid** to cover medical care received by this child in the last three (3) months? Yes ☐ No ☐
   If yes, you must send pay stubs for the months your child received care.

   Date(s) of care: _____

5. Does either parent or legal guardian of this child work for a Colorado state government agency and have access to State health benefits? Yes ☐ No ☐ *(Some children of Colorado State agency employees may not be eligible for **CHP+** due to federal law.)*

6. Does this child have a medical or developmental condition expected to last more than 12 months? Yes ☐ No ☐

7. Please check the child's ethnic group (you do not have to answer this question):
   ☐ White ☐ Hispanic/Latino ☐ African American ☐ Native American
   ☐ Asian ☐ Alaskan Native ☐ Pacific Islander
   ☐ Other: _____

Tell us about the next child

Write about one child on each page. For more than three (3) children, please attach a separate piece of paper.

This child is: Male ☐ Female ☐

_____
Child's last name Child's first name

Social Security #: ___ ___ ___ /___ ___ /___ ___ ___ ___ Check here if this child does not have a Social Security # ☐

Mother's name if living in the home: _____
Last name First name MI

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

1. Is this child a U.S. citizen? Yes ☐ No ☐
   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 (INS) card.)

3. Is this child a refugee, asylee or a certified victim of trafficking or deportee? Yes ☐ No ☐

4. If you qualify, do you want **Medicaid** to cover medical care received by this child in the last three (3) months? Yes ☐ No ☐
   If yes, you must send pay stubs for the months your child received care.

   Date(s) of care: _____

5. Does either parent or legal guardian of this child work for a Colorado state government agency and have access to State health benefits? Yes ☐ No ☐ *(Some children of Colorado State agency employees may not be eligible for **CHP+** due to federal law.)*

6. Does this child have a medical or developmental condition expected to last more than 12 months? Yes ☐ No ☐

7. Please check the child's ethnic group (you do not have to answer this question):
   ☐ White ☐ Hispanic/Latino ☐ African American ☐ Native American
   ☐ Asian ☐ Alaskan Native ☐ Pacific Islander
   ☐ Other: _____

Tell us about the next child

Write about one child on each page. For more than three (3) children, please attach a separate piece of paper.

This child is: Male ☐ Female ☐

Child's last name _____ Child's first name _____

Social Security #: ___ ___ ___ /___ ___ /___ ___ ___ ___ Check here if this child does not have a Social Security # ☐

Mother's name if living in the home: _____
Last name First name MI

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

1. Is this child a U.S. citizen? Yes ☐ No ☐
   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 (INS) card.)

3. Is this child a refugee, asylee or a certified victim of trafficking or deportee? Yes ☐ No ☐

4. If you qualify, do you want **Medicaid** to cover medical care received by this child in the last three (3) months? Yes ☐ No ☐
   If yes, you must send pay stubs for the months your child received care.

   Date(s) of care: _____

5. Does either parent or legal guardian of this child work for a Colorado state government agency and have access to State health benefits? Yes ☐ No ☐ *(Some children of Colorado State agency employees may not be eligible for **CHP+** due to federal law.)*

6. Does this child have a medical or developmental condition expected to last more than 12 months? Yes ☐ No ☐

7. Please check the child's ethnic group (you do not have to answer this question):
   ☐ White ☐ Hispanic/Latino ☐ African American ☐ Native American
   ☐ Asian ☐ Alaskan Native ☐ Pacific Islander
   ☐ Other: _____

Tell us about any adult 19 or older applying for health insurance

This adult is: Male ☐ Female ☐

Last name _____ First name _____

Social Security #: ___ ___ ___ /___ ___ /___ ___ ___ ___ Check here if you do not have a Social Security # ☐

1. What language do you use at home? _____

2. Are you a U.S. citizen? Yes ☐ No ☐
   If no, is this adult a legal permanent resident? Yes ☐ No ☐

3. Enter your alien registration number (if you have one): _____

4. On what date did you receive the U.S. Citizenship and Immigration Services (INS) card? (MM/DD/YYYY): _____
   (Include a copy of the front and back of the INS card.)

5. Are you a refugee, asylee or a certified victim of trafficking or deportee? Yes ☐ No ☐

6. Have you received **Medicaid** in the past three (3) months? Yes ☐ No ☐

7. If eligible, do you want **Medicaid** to cover medical care received in the last three (3) months? Yes ☐ No ☐
   If yes, you must send pay stubs for the months you received care. Please give date(s) of care and proof of income for those months:

   _____

8. Do you or your spouse work for a Colorado State Government agency and have access to State health benefits?
   Yes ☐ No ☐

9. Please check your ethnic group (you do not have to answer this question):
   ☐ White ☐ Hispanic/Latino ☐ African American ☐ Native American
   ☐ Asian ☐ Alaskan Native ☐ Pacific Islander
   ☐ Other: _____

If you are applying for Medicaid

You need to send proof of U.S. Citizenship and Identity.

You can send ONE of these to prove **both** Citizenship and Identity:

- ☐ A U.S. passport **OR**
- ☐ A Certificate of Naturalization **OR**
- ☐ A Certificate of U.S. Citizenship

If you don't have any of those, send one paper proving Citizenship AND one paper proving Identity from the list below.

Citizenship

- U.S. birth certificate
- Certificate of birth abroad
- U.S. Nation ID card
- Native American Tribal document
- Final adoption decree
- Official military record of service showing a U.S. place of birth

Identity

- Driver's license of state ID card with photo
- ID card issued by a federal, state, or local government agency
- U.S. military card or draft record or U.S. Coast Guard Merchant Mariner Card
- School ID card with photo
- School records or a written affidavit for children under age 16

Copies of original documents may be accepted if they are notarized by a notary public, **or** the copy is made by a county or medical assistance site worker who attests in writing on the copy that they saw the original document and it is a true copy of the original.

If you need help or more information, ask your county technician or visit www.chcpf.state.co.us

Si está solicitando Medicaid

Usted tiene que enviar pruebas de ciudadanía de EE.UU. e identificación.

Usted puede enviar UNO de lo siguiente, para demostrar **tanto** su ciudadanía como su identificación:

- ☐ Un pasaporte de EE.UU. **O**
- ☐ Un certificado de naturalización **O**
- ☐ Un certificado de ciudadanía de EE.UU.

Si usted no tiene ninguno de ellos, envíe un papel que demuestre su ciudadanía **Y** otro que demuestre su identidad de la lista de más abajo.

Ciudadanía

- Un certificado de nacimiento de EE.UU.
- Certificado de nacimiento en el extranjero
- Tarjeta de identificación de la nación estadounidense
- Documento tribal de americano nativo
- Decreto final de adopción
- Un expediente militar oficial, que muestre el lugar de nacimiento en los EE.UU.

Identidad

- Licencia de conductor o tarjeta de identificación estatal con foto
- Tarjeta de identificación emitida por alguna agencia gubernamental local, estatal o federal.
- Tarjeta militar de EE.UU. o expediente de reclutamiento o tarjeta de marino mercante del servicio de guardacostas de EE.UU.
- Tarjeta de identificación escolar con foto
- Expediente escolar o declaración jurada para niños menores de 16 años

Las **copias** de documentos originales pueden ser aceptadas, si son firmadas y selladas por un notario público **o** la copia está hecha por algún trabajador del condado o sitio de asistencia médica, que declare por escrito en la copia, que vio el documento original y que ésta es una copia verdadera del original.

Si necesita ayuda o más información, pregunte al técnico de su condado o visite www.chcpf.state.co.us

Below is information on the **CHP+** health plans you may choose. Please choose a health plan that is in your county.

	CHP+ Child Health Plan Plus	Colorado Access www.coaccess.com	Denver Health Medical Plan, Inc. www.denverhealth.org	Rocky Mountain HMO www.rmhp.org	Kaiser Permanente thrive www.kaiserpermanente.org	CHP+ State Managed Care Network (Anthem BlueCross BlueShield) www.chpplusproviders.com
Phone Numbers		**1-888-214-1101 or 303-751-9021**	**1-800-700-8140 or 720-956-2100**	**1-800-346-4643**	**1-800-632-9700 or 303-338-3800**	**1-877-523-8171**
What counties are CHP+ health plans in?		Adams, Alamosa, Arapahoe, Bent, Boulder, Broomfield, Clear Creek, Conejos, Costilla, Crowley, Custer, Denver, Douglas, Elbert, El Paso, Fremont, Gilpin, Huerfano, Jefferson, Kiowa, Larimer, Lincoln, Logan, Mineral, Morgan, Otero, Park, Phillips, Prowers, Pueblo, Rio Grande, Saguache, Teller, Washington, Weld and Yuma	Adams, Arapahoe, Denver and Jefferson	Delta, Mesa and Montrose	Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson	**This must be the HMO selection for pregnant women.** Archuleta, Baca, Bent, Chaffee, Cheyenne, Clear Creek, Conejos, Crowley, Custer, Dolores, Eagle, Elbert, El Paso, Fremont, Garfield, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kit Carson, Lake, La Plata, Larimer, Las Animas, Lincoln, Mineral, Moffat, Montezuma, Morgan, Otero, Ouray, Park, Pitkin, Pueblo, Rio Blanco, Rio Grande, Routt, San Juan, San Miguel, Sedgwick, Summit, Teller, Washington and Yuma.
How do members get medical care?		1. Call Colorado Access and choose a Primary Care Provider (PCP) 2. Make an appointment with the PCP 3. Present Colorado Access ID card to PCP at the appointment	1. Call Denver Health Medical Plan (DHMP) and choose a Primary Care Provider (PCP) 2. Make an appointment with the PCP 3. Present the DHMP ID card to PCP at the appointment	1. Call Rocky Mountain HMO (RMHMO) and choose a Primary Care Provider (PCP) 2. Make an appointment with the PCP 3. Present the RMHMO ID card to PCP at the appointment	1. Choose Kaiser Permanente on the CHP+ application 2. Call to schedule an appointment with a Primary Care Provider (PCP) 3. Present the Kaiser Permanente ID card at the appointment	1. Schedule an appointment with a selected participating provider 2. Present ID card at the participating provider's office at the appointment
What hospitals can CHP+ members use?		• The Children's Hospital • University of Colorado Hospital • Avista Hospital • Longmont United • McKee Medical Center • Medical Center of Aurora • North Colorado Medical Center • Penrose St. Francis • Platte Valley Medical Center • Poudre Valley Hospital • Presbyterian/St. Luke's Medical Center • Saint Joseph Hospital • St. Mary Corwin Hospital • Swedish Medical Center • Plus many more Call Colorado Access at 1-800-214-1101 for a list of hospitals or to check if a specific hospital is participating.	• Denver Health Medical Center	Any participating RMHMO hospital. Call Customer Service at 1-800-346-4643 for a list or to check if a specific hospital is participating.	• The Children's Hospital • Exempla Good Samaritan Medical Center • Exempla St. Joseph's Hospital	• The Children's Hospital • Centura Facilities • Colorado Plains Medical Center • Exempla Hospitals • Grand Junction Community Hospital • HealthONE Facilities • Longmont United Hospital • Loveland Surgery Center • Memorial Hospital • Mercy Medical Center • Montrose Memorial Hospital • National Jewish Medical and Research Center • Parkview • San Luis Valley Regional Medical Center • University Hospital • Plus many more
What pharmacies can CHP+ members use?		• Albertsons • Kmart • King Soopers • Medicine Shoppe • Rite Aid • Safeway • Walgreens • Wal-Mart • Plus many local pharmacies	• Albertsons • Denver Health • Kmart • King Soopers • Rite Aid • Safeway • Walgreens • Plus many local pharmacies Call 720-956-2302 for more participating pharmacies.	Any participating RMHMO Pharmacy. Call Customer Service at 1-800-346-4643 for a list or to check if a specific pharmacy is participating.	Kaiser Permanente pharmacies are available in all Kaiser Permanente medical offices. Mail order is also available.	• Albertsons • Kmart • King Soopers • Rite Aid • Safeway • Walgreens • Wal-Mart • Plus many more
What special services are available to CHP+ members?		• Food for Shots Program – get a $10 food gift certificate and a chance to win a $250 gift card when children are up-to-date on shots before age 2 • More than 200 over-the-counter medications like vitamins and Tylenol, when prescribed by a doctor • Special health care education programs, including Safe T. Tiger • $150 toward eyeglasses or contact lenses per benefit year • 40 outpatient visits per benefit year for physical, occupational & speech therapy • Reduced co-payments for prescriptions • $1200 hearing aid benefit per benefit year • Customer Service staff speak many languages, including Spanish	• $150 toward eyeglasses or contact lenses per benefit year. • 40 outpatient visits per benefit year for physical, occupational & speech therapy • 30 outpatient mental health visits per benefit year • Healthy Heroes Club for kids • $1200 hearing aid benefit per benefit year • Nurse advice line at 303-739-1211, when PCP office is closed • Bi-annual newsletter • Interpreter services	• Case management for pregnancy, asthma, diabetes & other chronic diseases • Quarterly newsletter • $50 toward eyeglasses • Covering doctor when PCP office is closed • Interpreter services • Spanish speaking Customer Service staff	• Nurse advice line at 303-338-4545/after hours at 303-861-3434 • Access to smoking cessation, women's health, diet & nutrition and stress management classes • Personal health evaluation & screening • $50 toward eyeglasses per year • $800 hearing aid benefit per year • 30 outpatient visits for physical, speech and occupational therapy per year • Interpreter services • Member newsletter	• $50 toward eyeglasses • Prenatal care coverage under participating specialist • $2,000 toward durable medical equipment • $800 toward hearing aids for congenital conditions and traumatic injuries
What if my child needs special care?		The PCP provides a referral to specialty care.	The PCP provides a referral to specialty care.	Members may make an appointment directly with any participating RMHMO specialist without a referral. Present the ID card at the time of service.	Members may self-refer to any Kaiser Permanente specialist listed in the member handbook.	The participating provider provides a referral to specialty care.
How do members get mental health services?		Members can go to any mental health provider that is in our network of mental health providers. Members can verify that their provider is in our network by contacting our Customer Service department.	Members can self-refer to a mental health provider in the DHMP. A DHMP clinical psychiatric nurse is available for questions and appointments at 303-436-7676.	Members may make an appointment directly with any participating RMHMO mental health provider without a referral. Present the ID card at the time of service.	Members may access mental health services by contacting the Kaiser Permanente mental health office closest to their home.	Members may access behavioral care by calling Anthem Behavioral Health at 1-800-424-4014.

Tell us about the next adult

This adult is: Male ☐ Female ☐

Last name _____ First name _____

Social Security #: ___ ___ ___ /___ ___ /___ ___ ___ ___ Check here if you do not have a Social Security # ☐

1. Are you a U.S. citizen? Yes ☐ No ☐
   If no, is this adult a legal permanent resident? Yes ☐ No ☐

2. Enter your alien registration number (if you have one): _____

3. On what date did you receive the U.S. Citizenship and Immigration Services (INS) card? (MM/DD/YYYY): _____
   (Include a copy of the front and back of the INS card.)

4. Are you a refugee, asylee or a certified victim of trafficking or deportee? Yes ☐ No ☐

5. Have you received **Medicaid** in the past three (3) months? Yes ☐ No ☐

6. If eligible, do you want **Medicaid** to cover medical care received in the last three (3) months? Yes ☐ No ☐
   If yes, you must send pay stubs for the months you received care. Please give date(s) of care and proof of income for those months:

   _____

7. Do you or your spouse work for a Colorado State Government agency and have access to State health benefits?
   Yes ☐ No ☐

8. Please check your ethnic group (you do not have to answer this question):
   ☐ White ☐ Hispanic/Latino ☐ African American ☐ Native American
   ☐ Asian ☐ Alaskan Native ☐ Pacific Islander
   ☐ Other: _____

Tell us about health insurance

1. Does anyone who is applying have health insurance now? Yes ☐ No ☐
   If yes, please answer the questions below (if you have it, please include a copy of the front and back of the insurance card).

   Name(s) of person(s) covered:

   _____

   _____

   Policyholder's name:

   _____
   Last name First name

   Policy # / Group #: _____

   Name of insurance company: _____

   Mailing address: _____

2. Has anyone in the household **who is applying** had health insurance through an employer's group in the last three (3) months? Yes ☐ No ☐
   If no, go to question # 3.

   Why did the person lose this insurance?

   ☐ Person is no longer employed by the company

   ☐ Employer no longer offers health insurance

   Please complete the section below.

   Name(s) of person(s) covered:

   _____

   _____

   When did this insurance end? (month/day/year) _____

   Policyholder's name:

   _____
   Last name First name

   Name of employer's insurance company: _____

   Amount you paid each month $_____ Amount employer paid each month $ _____

   Phone number of employer's insurance company: (_____) _____

3. Do you or any member of your household have access to group health insurance and want help paying the monthly premiums? Yes ☐ No ☐

Tell us about your household income

Send copies of paycheck stubs from this month or the last month. All paycheck stubs must be from the same month.

NAME OF PERSON WORKING LAST NAME, FIRST NAME	EMPLOYER NAME	EMPLOYER PHONE #	PAID HOW OFTEN? (WEEKLY, EVERY TWO WEEKS, TWICE A MONTH, MONTHLY)	TOTAL MONTHLY AMOUNT RECEIVED BEFORE TAXES & DEDUCTIONS

1. Is anyone in the household self-employed? Yes ☐ No ☐ If yes, complete the information below for each self-employed worker. If no, skip to question #2.

Last name, First name

ONE MONTH OF INCOME AND EXPENSE	
Business rent/mortgage expense	$
Gross business labor costs	$
Cost of merchandise for business	$
Business taxes paid	$
Interest paid for business	$
Utilities paid for business	$
Business equipment costs	$
Other business costs	$

Last name, First name

ONE MONTH OF INCOME AND EXPENSE	
Business rent/mortgage expense	$
Gross business labor costs	$
Cost of merchandise for business	$
Business taxes paid	$
Interest paid for business	$
Utilities paid for business	$
Business equipment costs	$
Other business costs	$

2. Tell us about other income anyone in your household gets, even if they are not applying. Fill out a line for every item. *(Do not combine income received. For example, if your household receives a child support check, list how much each child receives on a separate line.)*

TYPE OF INCOME:	PERSON MONEY IS USED OR MEANT FOR:	MONTHLY AMOUNT ($) (BEFORE TAXES AND DEDUCTIONS)

Tell us about your expenses

Write about each household member who has expenses such as:

- **Child care**
- **Dependent elder care**
- **Child support**
- **Alimony**
- **Health insurance premiums**
- **Medical expenses**

TYPE OF EXPENSE:	NAME OF PERSON PAYING EXPENSE:	NAME OF PERSON CARED FOR:	AMOUNT PAID THIS MONTH:

- To receive health care insurance by **CHP+**, you must choose a Health Maintenance Organization (HMO) for the child applying. You can find information about HMOs in your county at **www.chpplus.org**.
- If your children qualify for **Medicaid, Health***Colorado* will contact you to enroll in an HMO.

HMO _____

Signature Form

To help you organize your documents please check off each box of the items you are sending with this application.

- ☐ Proof of citizenship and identification for all applicants.
- ☐ 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 health insurance. Please include a front and back copy.
- ☐ If pregnant, send a doctor's note showing the due date.
- ☐ At least one pay check stub or letter from each employer that shows income in one calendar month, either the previous month or this month. All workers' income information must be from the same month.
- ☐ If covered by insurance, send a copy of the insurance card (front and back), if you have it.
- ☐ If asking for **Medicaid** to cover old medical bills send proof of income back to the month of the first bill.
- ☐ Choose an HMO for your child(ren).
- ☐ Please read the conditions below, and sign your name or make your mark, print your name and date.
- ☐ 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.

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. Under penalty of perjury I certify all information I have given is true.

All 18 or older adults applying for health insurance sign in the space below:

Your Signature Here: _____ Date: _____

Print Name Here: _____

Your Signature Here: _____ Date: _____

Print Name Here: _____

Authorized Representative, Conservator, or Guardian's Signature

Print Name Here: _____

Your Signature Here: _____ Date: _____

Print Name Here: _____

What happens next?

- Take or mail your application to your County Department of Human Services. Visit **www.chcpf.state.co.us** for your local county contact information.
- If we have everything we need, we will review your application and send a letter within 45 days. The letter will tell you if you qualify for **Medicaid** or **CHP+**. One family member may qualify for **Medicaid** and another for **CHP+**.

INTERNAL USE ONLY

Agency Representative/Enrollment Specialist: _____

Signature (person who helped fill out application): _____

What you should know

By signing the Application for Colorado Health Care understand the following:

- The Department of Health Care Policy and Financing is the state agency responsible for **Medicaid** and **CHP+**.
- 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.
- The information I have given is confidential. However, it can be used or shared by the program(s) that each of my family member(s) is enrolled for purposes of treatment, payment, program operations, and other purposes permitted by law.
- I know that I must tell the truth and answer all the questions on this application. If I do not tell the truth, I will lose my health care insurance, and I may have to pay the Department of Health Care Policy and Financing for the medical care I got.
- I know you will check my information 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.
- I know that the State can collect payments from anyone who may be responsible or has paid for health care costs. This may include child support payments, alimony payments or medical support payments.
- My information on this application may be reviewed and verified by my county Department of Human Services, the Department of Health Care Policy and Financing, or its designees.
- The law says the Department of Health Care Policy and Financing must check the immigration status and citizenship for anyone who is applying for health care insurance. They will not check immigration status of family members who are not applying.
- The Department will review my application no matter what my race is, or my color, sex, age, disability, religion, national origin or political beliefs.
- I am responsible for paying fees and copayments for myself and my family if they are required.
- If my family is enrolled in **Medicaid** and other insurance is paying for their medical care, **Medicaid** will pay last.
- I must give the needed documents before my family is qualified for benefits.
- If I receive **Medicaid,** I must tell my county Department of Human Services within 10 days of any changes to my case.
- I may request a Fair Hearing if I disagree with any action taken by **Medicaid** when this application is processed. Information on how to ask for a Fair Hearing is printed on the back of all letters sent by **Medicaid.**