COLORADO PUBLIC HEALTH INSURANCE FOR FAMILIES

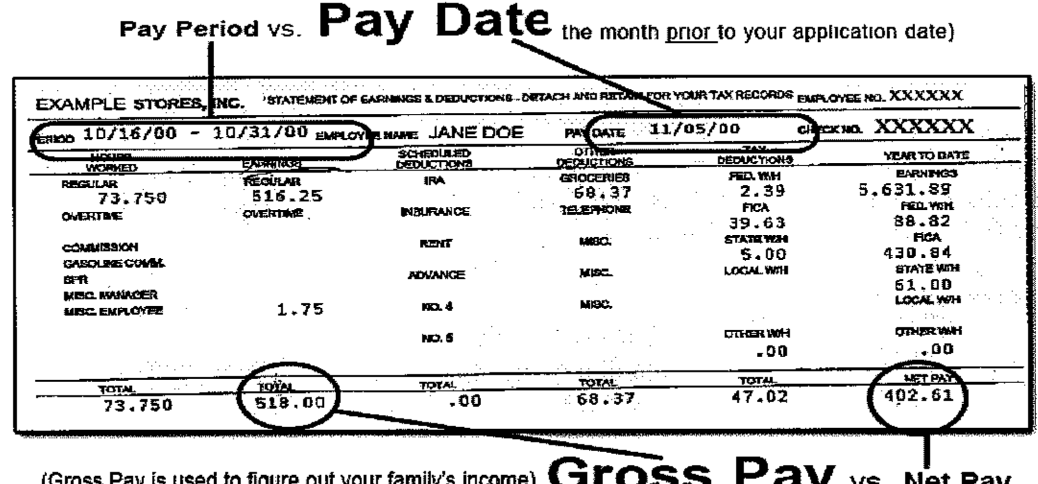
APPLICATION CHECKLIST

Please make sure to include all of the following with your application:

- ☐ Fill out each section completely.

  You can print the application and fill it out by hand OR you can click in each field online, type in your answers, and then print the application with your answers already typed in.

- ☐ If something does not apply, mark "none."
- ☐ For non-citizens applying for benefits, include a copy of the applicant's INS card (front and back).
- ☐ If you are self-employed, be sure to fill out the Self-Employment Form on page 9 of the application.
- ☐ If you are applying for Medicaid, send **proof of citizenship and identity** for all applying household members. If you need help or more information regarding additional documentation, ask your county technician or visit http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1217412405165.
- ☐ Sign and date the application.
- ☐ Include all pay stubs or an employer letter showing your family's **gross pay** for the previous or current month (see below for an example). Pay stubs must have a **pay date** from the current month or the month prior to your application date.



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

- U.S. passport **OR**
- Certificate of Naturalization (DHS Forms N-550 or N-570) **OR**
- Certificate of US Citizenship (DHS Forms N-560 or N-561)

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

Citizenship	Identity
• U.S. Birth Certificate	• Driver's license or state ID card with photo
• Certificate of birth abroad (Form FS 545)	• ID card issued by a federal, state, or local government agency
• U.S. National ID card (Form I-197 or I-179)	• U.S. military card or draft record or U.S. Coast Guard Merchant Mariner Card
• Native American Tribal Document	• School ID card with a photo
• Final adoption decree	• Verified School, Nursery or Daycare records (for children under 16)
• Official military record of service showing a U.S. place of birth	• Clinic, Doctor or Hospital records (for children under 16)
• Religious/School records	

Copies of the original documents may be accepted **ONLY** after originals have been viewed and certified by a site approved by the State of Colorado. A list of approved sites is available at: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1217412405165 under "List of Locations that can verify Documents."

For more information call:

Customer Service
Within Denver metro area: (303) 866-3513
Outside Denver metro area: (800) 221-3943

CHP+ Child Health Plan Plus	Colorado Access www.coaccess.com	Denver Health Medical Plan, Inc. www.denverhealth.org	Rocky Mountain Health Plans® Good health. That's the plan. www.rmhp.org	Kaiser Permanente. thrive www.kaiserpermanente.org	STATE MANAGED CARE NETWORK 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**	**303-338-3800 or 1-800-632-9700**	**1-800-414-6198**
What counties are CHP+ health plans in? *State Managed Care Network is the health plan for pregnant women in every county.	Adams, Alamosa, Arapahoe, Bent, Boulder, Broomfield, Clear Creek, Conejos, Costilla, Crowley, Custer, Denver, Douglas, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Kiowa, Larimer, Lincoln, Logan, Mineral, Morgan, Otero, Park, Phillips, Prowers, Pueblo, Rio Grande, Saguache, Washington, Weld and Yuma	Adams, Arapahoe, Denver and Jefferson	Delta, Mesa and Montrose	Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas and Jefferson	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. **This plan is NOT available in Adams, Alamosa, Arapahoe, Boulder, Broomfield, Costilla, Delta, Denver, Douglas, Gilpin, Jefferson, Kiowa, Logan, Mesa, Montrose, Phillips, Prowers, Saguache and Weld counties.** State Managed Care Network is the health plan for pregnant women in every county.
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 Health Plans (RMHP) and choose a Primary Care Provider (PCP) 2. Make an appointment with the PCP 3. Present the RMHP ID card to the PCP at the appointment	1. Call Kaiser Permanente and choose a Primary Care Provider (PCP) 2. Make an appointment with the 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?	• Centura facilities • The Children's Hospital • University of Colorado Hospital • Avista Hospital • Longmont United • McKee Medical Center • Medical Center of Aurora • Medical Center of the Rockies • National Jewish • North Colorado Medical Center • Penrose St. Francis • Platte Valley Medical Center • Poudre Valley Hospital • Presbyterian/St. Luke's Medical Center • Saint Joseph Hospital • San Luis Valley Regional Medical Center • Sky Ridge • St. Mary Corwin Hospital • Swedish Medical Center • Plus many more	• Denver Health Medical Center • The Children's Hospital* • University of Colorado Hospital* * *Emergency and urgent care only. Certain other services may be provided only if not offered at Denver Health Medical Center. Prior authorization from Denver Health Managed Care is required for all services except emergency and urgent care.*	Any participating RMHP 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 (CO Springs) • Memorial Hospital (Craig) • 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 • Target • 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 RMHP 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 • Medicine Shoppe • Rite Aid • Safeway • Target • Walgreens • Wal-Mart • Plus many more
What special services are available to CHP+ members?	• $150 toward glasses or contacts per benefit year • Reduced co-payments for prescriptions • More than 200 over-the-counter medicines like vitamins & Tylenol, with a prescription • 40 outpatient visits per benefit year for physical, occupational & speech therapy. • Health care education programs like Safe T. Tiger • Food for Shots - get a $10 grocery certificate & a chance to win a $250 gift card when children are up to date on shots before age 2 • Customer Service staff speak many languages, including Spanish	• No co-payments for covered visits and prescriptions • Many over-the-counter medicines, with a prescription • $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 to help kids learn healthy habits • Nurse Advice line available 24 hours • Quarterly member newsletter • Care Management Program including Health Coaches • Customer Service staff speaks many languages, including Spanish • Interpreter services and many bilingual providers	• Health education and case management for pregnancy, asthma, diabetes, heart disease and other chronic conditions. • Quarterly member newsletter • $50.00 toward eyeglasses • A covering doctor when the primary doctor's office is closed • Spanish speaking customer service staff • Interpreter services	• 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 • Member newsletter • Spanish speaking customer service staff • Interpreter services and many bilingual providers • Access to many case management programs • Access to secure member Web site, www.kp.org. Members can create a personal health assessment; email doctors; order prescription refills; make appointments; and get health information.	• $50 toward eyeglasses • Prenatal care coverage under participating specialist • $2,000 toward durable medical equipment • Customer service representatives speak several different languages including Spanish
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 RMHP 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 Network. A DHMP clinical psychiatric nurse is available for questions and appointments at 303-602-8270.	Members may make an appointment directly with any participating RMHP 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 the State Managed Care Network at 1-800-414-6198.

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 any child in your family 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 ______ MI

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 ______________________ MI

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 ☐

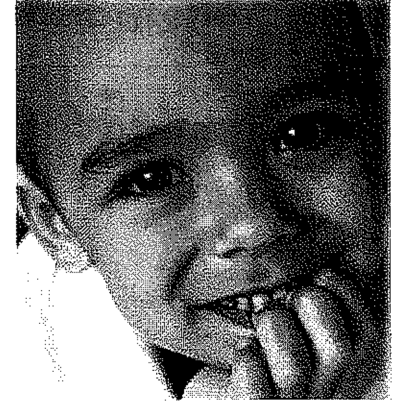
4. If you qualify, do you want **Medicaid** to cover medical care received by this child in the last three (3) months? Yes ☐ No ☐
   If yes, you must send pay stubs for the months your child received care.

   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 ______ MI

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 ______ MI ______

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 have a medical or developmental condition expected to last more than 12 months? Yes ☐ No ☐
9. Do you or your spouse work for a Colorado State Government agency and have access to State health benefits?
   Yes ☐ No ☐
10. 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 the next adult

This adult is: Male ☐ Female ☐

Last name ____________ First name ____________ MI ____

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 have a medical or developmental condition expected to last more than 12 months? Yes ☐ No ☐

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: ____________

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	
Gross Income	$
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	
Gross Income	$
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.

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+**.

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.**