



**PATIENT APPLICATION**  
Hospitals and Hospital Based Clinics

**Section I: PATIENT/APPLICANT**

Today's Date: \_\_\_\_\_

Homeless: \_\_\_\_\_  
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	Health First CO/CHP+ Ineligibility Codes (CICP Only)	Selected Program for Household Member (CICP, Hospital Discounted Care, or CICP & Hospital Discounted Care)
1. _____	PATIENT/APPLICANT	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____	_____
9. _____	_____	_____	_____	_____	_____
10. _____	_____	_____	_____	_____	_____
11. _____	_____	_____	_____	_____	_____
12. _____	_____	_____	_____	_____	_____
13. _____	_____	_____	_____	_____	_____
14. _____	_____	_____	_____	_____	_____
15. _____	_____	_____	_____	_____	_____

**Section II: Calculating Income**

Income Source	Monthly Income	Annualized Total
1. Gross Employment Income	\$ _____	\$ _____
2. Unearned Income	\$ _____	\$ _____
3. Self-Employment Income	\$ _____	\$ _____
<b>4. Total Income (Lines 1 + 2 + 3)</b>	\$ _____	\$ _____

5. Allowable Deductions <b>(See Worksheet 3)</b>	\$ _____
6. <b>Grand Total</b> 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 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:**



**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:**

Bonuses (enter full amount of bonuses included on pay stubs) \$ \_\_\_\_\_ \$ \_\_\_\_\_

Short Term Disability (enter full amount of remaining payments from STD) \$ \_\_\_\_\_ \$ \_\_\_\_\_

Unemployment Income (weekly amount multiplied by 52 to ensure correct annual FPG calculation) \$ \_\_\_\_\_ \$ \_\_\_\_\_

Tips and Commissions (only if not normal on paystub) \$ \_\_\_\_\_ \$ \_\_\_\_\_

Infrequent Overtime \$ \_\_\_\_\_ \$ \_\_\_\_\_

Earned Income Total \$ \_\_\_\_\_ \$ \_\_\_\_\_

Unearned Income Total \$ \_\_\_\_\_ \$ \_\_\_\_\_

**Total Income** \$ \_\_\_\_\_ \$ \_\_\_\_\_

Eligibility Technician Signature \_\_\_\_\_ Date \_\_\_\_\_

Facility \_\_\_\_\_ Phone \_\_\_\_\_



**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: \_\_\_\_\_

**Revenue:**

	<u>Monthly</u>	<u>Annualized</u>
Gross Business Income	\$ _____	\$ _____

**Business Property Expenses:**

Mortgage/Rent of Business Property	\$ _____	\$ _____
Utilities	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

**Other Expenses:**

Advertising	\$ _____	\$ _____
Business 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)

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Eligibility Technician Signature

Date

Facility

Date

Revised June 2024

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



**Worksheet 3 - Allowable Deductions**

<u>Type of Deduction</u>	<u>Amount</u>	<u>Frequency</u>	<u>Annualized Amount</u>
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
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_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____

Household declares they have no deductions

**Grand Total** \$ \_\_\_\_\_

\_\_\_\_\_  
 Eligibility Technician Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Facility

\_\_\_\_\_  
 Phone

Revised June 2024

**If your facility includes deductions, this worksheet must be signed and included with all client applications.**