



**Patient Business Affairs
Boulder Community Hospital**

Date _____

Dear _____,

Thank you for your interest in the Colorado Indigent Care Program/Wecare Program. In order to process your application, we will need **copies** of the following information **within 30 days** of the above date.

DO NOT FILL OUT THE APPLICATION, just gather the information listed below and sign the application which states that the information you have turned in for this application to be completed is true. Once you turn this information in to me, I will have what I need to complete the application. Only a CICP tech can complete the application.

1. Copy of Colorado Driver’s License or state ID card. If married, include spouse ID.
2. Fill out and sign Proof of Lawful Presence form included in this packet. Spouse must also complete form.
3. If employed, provide copy of last month’s paycheck stubs or a letter from employer stating gross income earned for last month. **State requires 2, 2 weeks stubs or 4, 1 week stubs**. If married must include spouse income.
4. If **self employed** please call to request a separate worksheet that the state requires you to fill out and sign. You may use bank statements, a profit and loss sheet or ledger to show your net income. Please call for more information, 303-544-5773. Tax Returns may NOT be used. Information must be current.
5. Provide proof of Social Security income, if applicable, either SSI or SSDI.
6. Include proof of any other income, this may include but is not limited to: Payments from pension plans, unemployment, child support, alimony, rental income, money from friends/family, etc.
7. If you have no income from any source please state none. _____
8. Copy of all bank accounts and investment accounts for last month.
9. State year and make of vehicle, vehicle value, and approx loan balance on your vehicle.
(Year,Make)_____ (Vehicle Value)_____ (Loan Balance)_____
If no vehicle please state none. _____.
10. Sign and date application and attached forms anywhere you see applicant signature.
11. Date of birth, SSN, and names of all family members you are currently responsible for supporting. In most cases this is spouse and children.

Once you have gathered the above information and signed the application please mail application and copies of information to: Boulder Community Hospital, POB 9049, Boulder, CO 80301-9049. You may also drop off the application at 311 Mapleton Ave, Boulder CO 80304.

If you have any questions or would like to set up an appointment to meet with me please call Christie at 303-544-5773.

**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, or

_____ I am a Legal Permanent Resident of the United States, or
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 public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or misrepresentation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Applicant Signature

Date

For Eligibility Technician Use: 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.

- Drivers License or Identification Card State of Issuance _____
- Birth Certificate
- United States Passport
- Certificate of Naturalization or Certificate of Citizenship
- Other _____ (insert document number from list on reverse side)

SAVE Verification Completion Date (for non-U.S. citizens only) _____

OPTIONAL

If a United States Citizen (or a person from American Samoa, Swains Island or Northern Mariana Islands) is unable to present any of the lawful presence documents (see reverse) the applicant may complete the self-declaration statement below to comply with the evidence of lawful presence requirement.

I, _____, swear or affirm under penalty of perjury under the laws of the State of Colorado and possibly subject to later verification of status that I am a United States citizen or non-citizen national (American Samoa, Swains Island or Northern Mariana Islands).

Signature

Date

COLORADO INDIGENT CARE PROGRAM (CICP) CLIENT APPLICATION

Check if Emergency Application

SECTION I: Applicant Information

Last Name	First Name	M.I.	Phone Number ()
Address		City/Zip	

	Household Members (First & Last Names)	Residency Code	Relation Code	Birth Date	Social Security or State ID #	Ineligibility Codes												
						Medicaid							CHP+					
						A	B	C	D	E	F	G		1	2	3	4	5
1	APPLICANT		1															
2																		
3																		
4																		
5																		
6																		
7																		

Please Explain Other Type of Ineligibility for Medicaid or CHP+:

Other Information:

Reference Codes

Medicaid Ineligibility Codes	CHP+ Ineligibility Codes
A Received Medicaid denial letter, attach letter to application	1 Received CHP+ denial letter, attach letter to application
B Applicant is not a U.S. citizen and has not been a legal resident for at least 5 years or have refugee status	2 Applicant is eligible for Medicaid
C Applicant is no longer pregnant and beyond post-partum	3 Applicant is not a U.S. citizen and has not been a legal resident for at least 5 years or have refugee status
D Transitional Medicaid benefits have been discontinued	4 Applicant has other primary health insurance coverage
E Individual no longer receiving SSI or SSDI	5 Applicant was insured under an employer plan with at least 50% employer coverage in the past 3 months, unless dropped due to change in employment status or employer eliminated coverage
F Does not meet Medicaid's definition of disability or incapacity and is under 65 years of age	6 A member of the family is eligible for health benefits coverage under a State health benefits plan or public agency in the state (i.e., employed by the State of Colorado)
G Other	7 Does not meet age requirement, Adult, 19 years of age or older and is not pregnant
Relation Codes: 1 Self 2 Spouse 3 Child 4 Stepchild	5 Other
Residency Codes: 1 Colorado resident & US citizen 2 Colorado resident & documented legal immigrant 3 Migrant farm worker & US citizen	4 Migrant farm worker & documented legal immigrant 7 Counted in family size only 5 Non-resident, counted in family size only 6 Medicaid eligible, counted in family size only

COLORADO INDIGENT CARE PROGRAM

Worksheet 1 - Employment Income and Unearned Income

Record all income and cash from other sources on this page and attach it to the Application

<i>Payment Sources</i>	<i>Monthly Amount</i>	<i>Annualized Amount</i>
Employment income	_____ X 12	_____
Old Age Pension	_____ X 12	_____
Supplemental Security Income (SSI/SSDI)	_____ X 12	_____
Pension plans (name of plan(s):	_____ X 12	_____
_____	_____ X 12	_____

Commissions, bonuses, & tips	_____ X 12	_____
Alimony received	_____ X 12	_____
Rental income	_____ X 12	_____
Interest income	_____ X 12	_____
Monetary gains	_____ X 12	_____
Trust accounts	_____ X 12	_____
Settlements (do not annualize, show total amount received)	_____	_____
Other income (list source)		
_____	_____ X 12	_____
_____	_____ X 12	_____
_____	_____ X 12	_____

Total _____

(use this figure on line 1 or 3 of Section II of the application)

Applicant Signature

Date

Eligibility Technician Signature

Date

Facility

Phone