

Colorado Indigent Care Program Operations Manual

Fiscal Year 2022-23

Section IV: Application

Effective July 1, 2022



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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	Dependent Code	Date of Birth	Health First CO Number	Social Security Number	Health First CO/CHP+ Ineligibility Codes
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)	\$ _____	\$ _____
5. Allowable Deductions (See Worksheet 3)	\$ _____	
6. Grand Total Annual Income	\$ _____	

FPG Percentage: _____

Client Copayment Annual Cap (Line 6 times .10): \$ _____

PENALTY CLAUSE, CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

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, 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. 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. 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 CICP ELIGIBILITY RATE

(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:

Section 1.02 Ineligibility Code Legend

Relationship Codes

1. Patient/Applicant
2. Spouse/Civil Union Partner
3. Parent/Guardian
4. Minor Child
5. Minor Sibling
6. Student Adult Child
7. Medical Power of Attorney
8. Other

Applying or Household Size Only – Clinics Only

1. Applying
2. Household Size Only

Medicaid/CHP+ Ineligibility Codes

- A. Has the Applicant Received a Medicaid/CHP+ Denial Letter?
- B. Applicant is not a U.S. Citizen, has been lawfully present for less than 5 years, and does not have refugee status
- C. Transitional Medical Benefits have been discontinued
- D. Over Income for Medicaid and is:
 - a. NOT A CHILD
 - b. NOT PREGNANT
 - c. NOT DISABLED
- E. Has Primary Insurance - NOT Eligible for CHP+
- F. Other - Provide a brief Explanation



CICP

Colorado Indigent Care Program

Worksheet 1 – Earned and Unearned Income (Hospitals)

Payment Sources Monthly Income Annualized Income

Earned Income:

Employment Income \$ _____ \$ _____

Monthly Unearned Income Sources: Documented Self-Declared

Supplemental Security Income (SSI) \$ _____ \$ _____

Social Security Disability Income (SSDI) \$ _____ \$ _____

Disbursement from Retirement Amount \$ _____ \$ _____

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) \$ _____ \$ _____

Earned Income Total \$ _____ \$ _____

Unearned Income Total \$ _____ \$ _____

Total Income \$ _____ \$ _____

Eligibility Technician Signature

Date

Facility

Phone

Revised May 2022

This worksheet must be signed and included with all client applications.



CICP

Colorado Indigent Care Program

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: _____

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

<u>Business Property Expenses:</u>		
Mortgage/Rent of Business Property	\$ _____	\$ _____
Utilities	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

<u>Other Expenses:</u>		
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	\$ _____	\$ _____

_____ \$ _____ \$ _____

_____ \$ _____ \$ _____

Day Care Provider Reductions (if applicable) \$ _____ \$ _____

Total Expenses: \$ _____ \$ _____

Total Expenses Attributed to Business: \$ _____ \$ _____

Net Profit \$ _____ \$ _____

line 3, Section II of
the CICP Application)

Eligibility Technician Signature Date

Facility Date

Revised May 2022

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



Section I: PATIENT/APPLICANT

Homeless: _____

Today's Date: _____

Emergency Application: _____

Last Name		First Name			Middle Initial	
Address	City	Zip Code	County	Phone Number	Health First CO/CHP+ Ineligibility Codes	
List Household Members	Dependent Code	Date of Birth	Health First CO Number	Social Security Number	Applying or Household Size Only	
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)	\$ _____	\$ _____
5. Allowable Deductions (See Worksheet 3)	\$ _____	
6. Grand Total Annual Income	\$ _____	

FPG Percentage: _____

Client Copayment Annual Cap (Line 6 times .10): \$ _____

PENALTY CLAUSE, CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

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 CICIP 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 CICIP, 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. I understand that if I am a legal immigrant or legally present non-citizen, that while I am receiving assistance under the CICIP, I agree to refrain from executing an affidavit of support for the purpose of sponsoring an immigrant. **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 CICIP and failure to do so voids this application for CICIP.**

YOU HAVE 30 CALENDAR DAYS TO APPEAL YOUR CICIP ELIGIBILITY RATE

(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:

Section 2.02 Ineligibility Code Legend

Relationship Codes

- 3. Patient/Applicant
- 4. Spouse/Civil Union Partner
- 5. Parent/Guardian
- 6. Minor Child
- 7. Minor Sibling
- 8. Student Adult Child
- 9. Medical Power of Attorney
- 10. Other

Applying or Household Size Only – Clinics Only

- 11. Applying
- 12. Household Size Only

Medicaid/CHP+ Ineligibility Codes

- G. Has the Applicant Received a Medicaid/CHP+ Denial Letter?
- H. Applicant is not a U.S. Citizen, has been lawfully present for less than 5 years, and does not have refugee status
- I. Transitional Medical Benefits have been discontinued
- J. Over Income for Medicaid and is:
 - d. NOT A CHILD
 - e. NOT PREGNANT
 - f. NOT DISABLED
- K. Has Primary Insurance - NOT Eligible for CHP+
- L. Other - Provide a brief Explanation



CICP

Colorado Indigent Care Program

Worksheet 1 – Earned and Unearned Income (Hospitals)

Payment Sources	Monthly Income	Annualized Income
-----------------	----------------	-------------------

Earned Income:

Employment Income \$ _____ \$ _____

Monthly Unearned Income Sources:	<u>Documented</u>	<u>Self-Declared</u>
---	-------------------	----------------------

Supplemental Security Income (SSI)	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
------------------------------------	----------	----------	--------------------------	--------------------------

Social Security Disability Income (SSDI)	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
--	----------	----------	--------------------------	--------------------------

Disbursement from Retirement Amount	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
-------------------------------------	----------	----------	--------------------------	--------------------------

Pension Payments	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
------------------	----------	----------	--------------------------	--------------------------

Payments from Trust Funds	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
---------------------------	----------	----------	--------------------------	--------------------------

Disbursement from Lottery Winnings	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
------------------------------------	----------	----------	--------------------------	--------------------------

Annual or One Time Income Sources:	<u>Documented</u>	<u>Self-Declared</u>
---	-------------------	----------------------

Bonuses (enter full amount of bonuses included on pay stubs)	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
--	----------	----------	--------------------------	--------------------------

Short Term Disability (enter full amount of Payments from STD)	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
--	----------	----------	--------------------------	--------------------------

Unemployment Income (enter full amount of current UBI bank)	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
---	----------	----------	--------------------------	--------------------------

Tips and Commissions (only if not normal on paystub)	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
--	----------	----------	--------------------------	--------------------------

Earned Income Total \$ _____ \$ _____

Unearned Income Total \$ _____ \$ _____

Total Income \$ _____ \$ _____

Eligibility Technician Signature

Date

Facility

Phone

Revised May 2022

This worksheet must be signed and included with all client applications.



CICP

Colorado Indigent Care Program

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	\$ _____	\$ _____

_____ \$ _____ \$ _____

_____ \$ _____ \$ _____

Day Care Provider Reductions (if applicable) \$ _____ \$ _____

Total Expenses: \$ _____ \$ _____

Total Expenses Attributed to Business: \$ _____ \$ _____

Net Profit \$ _____ \$ _____

line 3, Section II of
the CICP Application)

Eligibility Technician Signature

Date

Facility

Date

Revised May 2022

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

ARTICLE III. Other

Section 3.01 CICIP ID Card Templates

Do not include the backdating period in the Effective Date of the CICIP Card.

For homeless applicants put their rate on the "Rate" line and add an "H" after the rate to signify the applicant is homeless.

If your facility wants to use your own card, it must include spaces for the household member(s) name(s), rating, copay cap, SSN or birthdate, effective date, end date, and county code. If you are using the card for your own internal charity care program as well as CICIP, there must be an indicator showing which program the card is being issued for.

Example: 34 H

Colorado Indigent Care Program (CICIP) <i>This is not Health Insurance</i>	
Name: _____	
Rate: _____	SSN: _____
Copay Cap: _____	County Code: _____
Effective Date _____	
End Date: _____	
Technician's Signature _____	Phone _____

The following family members are covered under the FPL on the front of this card. (Family members eligible for Medicaid or CHP+ are not listed)	
Name _____	SSN _____
Name _____	SSN _____
Name _____	SSN _____
Name _____	SSN _____
Name _____	SSN _____
Name _____	SSN _____
Present card each time you receive services at a CICIP Provider	

Colorado Indigent Care Program (NOT Insurance)

Name: _____

Rate: _____ Copay Cap: _____

County Code: _____ SSN: _____

Begin Date: _____ End Date: _____

Technician's Signature _____ Phone _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Show this card any time you visit a CICP Provider

CICP Copays Due

Ambulatory Surgery _____

Inpatient _____

Hospital Physician _____

Emergency Room _____

Emergency Transportation _____

Outpatient Hospital _____

Specialty Outpatient Hospital _____

CICP Copays Due

Prescriptions _____

Laboratory _____

Basic Radiology & Imaging _____

High-Level Radiology & Imaging _____

Colorado Indigent Care Program (NOT Insurance)

Name: _____

Rate: _____ Copay Cap: _____

County Code: _____ SSN: _____

Begin Date: _____ End Date: _____

Technician's Signature _____ Phone _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Show this card any time you visit a CICP Provider

CICP Copays Due

Clinic Services _____

Specialty Outpatient Clinic _____

Prescription Drugs _____

Laboratory _____

Basic Radiology & Imaging _____

High-Level Radiology & Imaging _____

Other Information

Section 3.02 County Codes

01 Adams	23 Garfield	45 Otero
02 Alamosa	24 Gilpin	46 Ouray
03 Arapahoe	25 Grand	47 Park
04 Archuleta	26 Gunnison	48 Phillips
05 Baca	27 Hinsdale	49 Pitkin
06 Bent	28 Huerfano	50 Prowers
07 Boulder	29 Jackson	51 Pueblo
08 Chaffee	30 Jefferson	52 Rio Blanco
09 Cheyenne	31 Kiowa	53 Rio Grande
10 Clear Creek	32 Kit Carson	54 Routt
11 Conejos	33 Lake	55 Saguache
12 Costilla	34 La Plata	56 San Juan
13 Crowley	35 Larimer	57 San Miguel
14 Custer	36 Las Animas	58 Sedgwick
15 Delta	37 Lincoln	59 Summit
16 Denver	38 Logan	60 Teller
17 Dolores	39 Mesa	61 Washington
18 Douglas	40 Mineral	62 Weld
19 Eagle	41 Moffat	63 Yuma
20 Elbert	42 Montezuma	64 Broomfield
21 El Paso	43 Montrose	00 Unknown/Out of State
22 Fremont	44 Morgan	

Section 3.03 Client Statement of Responsibilities in English

Clients applying for or receiving discounted CICIP services shall:

1. Acknowledge that the CICIP is not health insurance, does not offer a specific benefit package, is not an entitlement to medical benefits and that there are limitations to services discounted;
2. Acknowledge that discounted CICIP health care services vary by provider location;
3. Give the CICIP provider all the necessary financial information and documentation needed to complete the application;
4. Not give false information with the intent to commit fraud;
5. Tell the CICIP provider if a CICIP financial rating was issued by another provider and notify the CICIP provider within 15 days if the CICIP rating is disputed;
6. Be responsible for paying any money owed on time, and as required, or work with the CICIP provider to make payment arrangements;
7. Notify the CICIP provider promptly of changes in resources, income and all other household changes that may affect the CICIP rating;
8. Communicate any information, concerns and/or questions related to the financial screening to the appropriate representative;
9. Keep track of all copayments made to CICIP providers for services discounted by CICIP and inform the provider once the household copayment cap has been met;
10. Respect the property of the CICIP provider, fellow clients and others; and
11. Follow all other rules and regulations of the CICIP provider's location relating to respectful treatment and rights of other clients and provider staff.

Section 3.04 Client Statement of Responsibilities in Spanish

Los clientes que soliciten o reciban servicios CICIP con descuento deberán:

1. Reconocer que el CICIP no es un seguro de salud, no ofrece un paquete de beneficios específico, no es un derecho a los beneficios médicos y que hay limitaciones a los servicios descontados;
2. Reconocer que los servicios de atención médica con descuento en CICIP varían según la ubicación del proveedor;
3. Dar al proveedor de CICIP toda la información financiera necesaria y documentación necesaria para completar la solicitud;
4. No dará información falsa con la intención de cometer fraude;
5. Informe al proveedor de CICIP si se ha emitido una calificación financiera CICIP por otro proveedor y notificar al proveedor de CICIP en un plazo de 15 días si se disputa la calificación CICIP;
6. Ser responsable de pagar el dinero adeudado a tiempo, y según sea necesario, o trabajar con el proveedor de CICIP para hacer arreglos de pago;
7. Notifique al proveedor de CICIP con prontitud de los cambios en los recursos, los ingresos y todos los demás cambios del hogar que puedan afectar la calificación de CICIP;
8. Comunicar cualquier información, inquietud y/o pregunta relacionada con el control financiero al representante correspondiente;
9. Mantener un seguimiento de todos los copagos realizados a los proveedores de CICIP por servicios descontados por el CICIP e informar al proveedor una vez que se haya cumplido el límite de copago del hogar;
10. Respete la propiedad del proveedor de CICIP, sus compañeros de clientes y otros; y
11. Siga todas las demás reglas y reglamentos de la ubicación del proveedor de CICIP en relación con el trato respetuoso y los derechos de otros clientes y el personal del proveedor.

Section 3.05 Copay Category

Percent of FPL	0 - 40% and Homeless	0 - 40%	41 - 62%	63 - 81%	82 - 100%	101 - 117%	118 - 133%	134 - 159%	160 - 185%	186 - 200%	201 - 250%
Ambulatory Surgery	\$0	\$15	\$65	\$105	\$155	\$220	\$300	\$390	\$535	\$600	\$630
Inpatient Facility	\$0	\$15	\$65	\$105	\$155	\$220	\$300	\$390	\$535	\$600	\$630
Hospital Physician	\$0	\$7	\$35	\$55	\$80	\$110	\$150	\$195	\$270	\$300	\$315
Emergency Room	\$0	\$15	\$25	\$25	\$30	\$30	\$35	\$35	\$45	\$45	\$50
Emergency Transportation	\$0	\$15	\$25	\$25	\$30	\$30	\$35	\$35	\$45	\$45	\$50
Outpatient Hospital Services	\$0	\$7	\$15	\$15	\$20	\$20	\$25	\$25	\$35	\$35	\$40
Clinic Services	\$0	\$7	\$15	\$15	\$20	\$20	\$25	\$25	\$35	\$35	\$40
Specialty Outpatient	\$0	\$15	\$25	\$25	\$30	\$30	\$35	\$35	\$45	\$45	\$50
Outpatient Pharmacy	\$0	\$5	\$10	\$10	\$15	\$15	\$20	\$20	\$30	\$30	\$35
Laboratory	\$0	\$5	\$10	\$10	\$15	\$15	\$20	\$20	\$30	\$30	\$35
Basic Radiology & Imaging	\$0	\$5	\$10	\$10	\$15	\$15	\$20	\$20	\$30	\$30	\$35
High-Level Radiology & Imaging	\$0	\$30	\$90	\$130	\$185	\$250	\$335	\$425	\$580	\$645	\$680

The following information explains the different types of medical care charges:

- **Ambulatory Surgery** charges are for all non-physician (facility) Ambulatory Surgery operative procedures received by a Client who is admitted to and discharged from the hospital setting on the same day. The Client is also responsible for the corresponding Hospital Physician charges.
- **Inpatient Facility** charges are for all non-physician (facility) services received by a Client while receiving care in the hospital setting for a continuous stay of 24 hours or longer.
- **Hospital Physician** charges are for services provided directly by a physician in the hospital setting, including inpatient, ambulatory surgery, and emergency room care.
- **Emergency Room** charges are for all non-physician (facility) services received by a Client while receiving Emergency Care or Urgent Care in the hospital setting for a continuous stay less than 24 hours (i.e., emergency room care).
- **Emergency Transportation** charges are for transportation provided by an ambulance.
- **Outpatient Hospital Service** charges are for all non-physician (facility) and physician services received by a Client while receiving non-Emergency Care or non-Urgent Care in the outpatient clinic setting. Charge includes primary and preventive medical care; does not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.
- **Clinic Services** charges are for all non-physician (facility) and physician services received by a Client while receiving care in the outpatient clinic setting. Charges include primary and preventive medical care. Charge does not include radiology or laboratory services performed at the clinic.
- **Specialty Outpatient** charges are for all non-physician (facility) and physician services received by a Client while receiving care in the specialty outpatient setting. These services can be provided in standalone clinics and outpatient hospital settings. Specialty Outpatient charges include distinctive medical care (i.e., oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventive medical care. Charges do not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.
- **Outpatient Pharmacy** charges are for prescription drugs received by a Client at a Qualified Health Care Provider's pharmacy as an outpatient service.
- **Laboratory Service** charges are for all laboratory tests received by a Client while receiving care in the outpatient hospital or clinic setting. Laboratory Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.
- **Basic Radiology and Imaging Service** charges are for all radiology and imaging services received by a Client while receiving care in the outpatient hospital or clinic setting. Basic Radiology and Imaging Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.
- **High-Level Radiology and Imaging Service** charges are for Clients receiving a Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Positron Emission Tomography (PET) or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory (cath lab) in the outpatient hospital, emergency room, or clinic setting. This copayment already includes the outpatient facility charge and therefore MAY NOT be combined with any other outpatient facility charge (i.e. Emergency Room, Specialty Outpatient Clinic).

Clients who are seen in the hospital setting in an observation bed should be charged the emergency room copay if their stay is less than 24 hours and the inpatient facility copay if their stay is 24 hours or longer.

Section 3.06 Annual Income Ranges for Each FPG Range

Family Size	Effective April 1, 2022 – March 31, 2023				
1	\$0 - \$5,436	\$5,437 - \$8,426	\$8,427 - \$11,008	\$11,009 - \$13,590	\$13,591 - \$15,900
2	\$0 - \$7,324	\$7,325 - \$11,352	\$11,353 - \$14,831	\$14,832 - \$18,310	\$18,311 - \$21,423
3	\$0 - \$9,212	\$9,213 - \$14,279	\$14,280 - \$18,654	\$18,655 - \$23,030	\$23,031 - \$26,945
4	\$0 - \$11,100	\$11,101 - \$17,205	\$17,206 - \$22,478	\$22,479 - \$27,750	\$27,751 - \$32,468
5	\$0 - \$12,988	\$12,989 - \$20,131	\$20,132 - \$26,301	\$26,302 - \$32,470	\$32,471 - \$37,990
6	\$0 - \$14,876	\$14,877 - \$23,058	\$23,059 - \$30,124	\$30,125 - \$37,190	\$37,191 - \$43,512
7	\$0 - \$16,764	\$16,765 - \$25,984	\$25,985 - \$33,947	\$33,948 - \$41,910	\$41,911 - \$49,035
8	\$0 - \$18,652	\$18,653 - \$28,911	\$28,912 - \$37,770	\$37,771 - \$46,630	\$46,631 - \$54,557
9	\$0 - \$20,540	\$20,541 - \$31,837	\$31,838 - \$41,594	\$41,595 - \$51,350	\$51,351 - \$60,080
10	\$0 - \$22,428	\$22,429 - \$34,763	\$34,764 - \$45,417	\$45,418 - \$56,070	\$56,071 - \$65,602
11	\$0 - \$24,316	\$24,317 - \$37,690	\$37,691 - \$49,240	\$49,241 - \$60,790	\$60,791 - \$71,124
12	\$0 - \$26,204	\$26,205 - \$40,616	\$40,617 - \$53,063	\$53,064 - \$65,510	\$65,511 - \$76,647
13	\$0 - \$28,092	\$28,093 - \$43,543	\$43,544 - \$56,886	\$56,887 - \$70,230	\$70,231 - \$82,169
14	\$0 - \$29,980	\$29,981 - \$46,469	\$46,470 - \$60,710	\$60,711 - \$74,950	\$74,951 - \$87,692
15	\$0 - \$31,868	\$31,869 - \$49,395	\$49,396 - \$64,533	\$64,534 - \$79,670	\$79,671 - \$93,214
16	\$0 - \$33,756	\$33,757 - \$52,322	\$52,323 - \$68,356	\$68,357 - \$84,390	\$84,391 - \$98,736
Poverty Level	0 - 40%	41 - 62%	63 - 81%	82 - 100%	101 -117%

Family Size	Effective April 1, 2022 – March 31, 2023				
1	\$15,901 - \$18,075	\$18,076 - \$21,608	\$21,609 - \$25,142	\$25,143 - \$27,180	\$27,181 - \$33,975
2	\$21,424 - \$24,352	\$24,353 - \$29,113	\$29,114 - \$33,874	\$33,875 - \$36,620	\$36,621 - \$45,775
3	\$26,946 - \$30,630	\$30,631 - \$36,618	\$36,619 - \$42,606	\$42,607 - \$46,060	\$46,061 - \$57,575
4	\$32,469 - \$36,908	\$36,909 - \$44,123	\$44,124 - \$51,338	\$51,339 - \$55,500	\$55,501 - \$69,375
5	\$37,991 - \$43,185	\$43,186 - \$51,627	\$51,628 - \$60,070	\$60,071 - \$64,940	\$64,941 - \$81,175
6	\$43,513 - \$49,463	\$49,464 - \$59,132	\$59,133 - \$68,802	\$68,803 - \$74,380	\$74,381 - \$92,975
7	\$49,036 - \$55,740	\$55,741 - \$66,637	\$66,638 - \$77,534	\$77,535 - \$83,820	\$83,821 - \$104,775
8	\$54,558 - \$62,018	\$62,019 - \$74,142	\$74,143 - \$86,266	\$86,267 - \$93,260	\$93,261 - \$116,575
9	\$60,081 - \$68,296	\$68,297 - \$81,647	\$81,648 - \$94,998	\$94,999 - \$102,700	\$102,701 - \$128,375
10	\$65,603 - \$74,573	\$74,574 - \$89,151	\$89,152 - \$103,730	\$103,731 - \$112,140	\$112,141 - \$140,175
11	\$71,125 - \$80,851	\$80,852 - \$96,656	\$96,657 - \$112,462	\$112,463 - \$121,580	\$121,581 - \$151,975
12	\$76,648 - \$87,128	\$87,129 - \$104,161	\$104,162 - \$121,194	\$121,195 - \$131,020	\$131,021 - \$163,775
13	\$82,170 - \$93,406	\$93,407 - \$111,666	\$111,667 - \$129,926	\$129,927 - \$140,460	\$140,461 - \$175,575
14	\$87,693 - \$99,684	\$99,685 - \$119,171	\$119,172 - \$138,658	\$138,659 - \$149,900	\$149,901 - \$187,375
15	\$93,215 - \$105,961	\$105,962 - \$126,675	\$126,676 - \$147,390	\$147,391 - \$159,340	\$159,341 - \$199,175
16	\$98,737 - \$112,239	\$112,240 - \$134,180	\$134,181 - \$156,122	\$156,123 - \$168,780	\$168,781 - \$210,975
Poverty Level	118 - 133%	134 - 159%	160 - 185%	186 - 200%	201 - 250%

Poverty Level refers to the percent of Federal Poverty Level.

Revised 3/2022

NO SOCIAL SECURITY NUMBER AFFIDAVIT
Colorado Indigent Care Program

I, _____, swear or affirm under penalty of perjury under the laws of the State of Colorado that I do not have a Social Security Number because (check one):

- I am homeless and I am unable to provide my Social Security Number.
- I am not eligible to receive a Social Security Number.
- I can only be issued a Social Security Number for a valid non-work reason.
- I hold a well-established religious objection to having a Social Security Number.

Applicant Signature

Date

Section 3.08 Electronic Signatures

Providers are allowed to utilize programs to collect electronic signatures from applicants. In order for the electronic signature program to be acceptable, it must have the ability to capture a date and time stamp of the applicant and eligibility technician signatures.

If the provider is sending the applicant an electronic "packet" that includes all necessary pages of the application, then the applicant would be allowed to sign a packet signature page. The packet signature page should include the Penalty Clause, Confirmation Statement and Authorization for Release of Information statement included on the CICIP Application worksheet with an additional sentence indicating that they agree to all information on every worksheet, their calculated rating, and their copayment cap.

This packet signature does NOT include the No SSN Form, which must be signed separately.

The following is an example of an approved packet signature page. The page should include the names and signatures of the applicant and the eligibility technician, the date of the signatures, and the facility name and phone number. If your facility wishes to use other language, it will need to be approved by the Department.

PENALTY CLAUSE, CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

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 CICIP 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 CICIP, 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.

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

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 CICIP and failure to do so voids this application for CICIP.

YOU HAVE 30 CALENDAR DAYS TO APPEAL YOUR CICIP ELIGIBILITY DETERMINATION
(Ask your eligibility technician for more information on the appeal process)

My signature below indicates I understand and agree with all information contained within the CICP application including but not limited to: the CICP worksheets, the final CICP rating, and the CICP copayment cap.



CICP

Colorado Indigent Care Program

Welcome to the Colorado Indigent Care Program (CICP)

The Colorado Indigent Care Program (CICP) is a discounted health care program for residents of Colorado. Health care providers who participate in the CICP offer discounted health care services to people who qualify for the program.

The CICP health care provider has assigned you a rating based on your financial resources. Your rating determined what your CICP copayment is. The copayment is the portion of your medical bills under the CICP that you will be responsible for. Payment of the copayment is expected at the time of service, unless you have made other payment arrangements with the CICP provider.

The CICP is not health insurance and the CICP cannot guarantee benefits. Services must be received by a qualified CICP provider. Available discounted services and copayments may be different from provider to provider. If your CICP provider refers you to a non-CICP health care provider for care, you may be responsible for the bill without a discount. Please check with your health care provider before receiving care so that you understand what CICP will cover and what it will not cover.

Please discuss questions about your medical bills and medical care directly with your CICP provider at the following phone number:

If you need more information about CICP, or have concerns that have not been resolved with your CICP provider, call:

Colorado Department of Health Care Policy and Financing
Customer Contact Center
1-800-221-3943

Information about CICP is also available on the Department of Health Care Policy and Financing's Website, including a Provider Directory: Go to www.colorado.gov/hcpf and click the link "Explore Programs and Benefits", "Adults", Colorado Indigent Care Program (CICP), then select "Program Information Page", and then "CICP Provider Directory" at the bottom of the page.

Your CICIP provider can enter your copayment amount for health care services in the table below. Copayments are different for different types of medical care, and your CICIP provider may not offer all types of services. The copayments listed below may only be valid at the issuing facility. You should ask your CICIP provider about what health care services are available at a discount and which copayment applies.

Your household rating: _____

CICIP Copayment Information for Clients based on rating:

<u>Service</u>	<u>Copayment per Visit</u>
Ambulatory Surgery	\$ _____
Inpatient Facility	\$ _____
Hospital Physician (while in the hospital or emergency room)	\$ _____
Emergency Room	\$ _____
Emergency Transportation	\$ _____
Outpatient Hospital Services	\$ _____
Clinic Services	\$ _____
Specialty Outpatient	\$ _____
Prescription	\$ _____
Laboratory	\$ _____
Basic Radiology & Imaging	\$ _____
High-Level Radiology Imaging*	\$ _____

*High-Level Radiology and Imaging includes Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Positron Emission Tomography (PET) or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory (cath lab) in the outpatient hospital, emergency room, or clinic setting. Some providers may charge a lower copay amount for certain High-Level Radiology and Imaging services.



CICP

Colorado Indigent Care Program

Bienvenidos al Programa de Atención de Indigentes de Colorado (CICP)

Programa de atención de indigentes de Colorado (CICP) es un programa de salud con descuento para residentes de Colorado. Proveedores médicos quienes participan en CICP ofrecen servicios médicos a bajo costo a gente que califica para el programa.

El proveedor de atención médica del CICP le ha asignado una calificación basada en sus recursos financieros. Su calificación determinó cuál es su copago de CICP. El copago es la porción de sus gastos médicos en el centro que usted será responsable. Pago de los copagos se espera que en el momento del servicio, a menos que hayan hecho otros arreglos de pago con el proveedor de CICP.

El CICP no es seguro de salud y el centro no puede garantizar beneficios. Servicios deben ser recibidas por un proveedor calificado del CICP. Servicios y copagos con descuento disponibles pueden variar de proveedor a proveedor. Si su proveedor de CICP refiere un centro no médico para el cuidado, usted puede ser responsable de la cuenta sin un descuento. Por favor compruebe con su médico antes de recibir atención para que entienda lo que cubrirá centro y lo que no cubrirá.

Por favor discutir preguntas acerca de sus gastos médicos y atención médica directamente con su proveedor CICP en el siguiente número de teléfono:

Si usted necesita más información sobre el programa, o tiene preocupaciones que no han sido resueltas con su proveedor de CICP, llame al:

Departamento de Colorado de Salud Política y Financiamiento
Centro de contacto al cliente
1-800-221-3943

Información sobre CICP también esta disponible en el sitio web del Departamento de Colorado de Salud Política y Financiamiento, incluyendo un directorio de proveedores visite www.colorado.gov/hcpf y haga clic en el enlace "Explore Programs and Benefits", "Adults", Programa de Atención para Indigentes de Colorado (CICP), seleccione "Programa de Información de la página", y luego "CICP Provider Directory" en la parte inferior de la página

Su proveedor de CICIP puede ingresar el monto de su copago para servicios de salud en la tabla debajo de. Los copagos son diferentes para diferentes tipos de atención médica y médico del centro no puede ofrecer todo tipo de servicios. Los co-pagos puesto en la lista abajo puede ser válida solo en el centro de expedición. Usted debe pedir a su proveedor de CICIP acerca de qué servicios de atención médica están disponibles con un descuento y que el copago se aplica.

Su calificación familiar: _____ CICIP Copago Información de Clientes Basada en su Clasificación:

<u>Servicio</u>	<u>Copago por Visita</u>
Cirugía Ambulatorial	\$ _____
Hospitalizados	\$ _____
Servicios Médicos (Mientras que en el hospital o sala de emergencia)	\$ _____
Carga de Servicio Urgencias	\$ _____
Transporte de Emergencia	\$ _____
Servicios Externa de Hospital	\$ _____
Servicios de la Clínica	\$ _____
Consulta Externa de Especialidad	\$ _____
Medicamentos Con Receta	\$ _____
Prueba de Laboratorio	\$ _____
Básico de Radiología y Imaging	\$ _____
Nivel alto de Radiología y Imaging*	\$ _____

*La Radiología e Imágenes de Alto Nivel incluye Imágenes por Resonancia Magnética (RM), Tomografía Computarizada (TC), Tomografía por Emisión de Positrones (PET) u otros servicios de Medicina Nuclear, Estudios del Sueño o Laboratorio de Cateterismo (laboratorio de cateterismo) en el hospital ambulatorio, sala de emergencias, o el entorno de la clínica. Algunos proveedores pueden cobrar una cantidad de copago más baja por ciertos servicios de Radiología e Imagen de Alto Nivel