Table of Contents

State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-13-0018

This file contains the following documents in the order listed:

The complete title XXI state plan for Colorado consists of the most recent state plan posted on Medicaid.gov under CHIP and State Plan Amendments. The link is provided below. The following approved templates are in addition to, or replace sections of the state's posted current state plan. The attached approval letter(s) explain how these templates fit into that state plan.

Link to state title XXI state plans and amendments: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-State-Program-Information.html

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

Children and Adults Health Program Group

NOV 26 2013

Mr. William Heller
Director, Child Health Plan *Plus*
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Dear Mr. Heller:

I am pleased to inform you that Colorado's Children's Health Insurance Program (CHIP) State Plan Amendment (SPA), CO-13-0018, submitted on August 30, 2013, has been approved. This SPA incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into Colorado's CHIP State Plan in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

The approval of SPA CO-13-0018 includes full approval of your state's alternative single streamlined application used to apply for multiple human service programs. Until April 30, 2014, the state is using an interim alternative single streamlined paper application. Until October 1, 2014, the state is using an interim alternative single streamlined online application. The state will implement revised applications that will address CMS concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the new state plan pages and attachments to be incorporated within a separate section at the end of Colorado's approved CHIP state plan:

- CS24
- Attachment 1- Statement of use with respect to the alternative single streamlined online application
- Attachment 2- Statement of use with respect to the alternative single streamlined paper application
- Attachment 3- Multibenefit Application

This approval and the attachments supercede the following sections of the current CHIP State Plan:

- Section 4.3: Single, Streamlined Application Screen and Enroll Process

- Section 4.4: Renewals, Screening by Other Insurance Affordability Programs

CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan Amendment. Your Title XXI project officer is Ms. Joyce Jordan. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Jordan's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Blvd.
Baltimore, MD 21244-1850
Telephone: (410) 786-3413
Facsimile: (410) 786-5882
E-mail: Joyce.Jordan@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Jordan and to Mr. Richard Allen, Associate Regional Administrator (ARA) in our Denver Regional Office. Mr. Allen's address is:

Mr. Richard Allen
Denver Regional Office
Colorado State Bank Building
1600 Broadway, Suite# 700
Denver, Colorado 80202-4967

If you have additional questions, please contact Linda Nablo, Director, Division of State Coverage Programs at (410) 786-5143.

We look forward to continuing to work with you and your staff.

Sincerely,

[redacted]

Eliot Fishman
Director

cc: Mr. Richard Allen, ARA, CMS Region VIII, Denver

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Program Group

Mr. William Heller
Director, Child Health Plan *Plus*
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

NOV 2 3 2013

Dear Mr. Heller:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services (CMS) approval of Colorado's Children's Health Insurance Program (CHIP) State Plan Amendment (SPA), CO-13-0018, submitted on August 30, 2013. Our review of this submission included a review of both the paper and online alternative single streamlined applications and the application used to apply for multiple human service programs developed by the state. Since the state's application materials are the same for both Medicaid and CHIP, this letter is identical to the Medicaid companion letter.

Until April 30, 2014, the state is using an interim alternative single streamlined paper application. In addition, until October 1, 2014, the state is using an interim alternative single streamlined online application. The interim applications must be revised to reflect the following changes.

Necessary changes:	**Date by which changes will be completed:**
Paper application: Co-branded Application for Health Coverage and Help Paying Costs:	
Question #7—Removal of the question of individual shared responsibility exemption.	April 30, 2014

Online application:	
If the applicant has not indicated that he or she is aged or blind or disabled, the following questions will not appear on applications for health coverage only. • Questions regarding bills, such as child care and child support • Questions related to non-MAGI income types, such as in-kind income, veterans benefits and SSI	February 28, 2014
The following question will not appear for household members not seeking any benefits. • The non-MAGI screening questions related to disability, blindness and long term care need. This function will be made dynamic.	April 30, 2014
The following questions will not appear for household members not seeking any benefits. • Residency information • All citizenship and immigration questions	February 28, 2014
Applicants will have the opportunity to identify themselves as American Indians and Alaska Natives for purposes of cost-sharing protections, and identify American Indian and Alaska Native income not countable for Medicaid and CHIP income determinations.	June 30, 2014
School attendance questions will only appear when necessary for	February 28, 2014

Medicaid eligibility determinations.	
The state will integrate questions for Medicaid, CHIP and APTC into a single application.	October 1, 2014

Please submit the revised alternative single streamlined paper application to CMS for review no later than April 1, 2014 to ensure approval by April 30, 2014. Also, please submit a revised alternative single streamlined online application to CMS for review no later than September 1, 2014, to ensure approval by October 1, 2014. We continue to be available to provide technical assistance. Your Title XXI project officer is Ms. Joyce Jordan. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Jordan's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Blvd.
Baltimore, MD 21244-1850
Telephone: (410) 786-3413
Facsimile: (410) 786-5882
E-mail: Joyce.Jordan@cms.hhs.gov

We look forward to continuing to work with you and your staff.

Sincerely,

[redacted]

Linda Nablo
Director, Division of State Coverage Programs

cc: Mr. Richard Allen, ARA, CMS Region VIII, Denver

Enclosures

Children's Health Insurance Program Eligibility

CO.0267.R00.00 - Jan 01, 2014

Children's Health Insurance Program Eligibility: Summary Page

State/Territory name: Colorado

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

CO-13-0018

Type of SPA:

- [ ] MAGI Eligibility & Methods
- [ ] XXI Medicaid Expansion
- [ ] Establish 2101(f) Group
- [x] Eligibility Processing
- [ ] Non-Financial Eligibility

Proposed Effective Date

01/01/2014 (mm/dd/yyyy)

Federal Statute/Regulation Citation

2102(b)(3) & 2107(e)(1)(O) of the SSA; 42 CFR 457 Subpart C

Federal Budget Impact

- [ ] This SPA has a budget impact.

Total budget impact:

State Funds: $

Federal Funds: $

Subject of Amendment

Please provide a brief summary of SPA changes.

Character Count:331 out of 2000

Defines Colorado's CHIP eligibility processes, including request for Secretary approval of alternative single, streamlined application (both paper and online), an alternative multi-benefit application, and a supplemental form to gather tax-filer information for individuals who recently completed a pre-MAGI

Signature of State Agency Official

Submitted By:	Barbara Prehmus
Last Revision Date:	Jan 16, 2014
Submit Date:	Aug 30, 2013

BACK CONTINUE

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
General Eligibility - Eligibility Processing **CS24**

2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

☑ The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.

☒ An alternative single, streamlined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

☑ The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.

The agency accepts applications in the following other electronic means.

☐ Other electronic means:

Screen and Enroll Process

☑ The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.

Procedures include:

☒ Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and

☒ Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and

CHIP Eligibility

☒ Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.

The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA. | No

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:

☒ Once every 12 months.

☒ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.

☒ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Screening by Other Insurance Affordability Programs

☑ The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.

☒ The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.

Check all types of agencies that apply:

☐ The Exchange

☒ Medicaid

☐ Other agency administering insurance affordability programs

☑ The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.

PRA Disclosure Statement

V.20130709

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: CO-13-0018	**STATE:** Colorado

Through October 1, 2014, the state is using an interim online alternative single streamlined application. After October 1, 2014, the state will use a revised online alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☒Paper Application ☐Online Application	
TRANSMITTAL NUMBER: CO-13-0018	**STATE:** Colorado

Through April 30, 2014, the state is using an interim paper alternative single streamlined application. After April 30, 2014, the state will use a revised paper alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

Application for Public Assistance

State of Colorado Departments of Health Care Policy and Financing and Human Services

Please check the programs you want:

Food	**Food Assistance** – Helps you buy food. **You have the right to file your application today. You can complete your name, address, and signature and turn this form into the county office where you live. An interview is required. Benefits begin from the date the office receives your signed application.** A decision will be made as quickly as possible, but no later than 30 days from the date the office receives your signed application. If expedited assistance is denied, you may ask for an informal hearing.	☐
Cash Programs	**Colorado Works** – For households with a child or a pregnant mother. Provides a cash benefit to families in need. With a few exceptions, parents must participate in work activities. You will be required to work with or receive Child Support Services.	☐
	Aid to the Needy Disabled Colorado Supplement to SSI (AND-CS) – Colorado Supplement provides an additional cash supplement to those persons not receiving the full SSI grant.	☐
	Aid to the Needy Disabled and **Aid to the Blind (AND-SO)** – For persons ages 18-59 who are totally disabled for at least six months or persons under age 59 who meet the definition of blindness. Provides a cash benefit.	☐
	Old Age Pension (OAP) – For low income persons age 60 or over. Provides a cash benefit and may include medical assistance.	☐
	Home Care Allowance (HCA) – For persons who need help on a regular basis with some or all of their daily self-care (such as bathing, dressing, eating, getting around, and using the bathroom) or who need 24 hour supervision in a non-medical facility. Provides a cash benefit that must be used to pay the provider for services. A functional assessment is required.	☐
	Personal Needs Allowance (PNA) – For persons residing in a nursing home who have income less than $50 per month for personal needs.	☐
Medical	**Medical** - Free or low-cost insurance from Medicaid or the Child Health Plan *Plus* Program (CHP+). - Affordable private health insurance plans that offer comprehensive coverage to help you stay well. - A new tax credit that can immediately help pay your premiums for health coverage.	☐

Your Legal **FIRST** Name	Middle Initial	Legal **LAST** Name	**MAIDEN** Name	Social Security Number - -	Date of Birth

Home Address (Number, Street)	City	State	ZIP	Phone Number Leave blank if you do not have one
Mailing Address (If Different from Home Address)	**City**	**State**	**ZIP**	**Other Phone Number**

Do You Speak and Read English?	Are You Homeless?	Are You a Resident of Colorado?
☐Yes No☐ If No, What Language(s) Do You Speak?	☐Yes No☐	☐Yes No☐

Under penalties of perjury, I state that I have examined this application, and to the best of my knowledge and belief my answers are true, including household composition, citizenship and non-citizenship information, and I have listed all amounts and sources of income and property I receive/own. If I am declaring an Authorized Representative, by signing below, I allow this person to sign my application, get official information about this application, and act for me on all future matters with this agency. I read, understand, and agree to "What I Should Know."

Your Signature	Date	Spouse's/ Co-Applicant Signature, if Applying (Not Required for Food Assistance)	Date
Authorized Representative, Conservator, Guardian Printed Name	**Date**	**Authorized Representative, Conservator, Guardian Printed Name**	**Date**
Authorized Representative Signature	**Date**	**Authorized Representative Signature**	**Date**

Person Who Helped Complete Application	Address/Phone	Date

We can send links that allow you to view electronic notices about your case. You may choose more than one option, but if you do not choose, you will receive paper notices by standard mail. Would you prefer?

☐ Paper notices ☐ An e-mail with a link to view my notices sent to: _____@_____

Instructions: List **EVERYONE LIVING IN YOUR HOME**, Even if You Are Not Applying for Them. Use More Paper if Necessary.
If you are a non-citizen who has a SPONSOR, list the Sponsor's information as here, including their SSN.

Relation to You	Legal Name (First, Middle, Last)	Birth Date (MM/DD/YY) and Birth State	*Male/ Female (M/F)	Does This Person Want Benefits?	*Married, Single, Divorced, Separated, Widowed	**Optional for People Not Applying.** This is voluntary for food assistance. Race information is optional, will not affect eligibility, and is to ensure that benefits are provided regardless of race/color/national origin.		
						Social Security Number (SSN)**	**Race**	**US Citizen or US National**
Self	My Name is on Page 1	My Birth Date is on Page 1 *State:		☐Yes ☐No		My SSN is on Page 1		☐Yes ☐No
Person 2		/ / *State:		☐Yes ☐No		- -		☐Yes ☐No
Person 3		/ / *State:		☐Yes ☐No		- -		☐Yes ☐No
Person 4		/ / *State:		☐Yes ☐No		- -		☐Yes ☐No
Person 5		/ / *State:		☐Yes ☐No		- -		☐Yes ☐No

*Optional for Food Assistance
**For programs other than Food Assistance, you must give your SSN if you are applying. You don't have to give it if you are not applying but if you do, it may speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

Do Any of the Children Living in the Home Have a Parent Living Outside the Home?	☐Yes ☐No	*If **Yes**, Have You Tried to Get Medical Support from the Child's Parent Living Outside the Home?*	☐Yes ☐No

Name of Parent	Address	Phone	For Which Child	Other Information You Can Provide

Including Yourself, How Many People in Your Home Do You Buy and Prepare Food for?		Do You Pay Any Heating or Cooling Costs? ☐Yes $_____/month ☐No	Did You Receive LEAP Last Year at Your Current Address? ☐ Yes ☐ No
Total Money My Household Expects to Get This Month (Before Deductions).	$	Do You Pay for Electricity? ☐Yes $_____/month ☐No	Do You Pay for Phone Service? ☐Yes $_____/month ☐No
If You Are Supposed to Pay Rent or Mortgage, Write the Amount.	$	Do You Pay for Water? ☐Yes $_____/month ☐No	Do You Pay for Sewer? ☐Yes $_____/month ☐No
Total Cash on Hand and Money in Your Checking/Savings Accounts.	$	Do You Pay for Garbage Service? ☐Yes $_____/month ☐No	Other Utility Expenses. Type: Amount: $_____/month
Is Anyone in the Home a Migrant or Seasonal Farm Worker?		☐Yes No☐	Home Insurance/Property Taxes/HOA Fees $_____
Did Anyone in the Home Get Benefits in Another State in the Last 30 Days?		☐Yes No☐	*You may receive food assistance within 7 days if anyone in the home is a migrant or seasonal farm worker and the household has less than $100 in cash on hand and in the bank; OR the household has less than $100 in assets and less than $150 income per month; OR if your monthly shelter costs are more than your monthly income plus any cash on hand and in the bank.*

Is Anyone in the Home Pregnant?	❑Yes No ❑	*If yes, please complete below.*			
Who is Pregnant?		What is the Due Date?		How Many Babies Are Expected?	
List the Name of the Father.					

Does Anyone in Your Home Have a Disability? *If Yes, Please List the Name Below.*	❑Yes No❑	If Yes, Does This Person Need Help with Self-Care Activities? (Such as Bathing, Dressing, Eating, Using the Bathroom)
Who?		❑Yes No❑
Who?		❑Yes No❑
Do anyone have a medical or developmental condition that has lasted, or is expected to last, more than 12 months?		❑Yes No❑
		If yes, who?

Have You or Anyone in the Home Applied for Supplemental Security Income (SSI) or Other Social Security Benefits?	❑Yes No❑	*If yes, please complete below.*					
Who		What program?	❑ SSI ❑ _____	Date of Application	/ /	Application Status	❑Pending ❑Denied / Approved ❑ Appealed ❑
Who		What program?	❑ SSI ❑ _____	Date of Application	/ /	Application Status	❑Pending ❑Denied / Approved ❑ Appealed ❑
If **No**, has anyone who is disabled ever received SSI or SSDI?	❑Yes No ❑	If yes, when did SSI or SSDI end?	/ /				

Is Anyone in the Home a Non-Citizen?	❑Yes ❑ No	*If yes, please include a copy of the front and back of your U.S. Citizenship and Immigration Services card and complete below.* ***If you have a sponsor, please provide that information.***
Name of Non-Citizen		Sponsor(s)' SSN, Name, Address, Phone Number
Alien Number		
Does the Non-Citizen Live with His or Her Sponsor?	❑Yes No ❑	Does the Non-Citizen Receive Free Room and Board? ❑Yes No ❑
Document Type, *such as I-94,*	Is their spouse or parent a veteran or an active-duty member of the US military?	❑Yes No ❑
	Document ID number	Has this person lived in the US since 1996? ❑Yes No ❑
Name of Non-Citizen		Sponsor(s)' SSN, Name, Address, Phone Number
Alien Number		
Does the Non-Citizen Live with His or Her Sponsor?	❑Yes No ❑	Does the Non-Citizen Receive Free Room and Board? ❑Yes No ❑
Document Type, *such as I-94,*	Is their spouse or parent a veteran or an active-duty member of the US military?	❑Yes No ❑
	Document ID number	Has this person lived in the US since 1996? ❑Yes No ❑

Is Anyone in the Home currently in Foster Care or Has Ever Been in Foster care?	❑Yes No❑	*If yes, please complete below.*			
Who?		Age?		When?	
Who?		Age?		When?	

Have You or Anyone in the Home Applied for Supplemental Security Income (SSI) or Other Social Security Benefits?	❑Yes No❑	*If yes, please complete below.*					
Who		What program?	❑ SSI ❑ _____	Date of Application	/ /	Application Status	❑Pending ❑Denied / Approved ❑ Appealed ❑
Who		What program?	❑ SSI ❑ _____	Date of Application	/ /	Application Status	❑Pending ❑Denied / Approved ❑ Appealed ❑

INCOME Use More Paper if There is Not Enough Room for Your Answers on This Application.

Is Anyone Working?	☐Yes ☐No	*If yes, please include one full month of income (before taxes and deductions) or proof of employment. If you did not provide your Social Security number, please include proof of your employment.*

INCLUDE Sponsor's income even if the Sponsor lives out of the home.

CURRENT JOB 1: Name of Person Who is Working:

Employer Name and Phone number		
Monthly Wages/Tips (Before Taxes):	*Average Hours Worked Each Week*	
How Often is This Person Paid? ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly		
Is This Job Considered Temporary and Expected to Last Less than 3	☐Yes No☐	

CURRENT JOB 2: Name of Person Who is Working:

Employer Name and Phone number		
Monthly Wages/Tips (Before Taxes):	*Average Hours Worked Each Week*	
How Often is This Person Paid? ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly		
Is This Job Considered Temporary and Expected to Last Less than 3 Months?	☐Yes No☐	

CURRENT JOB 3: Name of Person Who is Working:

Employer Name and Phone number		
Monthly Wages/Tips (Before Taxes):	*Average Hours Worked Each Week*	
How Often is This Person Paid? ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly		
Is This Job Considered Temporary and Expected to Last Less than 3 Months?	☐Yes No☐	

Complete if Anyone in the Home Is Starting a New Job:

Name of Person who is going to receive income:	
Employer Name and Phone number	
Date this person will start new job:	
Monthly wages/tips (before taxes):	
How often will this person be paid? ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly	
Is This Job Considered Temporary and Expected to Last Less than 3 Months?	☐Yes No☐

Complete this box if:

- Anyone has a **Home Business;** or
- Anyone sells things online on websites such as **eBay or craigslist;** or
- Anyone is **Self-Employed;** or if anyone earns money by **babysitting, donating plasma,** or **selling goods such as make-up or kitchenware.**

Who is Self-Employed?	
Name of Business	
Is Business a Corporation or LLC?	☐Yes☐ No
Last Month's Gross Income	$
Utilities Paid for Business	$
Business Taxes Paid	$
Interest Paid on Business Loans	$
Gross Business Labor Costs	$
Cost of Merchandise for Business	$
Other Business Costs. List:	$
	$
	$
	$
	$
Total Income (Net Income)	$

Signature of Person Who Has This Income.

For Any Other Income, Use More Paper if There is Not Enough Room for Your Answers on This Application.

Has Anyone in the Home Quit or Lost a Job in the Past 30 days? ☐Yes No☐ *If yes, please complete below.*

Name of Person Who Quit or Lost a Job:	*Employer Name and Phone number:*				
Start and End Date of Job:					
Monthly Wages/Tips (Before Taxes):					
Date and Amount of Your Last Paycheck:					
How Often Was This Person Paid?	☐Hourly	☐Weekly	☐Every 2 weeks	☐Twice a month	☐Monthly ☐Yearly

Does Anyone Have Other Income? ☐Yes No☐ If yes, check all that apply and complete below

☐ *Unemployment Benefits*	☐ *SSI*	☐ *Veteran Widow*	☐ *Worker's Compensation*	☐ *Railroad Retirement*
☐ *Child Support*	☐ *Survivor Benefits*	☐ *Dividends/Interest*	☐ *Disability Benefits*	☐ *Rental Income*
☐ *Retirement/Pension*	☐ *SSDI*	☐ *Alimony*	☐ *Financial Aid*	☐ *In-Kind Income (working for rent)*
☐ *Social Security Benefits*	☐ *Veterans Benefits*	☐ *Loans/Gifts*	☐ *Public Assistance*	☐ *Other Cash Received Monthly*

Person Getting Money	Money From	Monthly Amount	Person Getting Money	Money From	Amount
		$			$
		$			$
		$			$

Has Anyone Who is Applying Received a Lump Sum Payment? *(Lawsuit or Insurance Settlement, Social Security, SSI, SSDI, Veterans, Inheritance, Surrender of Annuity, or Life Insurance, Other)* ❑Yes No❑ *If yes, please complete below.*

Who	When Received	Type of Lump Sum	Amount
			$
Who	When Received	Type of Lump Sum	Amount
			$

Does Anyone Pay Child or Adult Daycare, Student Loan Interest, Child Support, Alimony *(Alimony Does Not Apply to Food Assistance Eligibility)*, **or Medical Expenses** *(such as Insurance Premiums, Prescription Medicines, or Copays)?* ❑Yes ❑No *If yes, please complete below.*

Expense	Who Pays Expense	Who it is for	Their Date of birth	Month	Amount Paid

Does Anyone in the Home Attend High School, Vocational, Trade School, or College? ❑Yes ❑No *If yes, please complete below.*

Name of Person	Name of School	Last Grade Completed	Expected Date of Graduation	Enrollment Status
				❑Half Time Full Time ❑
				❑Half Time Full Time ❑
				❑Half Time Full Time ❑

Are There Any Household Members Temporarily out of the Home in a Medical Facility *(such as a Nursing Home, Hospital, a Mental Health Institution, or a Group Home)*? ❑Yes No❑ *If yes, please complete below.*

Name of Person	Date Entered	Name of Facility	Phone

Are You Applying for Food Assistance or Colorado Works? ❑Yes No❑ *If yes, please complete below*

1. Have You or Any Member of Your Home Been Convicted of Fraudulently Receiving Duplicate Food Assistance Benefits in Any State After 9/22/1996? ❑Yes No❑
2. Are You or Any Member of Your Home Hiding or Running from the Law to Avoid Prosecution, Being Taken into Custody, Going to Jail for a Felony Crime or Attempted Felony Crime, or Violating a Condition of Parole or Probation? ❑Yes No❑
3. Have You or Any Member of Your Home Been Convicted of a Felony Under Federal or State Law for Possession, Use, or Distribution of a Controlled Drug Substance (Felony Drug Conviction) or for a Crime While Under the Influence of a Controlled Drug Substance after 8/22/1996? ❑Yes No❑
4. Have You or Any Member of Your Home Been Convicted of Buying or Selling Food Assistance Benefits for More than $500 After 9/22/1996? ❑Yes No❑
5. Have You or Any Member of Your Home Been Convicted of Trading Food Assistance Benefits for Guns, Ammunitions, Explosives, or Drugs After 9/22/1996? ❑Yes No❑
6. Have You or Any Member of Your Home Been Convicted of a Felony? *(Only Required for Colorado Works)* ❑Yes No❑
7. Have You or Any Member of Your Household Applying for Assistance Been Disqualified for an Intentional Program Violation or Been Convicted of Welfare Fraud in a Criminal Case? ❑Yes No❑

Has Anyone in the Home Been in the Military?	❑Yes No❑	*If Yes, Who?*	

If You Need Help to Pay Your Burial/Funeral Costs, Would You Prefer:		Cremation		Burial		No Preference

Affidavit of Lawful Presence

If You Are Applying for Colorado Works Everyone in Your House Over 18 Needs to Complete and Sign. If You Are Applying for Aid to the Needy Disabled, (AND-CS or AND-SO), Old Age Pension, or Home Care Allowance You Need to Complete and Sign.

Are You a Citizen of the United States ❑Yes No❑ If No, Are You a Legal Permanent Resident of the United States? ❑Yes No❑

I Am Lawfully Present in the United States Pursuant to Federal Law ❑Yes No❑

I understand 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 admit that making a false, fictitious, or fraudulent statement or representation 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.

Signature Date

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Signature Date

Does Anyone Have Any of the Following: ❑Yes No ❑ *List everything below.*

- *Cash*
- *Checking and Saving Accounts*
- *Certificates of Deposits (CD)*
- *Annuities*
- *College Funds*
- *Mutual Funds*
- *Inheritance*
- *PASS Accounts*
- *Individual Development Accounts*
- *Retirement Accounts*
- *Stocks*
- *Bonds*
- *Trusts*
- *Promissory Notes*
- *Education Accounts*
- *Property (Land, Homes)*
- *401 K*
- *Proceeds from Sale of Home(s)*
- *Other resources*

Person Who Has It	What Do They Have	Amount	Person Who Has It	What Do They Have	Amount
		$			$
		$			$
		$			$
		$			$

Does Anyone Own a Car, Truck, Van, Boat, Motorcycle, RV, or Trailer? ❑Yes No ❑ *List them below.*

Person Who Owns It	Make/Model and Year	Value	Person Who Owns It	Make/Model and Year	Value
		$			$
		$			$

Has Anyone Given Away Anything of Value or Sold Anything for Less than Fair Market Value in the Last Five Years? ❑Yes No ❑ *List what was sold or given away below.*

Person Who Gave It Away or Sold It	What was Given Away or Sold and When	Value	Person Who Gave It Away or Sold It	What was Given Away or Sold and When	Value
		$			$

Is Anyone Buying or Does Anyone Own Land, Property, House, Rental Property, Timeshare, Cabin, or Lot?	☐Yes ☐No	*List them below.*

Person Who is Buying/Owns	Address or Property Description	Value		Person Who is Buying/Owns	Address or Property Description	Value
		$				$

Does Anyone Have Life Insurance Policies?	☐Yes No ☐	*List policies below.*

Who	Company and Policy Number	☐Revocable ☐Irrevocable	Value $
Who	Company and Policy Number	☐Revocable ☐Irrevocable	Value $

Does Anyone Have Burial Insurance Policies?	☐Yes No ☐	*List policies below.*

Who	Company and Policy Number	☐Revocable ☐Irrevocable	Value $
Who	Company and Policy Number	☐Revocable ☐Irrevocable	Value $

Is Anyone enrolled in health coverage now from the following?	☐Yes. If yes, complete the following section. ☐No. If no, skip this section.
☐ Medicaid	Name: _____
☐ Child Health Plan *Plus* (CHP+)	Name: _____
☐ Medicare	Name: _____ Medicare claim number:_____ Check for: ☐Part A ☐Part B ☐Part D *Please include a copy of the front and back of the Medicare card if it is available.*
☐ TRICARE *(Do not check if you have direct care of Line of Duty)*	Name: _____ Policy Number: _____
☐ VA Health Care Programs	Name: _____ Policy Number: _____
☐ Peace Corps	Name: _____
☐ Employer Insurance	Name: _____ Policy number: _____ Start date of coverage (mm/dd/yyyy): _____ Is this COBRA coverage? ☐Yes No☐ Is this a retiree health plan? ☐Yes No☐ If eligible for Medicaid, do any members of this home have access to group health insurance and want help paying the monthly premium? ☐Yes No☐
☐ Other	Name: _____ Policy Number: _____ Name of health plan: _____ Start date of coverage (mm/dd/yyyy): _____

Does Anyone want help paying for medical bills from the last 3 months?	☐Yes No☐

Do you live with at least one child under the age of 19, and are you the main person taking care of this child?	☐Yes No☐

Instructions: Please complete for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. If you don't file a tax return, remember to still add family members who live with you. (Use More Paper if Necessary)

Do You Plan to File a Federal Income Tax Return NEXT YEAR?	❑Yes. If yes, answer questions 1-3 ❑No. If no, answer question 3	*You can still apply for Medicaid, CHP+, or health insurance even if you do not file a federal income tax return.*

1. Will you file jointly with a spouse?	❑Yes No ❑	If **yes**, please list full legal name of spouse	
2. Will you claim any dependents on your tax return?	❑Yes No ❑	If **yes**, list full legal name of dependents	
3. Will you be claimed as a dependent on someone's tax return?	❑Yes No ❑	If **yes**, list full legal name of the tax filer	
		How are you related to the tax filer?	

Does Anyone Else in the Home Plan to File a Federal Income Tax Return NEXT YEAR?	❑Yes. If yes, answer questions 1-3 ❑No. If no, answer question 3	*You can still apply for Medicaid, CHP+, or health insurance even if you do not file a federal income tax return.*

Name			
1. Will they file jointly with a spouse?	❑Yes No ❑	If **yes**, please list full legal name of spouse	
2. Will they claim any dependents on their tax return?	❑Yes No ❑	If **yes**, list full legal name of dependents	
3. Will they be claimed as a dependent on someone's tax return?	❑Yes No ❑	If **yes**, list full legal name of the tax filer	
		How are they related to the tax filer?	

Does Anyone Else in the Home Plan to File a Federal Income Tax Return NEXT YEAR?	❑Yes. If yes, answer questions 1-3 ❑No. If no, answer question 3	*You can still apply for Medicaid, CHP+, or health insurance even if you do not file a federal income tax return.*

Name			
1. Will they file jointly with a spouse?	❑Yes No ❑	If **yes**, please list full legal name of spouse	
2. Will they claim any dependents on their tax return?	❑Yes No ❑	If **yes**, list full legal name of dependents	
3. Will they be claimed as a dependent on someone's tax return?	❑Yes No ❑	If **yes**, list full legal name of the tax filer	
		How are they related to the tax filer?	

What I Should Know

PLEASE KEEP THIS FOR YOUR INFORMATION

By completing and signing the State of Colorado Application for Public Assistance and other documents required to determine whether I'm eligible for public assistance benefits AND by accepting benefits that I am eligible to receive, I understand the following information and agree to the following requirements:

I must tell the truth; it is a crime to lie on this application.
I may have to give papers that show what I've told you is true.
I may have to tell you of any changes to the information I gave you on my application.
If I think you made a mistake, I can ask for an appeal or fair hearing.

The department will not discriminate.
The department will confirm citizenship and immigration status for everyone applying for benefits.
The department will tell you if your benefits change.
The department will take back any benefits you should not have received.

1. The Department of Health Care Policy and Financing (HCPF) is the state agency responsible for Medical Assistance Programs in Colorado. The Department of Human Services is the state agency responsible for the other public assistance programs. The County Departments of Human/Social Services and Medical Assistance Sites are the agencies that receive and process applications for all public assistance programs. In this statement, the term "department" is used to refer to all agencies.

2. I must give the department all needed proof and documents before qualifying for benefits.

3. The information I give on the application and in the application interview is confidential. But, the department can use or share the information with other program(s) that any of my family members are getting or are applying for. The information can only be used for purposes of treatment, payment, determining eligibility, and other program and administrative operations, or other purposes permitted by law for my family members or me.

4. It is a crime to lie on the application or to take benefits that I know that my family and I are not eligible to receive and I may be subject to criminal prosecution for knowingly providing false information. **Giving false information may be punished by a fine of up to $250,000 or a jail term of up to 20 years, or both.**

5. A person found to have intentionally given false information cannot get food assistance and/or Colorado Works/TANF for 12 months for the first offense, 24 months for the second offense, and permanently for the third offense. A court can also stop a person from getting food assistance for another eighteen months. This crime is subject to prosecution under other state and federal laws. Receiving duplicate benefits of food assistance by lying about identity or residence will result in a 10 – year disqualification for the first and second offense and a permanent disqualification for the third offense.

6. The department will notify me in writing of how and when to tell the department of any changes.

7. If I do not tell the truth on my application or if information is left off of the application, or if I do not report changes to the department, as required, I may lose my assistance, and I may have to pay the department for the assistance received when I was not eligible. If I have to pay back money to the department, I understand that state or federal salaries, rebates, or tax refunds that would be received by me or another person on this application may be taken.

8. The law says the department must check the immigration status and citizenship for anyone who is applying. They will not check immigration status of family members who are not applying for benefits. I may be requested to give proof of non-citizen registration documentation received from the United States Citizen and Immigration Service (USCIS) for every non-citizen member in my house who is applying for benefits. The department will confirm information with USCIS and any information received from USCIS may affect my eligibility and benefits. Federal law (Public Law 97-98) requires me to give the department the Social Security number and/or alien registration number of all persons who are applying for public assistance. I must also provide the Social Security number and/or alien registration number for all sponsors. **For adult financial programs, sponsor information will be confirmed with USCIS and the information received from USCIS may affect sponsor repayment for my eligibility and benefits. My sponsor and I may be responsible for reimbursing the state for benefits that I receive.**

9. I do not have to be a U.S. citizen to apply for assistance. **Please do not let the fear about immigration status stop you from seeking benefits for your family.**

10. If I am a resident of an institution and jointly applying for SSI and food assistance prior to leaving the institution, the filing date of the application is my date of release from the institution. Processing time will begin from the date the application is received in the food assistance office.

11. Privacy Act Information: The department is authorized to collect information on the application, including Social Security numbers and will confirm information that may affect initial or ongoing eligibility and payments for all persons listed on my application. **I am allowing the department to use Social Security numbers and other information from my application to request and receive information or records to confirm the information in my application.** Food assistance will be denied to individuals that do not provide a Social Security number, and Social Security numbers will be used and disclosed in the same manner for both eligible and ineligible members. **I release the department from all liability for sharing this information with other agencies for this purpose.** For example, the department may get and share information with any of the following agencies: Social Security Administration; Internal Revenue Service; United States Customs and Immigration Services; Colorado Department of Labor and Employment; Financial institutions (banks, savings and loans, credit unions, insurance companies, landlords, leasing agents, etc.); child support enforcement agencies; employers; courts; and other federal or state agencies; and for food assistance, law enforcement officials for the purposes of apprehending persons fleeing to avoid the law.

If a food assistance over-payment occurs against my household, the information on this application, including all Social Security numbers, may be referred to Federal and State agencies, as well as private claims collection agencies for claims collection action.

12. The EBT (or Quest) card is used to pay me most of my public assistance benefits. I cannot trade or sell EBT cards. I cannot use or have in my possession EBT cards that are not mine. Unless I have an authorized representative, I cannot let someone else use my EBT card. I can only let my authorized representative use my EBT card.

13. For food assistance, I can name someone to be my representative. I must do this in writing. The person I designate to be my authorized representative may help me apply for assistance, get my benefits, and use my benefits to buy food for me. I may name one person to help me with each separate task or I may name one person to help me with all of these tasks.

14. If I think the department made a mistake, I can ask for a Fair Hearing. The department will tell me in writing how to make an appeal. I can ask for a Fair Hearing either verbally or in writing. My case may be presented by a member of my household or my representative, such as legal counsel, friend, or relative. I may request an appeal for any action on any program except for the CHP+ program.

15. 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 writing.

16. Colorado Works is Colorado's TANF (Temporary Assistance for Needy Families) program. It is not an entitlement program and benefits are not guaranteed. Each county has the authority to determine eligibility requirements and benefit levels. To remain eligible, I may be required to complete an assessment and develop a plan. Unless exempted, I will be required to participate in work readiness activities.

17. As an applicant for Colorado Works, I am required to assign all rights to child support that may be received on my behalf or for those in my household that I am applying for. This assignment starts when I am determined eligible and will continue until my Colorado Works benefits end. If I do not do this or refuse to cooperate with Child Support Enforcement at the time I apply or while receiving cash assistance through Colorado Works, without good cause, I will not receive assistance or a basic cash assistance grant for my family.

18. If I am an adult between the ages of 18 and 49, with no children under the age of 18 in my food assistance house, I will only be able to get food assistance benefits for three months during the next three years unless: I work in a job 80 hours each month and report that information to Employment First; or I work my assigned hours at my Employment First office, including *Workfare* or the Employment First work program; or I am determined to be physically or mentally unable to work; or the food assistance office tells me that I am exempt. As long as I do one of these activities each month, I will be able to receive food assistance benefits if I am otherwise eligible.

19. I understand and agree that to receive food assistance, certain members of the household need to register for work. This means that certain members of the household must: A) Report to the Employment First (work program) when the food assistance office schedules you for an appointment. B) Comply with the instructions the Employment First (work program) gives you including reporting for all scheduled appointments and following through on the written agreements you sign. C) Provide information to the food assistance office or the Employment First (work program) about any jobs you get while you are on food assistance. D) Tell the food assistance office or the Employment First (work program) if you are not able to work – you will be asked to provide verification; work any workfare hours you are assigned; go to job interviews arranged for you. Anyone who does not follow the work requirements may be disqualified from receiving food assistance.

20. I must cooperate fully with state and federal staff if my case is reviewed. My information on this application may be reviewed and confirmed by the department, or its representatives. My house will not be eligible for food assistance if I refuse to cooperate with any review of my case, including a quality control review.

21. I cannot use food assistance benefits to buy nonfood items, such as alcohol or cigarettes. I can be disqualified for using food assistance to pay for items purchased on credit. **A person found guilty of using food assistance benefits to illegally purchase or receive controlled substances shall be disqualified for two years for a first offense and permanently for a second offense. Individuals found by a Federal, State, or local court to have used or received benefits in a transaction involving the sale of firearms, ammunition, or explosives shall be permanently ineligible to receive food assistance upon the first occasion of such violation.**

22. Trafficking food assistance means knowingly transferring benefits to another person who does not use or does not intend to use them for the benefit of the household to whom the benefits were issued. The buying, selling, or transferring of food assistance benefits or Electronic Benefit Transfer Card for cash or consideration other than eligible food shall be considered trafficking. A person who traffics in food assistance benefits shall include any person who knowingly acquires, accepts, uses, or transfers to another for consideration, food assistance benefits not issued to him or her or to a household of which he or she is a member or for which he or she is an authorized representative. An individual convicted by a Federal, State, or local court of having trafficked benefits for an aggregate amount of $500 or more shall be permanently ineligible to receive food assistance upon the first occasion of such violation.

23. If I do not report and provide proof of rent, mortgage, housing fees, property insurance, property taxes, court ordered child support payments, child or adult care, and medical expenses paid by people in my household who are elderly or who have a disability, I am stating that I do not want that specific deduction used to determine my food assistance benefit amount.

24. I can ask for food assistance apart from asking for benefits from other programs. My eligibility for food assistance will be determined apart from any other programs. The food assistance office shall process all food assistance applications in accordance with food assistance timeliness, noticing, and fair hearing requirements, even if I am applying for other programs.

25. Colorado residents who have a qualifying disability, such as persons receiving SSI or SSDI benefits, or residents who are at least 65 years of age (or a surviving spouse age 58 or older) might also qualify for a Property Tax/Rent/Heat Rebate from the Department of Revenue. Visit www.TaxColorado.com and click on the PTC button at the top of the page or call 303-238-7378 for details.

Domestic violence information and services are available to me. If I ever feel I am in immediate danger I should call 911. If I would like to receive information regarding safety and services in Colorado, I will call the Colorado Coalition Against Domestic Violence at 303-831-9632 or toll free at 1-888-778-7091. I may also find the location of services near me by going to www.colorado.gov/cdhs/dvp. The National Domestic Violence Hotline at 1-800-799-SAFE (7233) or TTY 1-800-787-3224 or ndvh.org can also provide information. If I am a survivor of domestic violence, sexual assault, or stalking the Address Confidentiality Program (ACP) can provide me with a legal substitute address to use instead of my real address for use with state and local government agencies. I can find out more about ACP at acp.colorado.gov. If I need or receive either of these services, I should tell my department worker because it will allow him or her to provide better service and assistance to me.

Our non-discrimination policy. This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion and political beliefs. The U.S Department of Agriculture also prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination with USDA, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800)221-5689, which is also in Spanish or call the State Information/Hotline Numbers; found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm. To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (ITY). USDA and HHS are equal opportunity providers and employers.