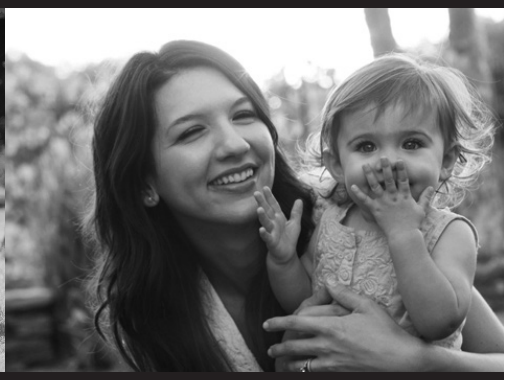
Application for Health Insurance & Help Paying Costs

CONNECT for HEALTH COLORADO™

COLORADO
Department of Health Care Policy & Financing



See Inside

Get Help in Other Languages

1-800-221-3943
1-855-752-6749

Spanish	Español
Chinese	普通话
Vietnamese	Tiếng Việt
Korean	한국어
Russian	Русский
Arabic	العربية
Hmoob	Ntawv Hmoob
Amharic	አማርኛ
Nepali	नेपाली
Somali	Soomaali
French	Français
German	Deutsch

Having health insurance can help give you peace of mind and stay healthy. With insurance, you will know you and your family can get health care when you need it.

Fill Out This Application to See What Insurance You May Qualify For:

- Free or low-cost public health insurance from Colorado Medicaid or the Child Health Plan *Plus* (CHP+) Program administered by the Department of Health Care Policy and Financing ⓘ.
- Affordable private health insurance plans that offer comprehensive coverage available through Connect for Health Colorado (the Marketplace)ⓘ.
- A tax credit that can help lower your premiums ⓘ for health coverage.

You may qualify for a free or low-cost health insurance if you earn as much as $46,500 a year for an individual or $95,000 a year for a family of 4.

Filing out this application does not mean you have to buy health insurance.

Apply Faster Online at

Colorado.gov/PEAK or **ConnectforHealthCO.com**

EN-002-01

Things to Know

Who Can Use This Application

- Anyone who is interested in getting health coverage
- Applying will not affect your immigration status or chances of becoming a permanent resident or citizen

What You May Need to Apply

- Social Security Numbers (or document numbers for any legal immigrants) for everyone in your household that needs insurance
- Employer and income information for everyone in your household
- Current health insurance information, including policy number for each member of your household
- Information about any job-related health insurance available to your household

Why Do We Ask For This Information

We ask about income and other information to find what health coverage you may qualify for and if you can get help paying for it. **We will keep all the information you provide us private and secure, as required by law.**

What Happens Next

- Send your completed, signed application to one of the addresses in Step 4. If you do not have all the information we ask for, sign and submit your application anyway. We will contact you, and tell you what you need to do next.
- If you do not hear from us, please contact the agency you sent your application to in Step 4

Get Help with Your Application for Free

- Worksheets are marked with the symbol in the application. The Worksheets are at the end of the main application.
- If someone is helping you fill out this application, you may need to complete **Worksheet A**
- **Glossary:** terms marked with an in the application can be found in the glossary
- If you need help in a language other than English, call and tell the customer service representative the language you need
- **En Español:** Llame a nuestro centro de servicio gratis para ayuda o para obtener una copia de este formulario en Español

	Colorado Medicaid and CHP+	**Connect for Health Colorado**
Online:	Colorado.gov/PEAK	ConnectforHealthCO.com
Phone:	1-800-221-3943	1-855-PLANS-4-YOU (1-855-752-6749)
TTY/TDD:	1-800-659-2656	1-855-346-3432
In Person:	There may be Application Assistance Sites in your area who can help. Find a location for help: Colorado.gov/hcpfmap	Visit the ConnectforHealthCO.com for a list of Certified Connect for Health Colorado Health Coverage Guides, Certified Application Counselors, and Agents/Brokers in your area who can help

Instructions

There are four steps to complete this application for Medical Assistance. The questions on this application will help us determine what you and your household may qualify for.

Before you begin the application, please read the privacy statement on page v. and vi.

STEP 1: Tell Us About Your Household
There are 5 parts to Step 1:

- **First**, read the section on who you need to include in this application. This section will tell you who is part of your household for purposes of filling out this application. We need to know who is in your household to figure out what you and your family may qualify for.
- **Second**, fill out the Who is in Your Household chart. This chart will tell us how the members of your household are related to each other. This chart will also help you make sure that you haven't left off a member of your household on the application.
- **Third**, there are five questions in this section used to find out if anyone in your household may qualify for special services through Colorado's Early and Periodic Screening, Diagnostic and Treatment program or Health Communities Program. These questions are optional.
- **Fourth**, tell us if anyone in your household has passed away in the current calendar year. If a member of your household has passed away in the current calendar year, and you are applying for coverage for the current calendar year, they can still count as a member of your household for tax credits and help with costs. If a member of your household has passed away in the last three months, Medicaid may be able to help for medical bills that they got during the three months before your submitted this application.
- **Fifth**, tell us whether you will be applying for health coverage this year or next year. For most people who qualify for Medicaid or CHP+, your benefits will start right away and your coverage start date will be the first day of the month you applied.

Some questions will have this picture next to them  . This picture tells you that you need to fill out a Worksheet. These Worksheets are necessary to find out what benefits you qualify for. You may find it easier to fill out Worksheets that are needed, then come back to where you stopped in the main application.

STEP 2: Person 1-Tell us about yourself
Person 1 is the main contact person for this application, and must be an adult 18 years or older. If you need health coverage, please fill out all questions. If you do not need health insurance, fill out all questions in this section through question 29, and then skip to question 39. Even if you do not need health insurance we need information about every person in your household to find out what others in your household may qualify for.

We need to know information about your current job and income. You should fill out all job and income information that applies to you. If your current income, deductions, or expenses do not change each pay period or do not change each month, then only fill out the current amount, you can skip filling out the actual annual amount. If your current income, deductions, or expenses change each pay period or change each month you will need to tell us your current amount **and** the actual annual amount.

Next fill out the information for each person in your household.

STEP 2: Person 2
The application has space for up to 2 people. Fill out Step 2: Person 2 for the next person in your household. If you have more than 2 people in your household, you can fill out Worksheet K and/or make copies of Worksheet K pages and complete and attach them for each additional person.

Instructions (continued)

STEP 3: Rights, Responsibilities and Penalties
Read this section completely. This section tells you about your rights, responsibilities, and possible penalties. You are agreeing to these rights, responsibilities, and possible penalties by signing and submitting this application. We can't process your application if Person 1 or an authorized representative does not sign the application.
Be sure to attach any Worksheets you fill out. There is a complete list of Worksheets in the application at the end of STEP 3.

STEP 4: You can mail your completed application and Worksheets to either of the addresses listed in Step 4. If you need to fill out Worksheet B or Worksheet D, we recommend you mail your application to the Colorado Medical Assistance Program address.

If you are interested in applying for an individual shared responsibility exemption ⓘ, please see the Glossary.

For additional information, please see the separate Instruction Booklet available at Colorado.gov/hcpf/how-to-apply and ConnectforHealthCO.com/about-us/customer-resources/

Privacy Statement

Connect for Health Colorado (the Marketplace) and the Department of Health Care Policy and Financing will maintain information you provide as private as required by law. If you chose to apply for financial assistance, the Department of Health Care Policy and Financing can use or share the information you provide about you or your family members with other programs. The information you provide will be used for purposes of treatment; payment; determining eligibility; other program and administrative operations; or other purposes permitted by law.

Your answers on this application will only be used to determine eligibility for health insurance or help paying for health insurance. As part of the process, we will communicate with you or your authorized representative, and then provide the information to the health plan you select so that they can enroll those who are eligible in a qualified health plan or an insurance affordability program. Information on race and ethnicity will not be provided to the insurance carriers, unless you are an American Indian or Alaska Native because that information could positively affect your benefits. We will verify your answers using information in our electronic databases and the databases of partner agencies. If the information you provide does not match these sources, we may ask you to send us proof of the information you provide.

Health insurance carriers can no longer deny coverage based on your health status. If you are seeking medical financial assistance, we may ask you screening questions about your medical history to help us determine the assistance programs for which you are eligible. This information is not used to determine your insurance rates. Household members who do not want insurance will not be asked questions about citizenship or immigration status.

If you don't have an exemption from the shared responsibility payment and you don't maintain qualifying health insurance for three months or longer during the year, you may be subject to a federal penalty.

Important: Connect for Health Colorado and the Department of Health Care Policy and Financing are authorized to collect information on the application, including Social Security numbers, and will confirm information that may affect initial or ongoing eligibility for all persons listed on your application. You are allowing Connect for Health Colorado and the Department of Health Care Policy and Financing to use Social Security numbers and other information from your application to request and receive information or records to confirm the information in your application; if you apply for other public assistance programs, the Department of Human Services may use this information as well. You release Connect for Health Colorado from all liability for sharing this information with other agencies for this purpose. For example, Connect for Health Colorado and the Department of Health Care Policy and Financing may get and share your information with any of the following agencies: Social Security Administration; Internal Revenue Service; United States Customs and Immigration Services; Department of Homeland Security; Centers for Medicare and Medicaid Services; Colorado Department of Labor and Employment; Financial institutions (banks, savings and loans, credit unions, insurance companies, etc.); child support enforcement agencies; employers; courts; other federal or state agencies; and Agents/Brokers and managing general agencies contracting with those agents/brokers, as applicable, which are certified by the Marketplace to assist applicants/enrollees. We need this information to check your eligibility for health insurance or help paying for health insurance and to give you the best service possible if you choose to apply. Regulations that support getting this data can be found under the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), the Social Security Act, and Colorado S.B. 11-200, the Colorado Health Benefit Exchange Act, codified at C.R.S. § 10-22-101.

We may use the information you provide in computer matching programs with any of the following entities to make eligibility determinations, to verify continued eligibility for enrollment in a qualified health plan or Federal benefit program, or to process appeals of eligibility determinations:

- Other verification sources including consumer reporting agencies;
- Employers identified on applications for eligibility determinations;
- Applicants/enrollees, and authorized representatives of applicants/enrollees;

Privacy Statement (continued)

- Issuers of qualified health plans, as applicable, which are certified by Colorado Division of Insurance;
- Agents and brokers, as applicable, who are certified by the Marketplace to assist applicants/ enrollees;
- Financial institutions (banks, credit unions, etc.) including Network Merchants, Inc. for all ACH/ credit card payments;
- Connect for Health Colorado contractors engaged to perform a function for the Marketplace; and
- Anyone else as required by law or allowed under Colorado S.B. 11-200.

The Marketplace and the Department of Health Care Policy and Financing will also use the information you provide as part of the ongoing operation of both agencies, including activities such as reporting on and managing the insurance affordability programs for eligible individuals, performing oversight and quality control activities, combatting fraud, and responding to any concerns about the security or confidentiality of the information. We use your personally identifiable information for our internal business purposes only, and we do not sell or trade it.

As part of overall performance and effectiveness monitoring, the Marketplace utilizes Google Analytics to identify and track customer activities to analyze communication campaigns, website navigation, and potential bottlenecks.

For additional information about Google Analytics please see How Google uses data when you use our partners' sites or apps

Protection of your data

Connect for Health Colorado and the Department of Health Care Policy and Financing have significant protections in place to ensure the privacy of your personal information. The Marketplace and the Department of Health Care Policy and Financing systems are being implemented in compliance with federal and state rules, regulations, and laws designed to protect customer information.

You will be asked to provide only the minimum information necessary to determine eligibility for medical financial assistance and relevant health plan options, as applicable. Multiple layers of physical, administrative, and electronic protections have been put in place to protect all information from unauthorized use, access, or malicious activity. Personnel procedures and processes have been developed with an emphasis on privacy.

Connect for Health Colorado (and contractors) adhere to Fair Information Practice Principles, as defined in ACA §155.260. Additionally, our customer-support partners — Health Coverage Guides, Assistance Site staff, certified health insurance agents and brokers, and others — must all comply with and support our security and privacy efforts, including security and privacy training, as part of their agreements. Their access to customer data is restricted based on the roles they serve. For example, Health Coverage Guides will not have access to customer data through the Marketplace. Licensed health insurance agents and brokers will have access to portions of client data, but only after completing a certification process and being authorized by the client. Within our own Customer Service Center, representatives will also receive training, screening, and be subject to controls.

Under ACA regulations, any person who knowingly and willfully uses or discloses information in violation of section 1411(g) of the Affordable Care Act will be subject to a civil penalty of not more than $25,000 per person or entity, per use or disclosure, in addition to other penalties that may be prescribed by law.

Finally, the Department of Health Care Policy and Financing and the Marketplace systems will be tested, inspected, and audited by independent third parties and federal and state organizations. Effective customer privacy and security are a top priority as part of our overall mission to provide this service to Colorado.

You have the right to see whatever information we have about you. You also have the right to have this information corrected if we have any incorrect information on file.

STEP 1 Tell Us About Your Household

Who do you need to include on this application?

Your income and household size help us decide what programs you qualify for. You don't need to file a federal income tax return ⓘ to apply. You don't need to file federal income taxes to qualify for Medicaid or CHP+. You must file federal income taxes to get tax credits and help to lower the costs of your health care costs.

DO Include the following individuals on your application:

- Yourself
- Your spouse ⓘ
- Your children under 19 who live with you
- Anyone on your **federal income tax return**. This could include children over 19, even if they do not live with you.
- Your unmarried partner ⓘ who needs health coverage
- Anyone else under 19 who you take care of and lives with you
- If you are claimed as a dependent ⓘ on someone else's federal tax return include:
  - The person(s) who claims you,
  - All members of that federal tax filing household claimed as dependents
  - Any family member living with you.

You DO NOT have to include other unrelated roommates.

Who is in Your Household

Instructions: We are asking how each member of your household is related to each other to figure out what you qualify for. List each person in the household on the next page. Use the information above to figure out who should be included in your household. Start with Person 1, and fill in the relationship that person has to each member of the household. Repeat this step for each person listed in the household. See the example below.

Example:

A household is made up of Jane, John, and Betsy. Jane is the person filling out this application and is known as PERSON 1. Jane and John are married and Betsy is Jane's daughter from a previous relationship.

Person 1: Jane Person 2: John Person 3: Betsy

Person 1 Jane	**is the**	Wife	Mother			
		Of Person 2	**Of Person 3**	**Of Person 4**	**Of Person 5**	**Of Person 6**
Person 2 John	**is the**	Husband	Stepfather			
		Of Person 1	**Of Person 3**	**Of Person 4**	**Of Person 5**	**Of Person 6**
Person 3 Betsy	**is the**	Daughter	Stepdaughter			
		Of Person 1	**Of Person 2**	**Of Person 4**	**Of Person 5**	**Of Person 6**

? **NEED HELP WITH YOUR APPLICATION?** See our contact information on page i of this application or on Step 4.

STEP 1 Continue To Tell Us About Your Household

Person 1: _____ Person 2: _____ Person 3: _____

Person 4: _____ Person 5: _____ Person 6: _____

Person 1 **YOU**	**are the**					
		Of Person 2	**Of Person 3**	**Of Person 4**	**Of Person 5**	**Of Person 6**
Person 2	**is the**					
		Of Person 1	**Of Person 3**	**Of Person 4**	**Of Person 5**	**Of Person 6**
Person 3	**is the**					
		Of Person 1	**Of Person 2**	**Of Person 4**	**Of Person 5**	**Of Person 6**
Person 4	**is the**					
		Of Person 1	**Of Person 2**	**Of Person 3**	**Of Person 5**	**Of Person 6**
Person 5	**is the**					
		Of Person 1	**Of Person 2**	**Of Person 3**	**Of Person 4**	**Of Person 6**
Person 6	**is the**					
		Of Person 1	**Of Person 2**	**Of Person 3**	**Of Person 4**	**Of Person 5**

The next five (5) questions are used to figure out if you qualify for services from the Healthy Communities Program ⓘ through Early and Periodic Screening, Diagnostic and Treatment ⓘ provisions of Medicaid. These questions are optional.

1. Does anyone in your household who is applying for coverage have a physical or behavioral disability which has lasted or is expected to last more than 12 months? ☐ **Yes** ☐ **No**

2. Is anyone who is in your household, or for whom you are applying for, currently in a medical facility, such as a nursing facility, hospital, a mental health institution, or a group home (or has been within the last 90 days)? ☐ **Yes** ☐ **No**

3. Special services may be available to children and pregnant women. Please check any health services that any pregnant women or children in your household get or use: ☐ Medical Services ☐ Mental or Behavioral Health Services ☐ School Health Services ☐ Prescriptions ☐ Other:_____

4. Has any child in your household been to the emergency room for treatment since his or her last visit to the doctor? ☐ **Yes** ☐ **No**

5. Is anyone in the household pregnant? ☐ **Yes** ☐ **No**

6. **Has anyone in your household passed away in the last calendar year? ☐ **Yes** ☐ **No**

Name: _____ Date of Death: _____

Name: _____ Date of Death: _____

***Make sure to include the deceased household member(s) in the table above and complete information about each deceased person in the household by filling out Step 2.*

? **NEED HELP WITH YOUR APPLICATION?** See our contact information on page i of this application or on Step 4.

7. What year are you applying for coverage for your household? 20_____

Coverage Year: The coverage year is the calendar year you are applying to get tax credits or help to lower your health care costs. For example, if you are applying in November of 2014 for 2015 health care coverage, the coverage year would be 2015. Or if you are applying in February of 2015 for 2015 health care coverage, the coverage year would be 2015. For most people who qualify for Medicaid or CHP+, your benefits will start right away and your coverage start date will be the first day of the month you applied.

8. ☐ **Is someone helping you fill out this application? If yes, fill out Worksheet A**

Complete Step 2 for each person in your household. Start with yourself, then add other adults and children in your household. If you have more than 2 people in your household, you can fill out **Worksheet K** and make copies of the pages if needed. **You do not need to provide immigration status or a Social Security Number (SSN) for household members who do not need health coverage.** We will use your personal information only to check if you qualify for health coverage.

STEP 2: Person 1 (Start with Yourself)

You will be the main contact person for this application. The main contact person should be an adult at least 18 years old. See page 1 for more information about who to include on your application.

1. Legal Name (First)	(Middle)	(Last)	Suffix	2. Relationship to you? SELF

3. Date of Birth (mm/dd/yyyy) _____ 4. Sex ☐ Male ☐ Female

5. Home address (Leave blank if you do not have one) _____ 6. Apartment/Suite # _____

7. City	8. State	9. ZIP code	10. County

11. Mailing address (If different from home address) _____ 12. Apartment/Suite # _____

13. In Care Of (If applicable) _____

14. City	15. State	16. ZIP code	17. County

18. Email address _____

19. Primary Phone _____ Ext. _____ Phone Type: ☐ Cell ☐ Home ☐ Work

20. Secondary Phone _____ Ext. _____ Phone Type: ☐ Cell ☐ Home ☐ Work

21. Preferred spoken language: ☐ English ☐ Spanish ☐ Other:_____

22. Preferred written language: ☐ English ☐ Spanish

NEED HELP WITH YOUR APPLICATION? See our contact information on page i of this application or on Step 4.

STEP 2: Person 1 (Continue with Yourself)

23. Are you a resident of Colorado? ☐ **Yes** ☐ **No**

24. Are you living outside of Colorado temporarily? ☐ **Yes** ☐ **No**

25. If you are living outside of Colorado temporarily, where will you be living in Colorado when you return?

City _____ ZIP code _____ County _____

26. Social Security Number (SSN) ☐☐☐ – ☐☐ – ☐☐☐☐

If you want health coverage and have an SSN, we need this information. If you do not want health coverage, providing your SSN may help speed up the application process. We use SSNs to check income and other information to see what you may qualify for.

If **No** SSN and applying for coverage, tell us why: ☐ Has applied for SSN ☐ Illness ☐ Lawfully Present Non-citizen ☐ Religion

27. Do you plan to file a federal income tax return for the coverage year ⓘ? ☐ **Yes** ☐ **No**
You can still apply for Medicaid, CHP+, or health insurance even if you do not file a federal income tax return. However, you must plan to file taxes for the coverage year to get a tax credit and reduced out of pocket costs available through the Marketplace.

a. What is your federal income tax filing status? (Check all that apply)
☐ Single ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Head of Household

b. If you told us that you are the "Head of Household" or "Married Filling Separately," do exceptional circumstances ⓘ apply to your case? ☐ **Yes** ☐ **No**

c. If you are married filing jointly, please name your spouse: _____

d. Will you claim dependents on your tax return? ☐ **Yes** ☐ **No**
If Yes, list the legal name(s) of your dependents: _____

e. If you are a tax dependent, list who claims you as a dependent: _____
Is this person listed on the application? ☐ **Yes** ☐ **No**
Is this person a non-custodial parent? ☐ **Yes** ☐ **No**

f. Are you living with both parents but your parents do not expect to file a joint federal income tax return?
☐ **Yes** ☐ **No**

The answers to questions with an (*) cannot be used to determine the availability or cost of premiums for any health insurance purchased through the Marketplace.

28. *Are you pregnant? ☐ **Yes** ☐ **No**
If Yes, how many babies are expected? _____ Due Date (mm/dd/yyyy)? _____

29. Do you need health coverage?

☐ **Yes**. **If Yes,** answer all of the following questions. ☐ **No**. **If No**, SKIP to question 39.

STEP 2: Person 1 (Continue with Yourself)

30. *Do you have a medical or developmental condition that has lasted, or is expected to last, more than 12 months, including blindness? ☐ **Yes** ☐ **No**

31. *Do you regularly need help with some or all of your self-care activities (such as bathing, dressing, eating, using the bathroom)? ☐ **Yes** ☐ **No**

32. *Do you need to move to a nursing home, acute care, hospital, group home, mental health institution or long-term care facility within the next 30 days, or do you need in-home health care to stay in your home? ☐ **Yes** ☐ **No**

If you have answered 'yes' to any of the three questions above, fill out Worksheet B

33. Are you a U.S. citizen or U.S. national? ☐ **Yes** ☐ **No**
If No, fill out **Worksheet C**

Other Health Coverage

34. Do you want help paying for medical bills from the last 3 months? ☐ **Yes** ☐ **No**

If Yes, what is the date(s) of service (mm/dd/yyyy) _____

35. Are you being treated for an injury that you have or may bring a claim? ☐ **Yes** ☐ **No**

If you answered "yes" to the above question, fill out Worksheet D

36. Do you qualify for or are you enrolled in the following health care coverage? **If Yes**, fill out **Worksheet E**
☐ Medicare ☐ TRICARE ☐ Peace Corps ☐ Other State or Federal Heath Benefit Program
☐ VA Health Care Program ☐ Railroad Retirement ☐ Other: _____

37. Do you qualify for or are you enrolled in the following health care coverage? **If Yes**, fill out **Worksheet F**
☐ Current Employer-Sponsored Health Coverage ☐ Retiree Health Plan ☐ COBRA

38. Are you currently incarcerated? ☐ **Yes** ☐ **No**

a. **If Yes,** where are you incarcerated? ☐ City/County Jail ☐ State/Federal Prison

b. **If Yes,** are you currently waiting for a decision on charges? ☐ **Yes** ☐ **No**

39. **Race (OPTIONAL—check all that apply.)**

☐ White or Caucasian	☐ Asian Indian	☐ Filipino	☐ Vietnamese	☐ Samoan
☐ Black or African American	☐ American Indian or Alaska Native (fill out **Worksheet G**)	☐ Japanese	☐ Other Asian	☐ Other Pacific Islander
☐ Hispanic/Latino		☐ Korean	☐ Native Hawaiian	☐ Other _____
		☐ Chinese	☐ Guamanian or Chamorro	

You may get additional benefits: If you are an American Indian or Alaska Native, fill out Worksheet G.

40. Were you uninsured in the last six months? (optional) ☐ **Yes** ☐ **No**
Your answer to this question will not affect what you qualify for.

STEP 2: Person 1 (Continue with Yourself)

41. Current Job & Income Information (Check all that apply)

☐ **I do not have a job**
SKIP to question 70.

☐ **I have a job**
If you are currently employed, tell us about your income. Start with question 42.

☐ **I am self-employed**
Fill out **Worksheet H** and return to question 70.

☐ **I have other income** (including rental income) Fill out **Worksheet I** and return to question 70.

CURRENT JOB 1:

42. Employer Name

43. Employer Address | 44. Apartment/Suite # | 45. Employer Phone

46. City | 47. State | 48. ZIP code

49. Wages/tips (before taxes)
$_____

Pay Period:
☐ Daily ☐ Twice a month
☐ Weekly ☐ Monthly
☐ Every 2 weeks ☐ Yearly

50. Average hours worked each WEEK
_____

51. When did you start this job (mm/yyyy)? _____

52. When was your most recent paycheck received for this job (mm/dd/yyyy)? _____

53. Tell us the total gross pay ⓘ that you got or will get this month as a one time payment from this employer. (This could be a bonus or other extra pay you got.) _____

54. Does your income from this job change month to month? ☐ **Yes** ☐ **No**
If Yes, fill out the current amount **AND** annual amount for this job.
If No, only fill out the current amount. You do **not** need to fill out the annual amount.
55. Annual income ⓘ from this job: $_____

CURRENT JOB 2:

56. Employer Name

57. Employer Address | 58. Apartment/Suite # | 59. Employer Phone

60. City | 61. State | 62. ZIP code

63. Wages/tips (before taxes)
$_____

Pay Period:
☐ Daily ☐ Twice a month
☐ Weekly ☐ Monthly
☐ Every 2 weeks ☐ Yearly

64. Average hours worked each WEEK
_____

65. When did you start this job (mm/yyyy)? _____

66. When was your most recent paycheck received for this job (mm/dd/yyyy)? _____

67. Tell us the total gross pay ⓘ that you got or will get this month as a one time payment from this employer. (This could be a bonus or other extra pay you got.) _____

68. Does your income from this job change month to month? ☐ **Yes** ☐ **No**
If Yes, fill out the current amount **AND** annual amount for this job.
If No, only fill out the current amount. You do **not** need to fill out the annual amount.
69. Annual income ⓘ from this job: $ _____

70. **DEDUCTIONS**: Check all that apply, and give the amount and how often you pay it. Telling us about these deductions could make the cost of your health insurance lower. You should not include a cost that you already considered in your answer to job income and net self-employment.

71. Do your deductions change month to month? ☐ **Yes** ☐ **No**

If Yes, fill out the current Amount **AND** Actual Annual Amount columns for each type of deduction that applies to you. **If No,** only fill out the current Amount column. You do **not** need to fill out the Actual Annual Amount column.

Deduction Type:

- Alimony
- Student Loan Interest
- Contribution made to your Traditional IRA
- Capital Losses
- HSA Deduction
- Moving Expenses
- Penalty of Early Withdrawal of Savings
- Reimbursement of Expenses
- Domestic Production Activities

Type of Expense:	Current Amount:	Actual Annual Amount:
Type of Expense:______________ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:
Type of Expense:______________ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:
Type of Expense:______________ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:
Type of Expense:______________ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:

72. Did you have income from a past job, self-employment, or other sources during the coverage year which is not listed as current income that you will need to include on your tax return? ☐ **Yes** ☐ **No**

If Yes, fill out **Worksheet J**

73. After you submit this application, we will verify your income. Please tell us if any of the following have happened to you in the past few months to help us with this verification process: ☐ Stopped working at a job ☐ Hours changed at a job ☐ Change in employment ☐ Married, Legal Separation, or Divorce ☐ Other: ______________________

If you have more people in your household, continue filling out the application for each person in your household.

STEP 2: Person 2

1. Legal Name (First) (Middle) (Last) Suffix

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your federal income tax return ⓘ. See Step 1 for more information about who to include.

2. Relationship to you?

3. Date of Birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Home address (Leave blank if you do not have one)

6. Apartment/Suite #

7. City

8. State

9. ZIP code

10. County

11. If you are 18 years or older, would you like to receive your own mail about to your health coverage?
☐ **Yes** ☐ **No**
If Yes, please fill out mailing address below.

12. Mailing address (If different from home address)

13. Apartment/Suite #

14. In Care Of (If applicable)

15. City

16. State

17. ZIP code

18. County

19. Email address

20. Primary Phone Ext. Phone Type: ☐ Cell ☐ Home ☐ Work

21. Secondary Phone Ext. Phone Type: ☐ Cell ☐ Home ☐ Work

22. Preferred spoken language: ☐ English ☐ Spanish ☐ Other:_____

23. Preferred written language: ☐ English ☐ Spanish

24. Is **PERSON 2** a resident of Colorado? ☐ **Yes** ☐ **No**

25. Is **PERSON 2** living outside of Colorado temporarily? ☐ **Yes** ☐ **No**

26. If **PERSON 2** is living outside of Colorado temporarily, where will this person be living in Colorado when he or she returns?

City

ZIP code

County

STEP 2: Person 2 (Continue with PERSON 2)

27. Social Security Number (SSN) ☐☐☐ – ☐☐ – ☐☐☐☐

If PERSON 2 wants health coverage and has a SSN, we need this information. If they do not want health coverage, providing their SSN may help speed up the application process. We use SSNs to check income and other information to see what **Person 2** may qualify for.

If no SSN and applying for coverage, tell us why: ☐ Has applied for SSN ☐ Illness
☐ Lawfully Present Non-citizen ☐ Religion

28. **Does PERSON 2 plan to file a federal income tax return for the coverage year ⓘ? ☐ Yes ☐ No**
PERSON 2 can still apply for Medicaid, CHP+, or health insurance even if they do not file a federal income tax return. However, they must plan to file taxes for the coverage year to see if you could be eligible for tax credits and reduced out of pocket costs available through the Marketplace.

a. What is **PERSON 2's** federal income tax filing status? (Check all that apply)
☐ Single ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Head of Household

b. If **PERSON 2** checked that they are the "Head of Household" or "Married Filling Separately", do exceptional circumstances ⓘ apply to their case? For more information, see the instructions ☐ **Yes** ☐ **No**

c. If **PERSON 2** is filing jointly, please name his or her spouse: _____

d. Will **PERSON 2** claim any dependents on his or her tax return? ☐ **Yes** ☐ **No**
If Yes, list legal name(s) of dependents:_____

e. If **PERSON 2** is a tax dependent, list who will claim them as a dependent:

_____ _____
Is this person listed on the application? ☐ **Yes** ☐ **No**
Is this person a non-custodial parent? ☐ **Yes** ☐ **No**

f. Is **PERSON 2** living with both parents, but their parents do not expect to file a joint federal income tax return? ☐ **Yes** ☐ **No**

The answers to questions with an (*) cannot be used to determine the availability or cost of premiums for any health insurance purchased through the Marketplace.

29. *Is **PERSON 2** pregnant? ☐ **Yes** ☐ **No**
If Yes, how many babies are expected? _____ Due Date (mm/dd/yyyy)? _____

30. **Does PERSON 2 need health coverage?**

☐ **Yes**. **If Yes,** answer all of the following questions. ☐ **No**. **If No**, SKIP to question 40.

STEP 2: Person 2 (Continue with PERSON 2)

31. *Does **PERSON 2** have a medical or developmental condition that has lasted, or is expected to last, more than 12 months, including blindness? ☐ **Yes** ☐ **No**

32. *Does **PERSON 2** regularly need help with some or all of their self-care activities (such as bathing, dressing, eating, using the bathroom)? ☐ **Yes** ☐ **No**

33. *Does **PERSON 2** need to move to a nursing home, acute care, hospital, group home, mental health institution or long-term care facility within the next 30 days, or do they need in-home health care to stay in their home? ☐ **Yes** ☐ **No**

If you have answered '**Yes**' to any of the three questions above, fill out **Worksheet B**

34. Is **PERSON 2** a U.S. citizen or U.S. national? ☐ **Yes** ☐ **No**
If No, fill out **Worksheet C**

Other Health Coverage

35. Does **PERSON 2** want help paying for medical bills from the last 3 months? ☐ **Yes** ☐ **No**

If **Yes**, what is the date(s) of service (mm/dd/yyyy) _____

36. Is **PERSON 2** being treated for an injury that they have or may bring a claim? ☐ **Yes** ☐ **No**
If you answered "yes" to the above question, please fill out Worksheet D

37. Does **PERSON 2** qualify for or is enrolled in the following health care coverage? **If Yes**, fill out **Worksheet E**
☐ Medicare ☐ TRICARE ☐ Peace Corps ☐ Other State or Federal Heath Benefit Program
☐ VA Health Care Program ☐ Railroad Retirement ☐ Other: _____

38. Does **PERSON 2** qualify for or is enrolled in the following health care coverage? **If Yes**, fill out **Worksheet F**
☐ Current Employer-Sponsored Health Coverage ☐ Retiree Health Plan ☐ COBRA

39. Is **PERSON 2** currently incarcerated? ☐ **Yes** ☐ **No**

a. **If Yes,** where is **PERSON 2** incarcerated? ☐ City/County Jail ☐ State/Federal Prison

b. **If Yes,** is **PERSON 2** currently waiting for a decision on charges? ☐ **Yes** ☐ **No**

40. **Race (OPTIONAL—check all that apply.)**

☐ White or Caucasian	☐ Asian Indian	☐ Filipino	☐ Vietnamese	☐ Samoan
☐ Black or African American	☐ American Indian or Alaska Native (fill out **Worksheet G**)	☐ Japanese	☐ Other Asian	☐ Other Pacific Islander
☐ Hispanic/Latino		☐ Korean	☐ Native Hawaiian	☐ Other _____
		☐ Chinese	☐ Guamanian or Chamorro	

You may get additional benefits:
If PERSON 2 is an American Indian or Alaska Native, fill out Worksheet G.

41. Was **PERSON 2** uninsured in the last six months? (optional) ☐ **Yes** ☐ **No**
Your answer to this question will not affect what you qualify for.

STEP 2: Person 2 (Continue with PERSON 2)

42. Current Job & Income Information (Check all that apply)

☐ **I do not have a job**
SKIP to question 71.

☐ **I have a job**
If you are currently employed, tell us about your income. Start with question 43.

☐ **I am self-employed**
Fill out **Worksheet H** and return to question 71.

☐ **I have other income** (including rental income) Fill out **Worksheet I** and return to question 71.

CURRENT JOB 1:

43. Employer Name

44. Employer Address | 45. Apartment/Suite # | 46. Employer Phone

47. City | 48. State | 49. ZIP code

50. Wages/tips (before taxes)
$_____

Pay Period:
☐ Daily ☐ Twice a month
☐ Weekly ☐ Monthly
☐ Every 2 weeks ☐ Yearly

51. Average hours worked each WEEK
_____

52. When did **PERSON 2** start this job (mm/yyyy)? _____

53. When was **PERSON 2's** most recent paycheck received for this job (mm/dd/yyyy)? _____

54. Tell us the total gross pay ⓘ that **PERSON 2** got or will get this month as a one time payment from this employer. (This could be a bonus or other extra pay you got.) _____

55. Does **PERSON 2** income from this job change month to month? ☐ **Yes** ☐ **No**
If Yes, fill out the current amount **AND** annual amount for this job.
If No, only fill out the current amount. You do **not** need to fill out the annual amount.
56. Annual income ⓘ from this job: $ _____

CURRENT JOB 2 for PERSON 2:

57. Employer Name

58. Employer Address | 59. Apartment/Suite # | 60. Employer Phone

61. City | 62. State | 63. ZIP code

64. Wages/tips (before taxes)
$_____

Pay Period:
☐ Daily ☐ Twice a month
☐ Weekly ☐ Monthly
☐ Every 2 weeks ☐ Yearly

65. Average hours worked each WEEK
_____

66. When did **PERSON 2** start this job (mm/yyyy)? _____

67. When was **PERSON 2's** most recent paycheck received for this job (mm/dd/yyyy)? _____

68. Tell us the total gross pay ⓘ that **PERSON 2** got or will get this month as a one time payment from this employer. (This could be a bonus or other extra pay you got.) _____

69. Does **PERSON 2's** income from this job change month to month? ☐ **Yes** ☐ **No**
If Yes, fill out the current amount **AND** annual amount for this job.
If No, only fill out the current amount. You do **not** need to fill out the annual amount.
70. Annual income ⓘ from this job: $ _____

71. **DEDUCTIONS:** Check all that apply, and give the amount and how often **PERSON 2** pays it. Telling us about these deductions could make the cost of your health insurance lower. You should not include a cost that **PERSON 2** already considered in your answer to job income and net self-employment.

72. Do **PERSON 2's** deductions change month to month? ☐ **Yes** ☐ **No**

If Yes, fill out the current Amount **AND** Actual Annual Amount columns for each type of deduction that applies to **PERSON 2**. **If No,** only fill out the current Amount column. You do **not** need to fill out the Actual Annual Amount column.

Deduction Type:

- Alimony
- Student Loan Interest
- Contribution made to your Traditional IRA
- Capital Losses
- HSA Deduction
- Moving Expenses
- Penalty of Early Withdrawal of Savings
- Reimbursement of Expenses
- Domestic Production Activities

Type of Expense:________________ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:
Type of Expense:________________ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:
Type of Expense:________________ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:
Type of Expense:________________ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:

73. Does **PERSON 2** have income from a past job, self-employment, or other sources during the coverage year which is not listed as current income that you will need to include on your tax return? ☐ **Yes** ☐ **No**

If Yes, fill out **Worksheet J**

74. After you submit this application, we will verify **PERSON 2's** income. Please tell us if any of the following have happened to **PERSON 2** in the past few months to help us with this verification process:

☐ Stopped working at a job ☐ Hours changed at a job ☐ Change in employment

☐ Married, Legal Separation, or Divorce ☐ Other: ________________________

If you have more than two people in your household to include, go to Worksheet K, make additional copies as needed, and complete.

STEP 3 What I Should Know

Please read the What I Should Know language and sign your application.

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 must tell you of any changes in money I get.
- I must 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.
- In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs. To file a complaint of discrimination, contact USDA or HHS Write USDA Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). Write HHS Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202)619-0403 (voice) or (202)619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.
- The discrimination policy of Connect for Health Colorado is as follows: Following federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- The Department of Health Care Policy and Financing (HCPF) is the state agency responsible for Medical Assistance Programs in Colorado such as Medicaid and Child Health Plan Plus (CHP+). The County Departments of Human/Social Services and Medical Assistance Sites are agencies that receive and process applications for all public assistance programs. In this statement, the term "department" is used to refer to all agencies.
- Connect for Health Colorado (the Marketplace) is a marketplace for individuals, families and small employers in Colorado to shop for health plans and to access federal tax credits that can reduce monthly premiums and out of pocket costs.
- The department will tell you if your benefits change.
- The department will take back any benefits you should not have received.
- I understand that if I am eligible for Advance Premium Tax Credit (APTC) and/or Reduced Co-pays and Deductibles these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or Reduced Co-pays and Deductibles may impact my annual tax liability. I will be given the option to apply all, some or none of any APTC amount I may be eligible for to my monthly premium.
- I understand that my answers, together with any supplements or additional pages, are the basis for the policy that is issued. I agree that no insurance or financial assistance program will be effective until the date specified by the insurance company or organization providing the certificate, policy, or notice. This application, or the information contained herein, will become a part of the contract when coverage is approved and issued.
- I know I or another applicant may be automatically provided enrollment into Medicaid or Child Health Plan Plus (CHP+) if we are eligible.
- I must give the department all needed proof and documents before qualifying for benefits.
- I know I have 10 calendar days to report any changes if I am enrolled in Medicaid or Child Health Plan Plus (CHP+). Changes are to be reported to my local county office for Medicaid or to CHP+. I know I have 30 calendar days to report any changes to Connect for Health Colorado if I am receiving Advance Premium Tax Credits, Reduced Co-Pays or Deductibles or I am enrolled in a Qualified Health Plan. I understand that a change in my information could affect my eligibility and eligibility for member(s) of my household.

- If there is an absent parent(s) from my home and I am applying for Medicaid, I must seek medical support from the absent parent(s). I may contact Child Support Enforcement for assistance.
- I am responsible for paying fees and co-payments for myself and my family if they are required for Medical Assistance benefits.
- If enrolled in Medicaid and other insurance is paying for medical care, Medicaid will pay last.
- 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. 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.
- I know that it is unlawful to receive Advance Premium Tax Credits and Reduced Co-Pays and Deductibles from two state Marketplaces at the same time.
- 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.
- Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- The department will notify me in writing of how and when to tell the department of any changes.
- 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, including Medical Assistance received and medical premium payments. Income tax refunds the persons on my application and I might get, may be taken to pay back money to the department.
- 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 verify 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 verify 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 medical assistance and adult financial programs, sponsor information will be verified with USCIS and the information received from USCIS may affect sponsor repayment for my eligibility and benefits. My sponsor is responsible for reimbursing the state for benefits I receive.
- I do not have to be a U.S. citizen to apply for assistance. Both U.S. citizens and qualified non-citizens may be eligible for Medical Assistance. Please do not let the fear about immigration status stop you from seeking benefits for your family. Receiving Medical Assistance will not stop you from gaining lawful permanent residence or U.S. citizenship.
- 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, 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.

- I understand and consent to my information being entered into an electronic system in order to determine my eligibility for medical assistance.
- 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 may request an appeal for any action on any program except for the CHP+ program.
- 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.
- I will immediately notify the State of any medical claim or lawsuit I have. I will cooperate with the State in collecting the medical bills the State has paid. The State may collect from any insurance company or court settlement for medical bills that the State has paid. If I am on Medical Assistance and receive money for the same medical bills that the State has paid, I will give the money to the State. I assign to the State all rights to payment for medical expenses and treatment. I also assign my right to appeal a denial of benefits by another party responsible for payment for the benefits to the State.
- For Medicaid clients who were over the age of 55 when benefits were provided, the Department recovers payments for nursing facility services, home and community-based services, and related hospital and prescription drug services from their estates when deceased. For Medicaid clients who are permanently institutionalized in a hospital, nursing or other facility, federal and Colorado state law require the Department of Health Care Policy and Financing to recover all medical assistance benefits, including capitation payments, paid on their behalf from their estates when deceased. There are certain exemptions to estate recovery. For further information, please contact your county and request the "Medical Assistance Estate Recovery Program" brochure.
- Domestic violence information and services are available to me. If I ever feel I am in immediate danger I will 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 http://www.colorado.gov/cdhs/dvp. The National Domestic Violence Hotline at 1-800-799-SAFE (7233) or TTY 1-800-787-3224 or http://www.thehotline.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 will tell my department worker.
- By signing this application, I agree to allow my information to be used and collected from data sources for this application. I have consent for all people I list on the application allowing collection of information about them from data sources for this application. (See page ii for full Privacy Statement.)

Sign this application. The person who filled out STEP 1 should sign this application. If you are an authorized representative, you may sign here as long as you have provided the information required in Worksheet A.

PERSON 1 Signature or Authorized Representative

Date (mm/dd/yyyy)

NEED HELP WITH YOUR APPLICATION? See our contact information on page i of this application or on Step 4.

ATTENTION! YOU MAY NOT BE DONE.

Fill out all required worksheets that are required for anyone on your application.

☐ Did you get help with this application? Fill out **Worksheet A**.
☐ Any of the following apply to anyone on the application? Fill out **Worksheet B**:
- A person on the application has a medical or developmental condition that has lasted, or is expected to last, more than 12 months, including blindness .
- A person on the application needs help with some or all of his/her self-care activities (bathing, dressing, eating, or using the bathroom.)
- A person on the application who is in, or has been in a medical facility (such as a nursing home, hospital, mental health institution, or a group home) within the last 90 days.
- Qualify for or enrolled in Medicare.

☐ Not a U.S. Citizen or U.S. National? Fill out **Worksheet C**.
☐ Anyone on this application being treated for an injury that has or may bring a legal claim? Fill out **Worksheet D**.
☐ Qualified for or are enrolled in: Medicare, TRICARE, Peace Corp, Other State or Federal Health Benefit Program, VA Health Care Program, Railroad, or Other Coverage, fill out **Worksheet E.**
☐ Qualified for or are enrolled in: COBRA, Retiree, or Current Employer, fill out **Worksheet F**
☐ American Indian/Alaska Native? Fill out **Worksheet G**.
☐ Self-employed? Fill out **Worksheet H**.
☐ Other income that is not from a job or self-employment? Fill out **Worksheet I**.
☐ Income from previous job, self-employment, or other type of income? Fill out **Worksheet J**.
☐ More than two people in the household? Fill out **Worksheet K** for each additional person.

STEP 4 Mail Your Completed Application and Worksheets

Your application can be processed at both addresses or at your local County Department of Human and Social Services Office.

If you think you may qualify for Medicaid or CHP+, or if you were required to fill out **Worksheet B** or **Worksheet D**, you may wish to mail your signed application to:

Colorado Medical Assistance Program
Colorado Medicaid and CHP+
P.O. Box 929
Denver, CO 80201-0929

Colorado.gov/PEAK
1-800-221-3943
TDD: 1-800-659-2656

Note: If you need help in a language other than English, call and tell the customer service representative the language you need.

En Español: Llame a nuestro centro de servicio gratis para ayuda o para obtener una copia de este formulario en Español, al 1-800-221-3943.

If you think you may qualify for tax credits or cost sharing reductions, you may wish to mail your signed application to:

Connect for Health Colorado
Individual Applications
P.O. Box 35033
Colorado Springs, CO 80935

ConnectforHealthCO.com
1-855-PLANS-4-YOU (1-855-752-6749)
TTY: 1-855-346-3432

Note: If you need help in a language other than English, call and tell the customer service representative the language you need.

En Español: Llame a nuestro centro de servicio gratis para ayuda o para obtener una copia de este formulario en Español, al 1-855-PLANS-4-YOU (1-855-752-6749).

Name of Person 1_____ **Date of Birth**_____

WORKSHEET A: Tell us About Who is **Helping** You with Your **Application**.

- Fill out **Section A** for Authorized Representative.
- Fill out **Section B** for Certified Application Counselor, Health Coverage Guide, Agent/Broker, Agency Representative or Outreach Specialist

SECTION A: Help Filling Out Your Application

You can choose an authorized representative or authorized organization.
An Authorized Representative or Authorized Organization is a trusted person or organization who would be given permission to talk about this application with us, see your information, and act for you on matters related to this application. This includes getting information about your application and signing your application on your behalf. An Authorized Representative or Authorized Organization takes legal responsibility for the information provided in this application. If you ever need to change your Authorized Representative, contact Colorado Medicaid & CHP+ or Connect for Health Colorado.

1. Name of authorized representative (First) (Middle) (Last) (Suffix)

2. Company/Organization name (if applicable)

3. Company/Organization ID number (if applicable)

4. How is the Authorized Representative related to you?

5. Name of Authorized Organization

6. Authorized Representative's address (Leave blank if you do not have one)

7. Apartment or suite number

8. In Care Of (If Applicable)

9. City

10. State

11. ZIP code

12. Phone number

Ext.

Phone Type: ☐ Cell ☐ Home ☐ Work

13. Email address

By signing, you allow this person to sign your application, get information about this application, and act for you on all future matters with this agency.

Applicant's Signature

Date (mm/dd/yyyy)

☐ I, the a**uthorized representative/authorized organization**, would like to submit a proof of legal reason that PERSON 1 cannot represent themselves. (Please provide a copy of one of the following documents with this application when it is submitted: a power of attorney, court order establishing legal guardianship, or other legal document explicitly stating that you may legally act on behalf of the customer.)

Authorized Representative Signature

Date (mm/dd/yyyy)

(in case of Authorized Organization the signature of either a provider, staff member or volunteer of the Authorized Organization is required.)

NEED HELP WITH YOUR APPLICATION? See our contact information on page i of this application or on Step 4.

WORKSHEET A: (Continued)

SECTION B:

For certified application counselors, Health Coverage Guides ⓘ, Agents ⓘ, Brokers ⓘ, Agency Representative, or Outreach Specialists ⓘ only.

Complete this section if you are a Certified Application Counselor, Health Coverage Guide, Agent, Broker, Agency Representatives, or Outreach Specialists filling out this application for somebody else.

14. Date (mm/dd/yyyy)

15. Select one:

☐ Certified Application Counselor ☐ Health Coverage Guide ☐ Agent/Broker

☐ Agency Representative ☐ Outreach Specialist

16. Name (First) (Middle) (Last) (Suffix)

17. Organization/Site Name

18. ID Number (Guide ID or state license number, as applicable)

Name of Person 1_____ **Date of Birth**_____

WORKSHEET B: Tell us About Household Member(s) Who May Be **Aged, Blind, Disabled,** or Need **Long Term Care** Services

1. Name:_____Date of Birth (mm/dd/yyyy): _____

Additional Information Required

This information is required for individuals that are 65 years of age or older or have Disabilities needing medical assistance or Medicare premium assistance. This is also required for individuals that are in, or have been in, a medical facility or need help with self-care activities in the home (Long Term Care Services and Support). If you are required to fill out this worksheet, please send this application to the Colorado Medical Assistance Program. Please fill out completely.

---

2. Tell us about **Additional Income** you or your spouse received this month or last month. Do not repeat income that may have already been listed on earlier income pages.

☐ **No Additional Income**

Examples of **Additional Income** include:

- Public Assistance (cash) Benefits
- Railroad Retirement
- Rental Income
- Survivor Benefits
- Retirement/Pension
- Social Security Benefits
- Supplemental Security Income
- Social Security Disability Insurance
- Veterans Benefits
- Veteran Widow Benefits
- Child Support
- Dividends/Interest
- Alimony
- Unemployment
- Worker's Compensation
- Disability Benefits
- Financial Aid
- Other Cash Received Monthly
- Employment Income

Type of Income	Month Received	Who it is for?	Monthly Amount before Taxes and Deductions

3. Tell us about **Expenses** you or your spouse have, even if you or your spouse are not requesting assistance.

☐ **No Expenses**

Examples of **Expenses** include:

- Child Care
- Dependent Elder Care
- Medical Expenses
- Mortgages (first, second, third)
- Rent
- Heating
- Cooking
- Child Support
- Alimony
- Facility
- Care Provider
- Medical
- HOA Fees
- Phone/Cell
- Health Insurance Premiums
- Prescriptions
- Water
- Sewer
- Trash
- Electricity

Type of Expense	Who Pays this Expense	Who it is for?	Month	Amount

Name of Person 1_____ **Date of Birth**_____

WORKSHEET B: (Continued)

4. Tell us about **Resources** you or your spouse own, even if you or your spouse are not requesting assistance.
☐ **No Resources** Examples of **Resources** include:

- Cash
- Checking & Savings Accounts
- Certificates of Deposits (CD)
- Annuities
- Mutual Funds
- Inheritance
- PASS Accounts
- Individual Development Accounts
- Retirement Accounts
- Stocks
- Bonds
- Trusts
- Promissory Notes
- College Funds
- Education Accounts
- Property (Land, Homes)
- Proceeds from Sale of Home(s)

Type of Resource	Owner Name(s)	Account Number	Amount	Name of Financial Institution	Jointly Owned
					☐ **Yes** ☐ **No**
					☐ **Yes** ☐ **No**
					☐ **Yes** ☐ **No**
					☐ **Yes** ☐ **No**

5. Tell us about **Property** you or your spouse own or are buying, even if you or your spouse are not requesting assistance. ☐ **No Property** Examples of **Property** include:

- House
- Warehouse
- Rental Property
- Empty Lot
- Timeshare
- Land

Owner Name(s)	Jointly Owned	Full Address of Property	Type of Property	Value	Amount Owed
	☐ **Yes** ☐ **No**				
	☐ **Yes** ☐ **No**				
	☐ **Yes** ☐ **No**				

6. Tell us about **Vehicles** you or your spouse own or are buying, even if you or your spouse are not requesting assistance. ☐ **No Vehicles** Examples of **Vehicles** include:

- Car
- Van
- Trailer
- Truck
- ATV
- RV
- SUV
- Boat

Owner Name(s)	Jointly Owned	Type of Vehicle	Year	Make/Model	Value	Amount Owed
	☐ **Yes** ☐ **No**					
	☐ **Yes** ☐ **No**					
	☐ **Yes** ☐ **No**					

7. Tell us about **Life Insurance Policies** you or your spouse own, even if you or your spouse are not requesting assistance.
☐ **No Life Insurance Policies**

Owner Name(s)	Policy Number	Individuals Covered	Insurance Company	Face Value	Cash Value

Name of Person 1_____ **Date of Birth**_____

WORKSHEET B: (Continued)

8. Tell us about **Burial Policies** you or your spouse own or are buying, even if you or your spouse are not requesting assistance.

☐ **No Burial Policies**

Name of Applicant or Spouse	Amount	Is it Irrevocable	Name of Institution or Person Holding the Money
		☐ **Yes** ☐ **No**	
		☐ **Yes** ☐ **No**	
		☐ **Yes** ☐ **No**	

9. Tell us if you, your spouse, or anyone acting on you or your spouse's behalf has given away anything of value within the last 5 years, you or your spouse are not requesting assistance.

☐ **Nothing of value has been given away within the last 5 years**

Examples include:

• Home • Land • Cash • Vehicles

Person Who Gave Item Away	Item Given Away	Date Given Away	Value of Item	Amount Owed

If you need to add more information, make a copy of this page and include it with your application.

Disability Questions

10. Has anyone who is disabled applied for Supplemental Security Income? ☐ **Yes** ☐ **No**

If Yes, Name of person_____ Date of application? (mm/dd/yyyy)_____

What is the status of the application (pending, approved, denied)? _____

11. Does this person receive Supplemental Security Income or Social Security Disability Insurance? ☐ **Yes** ☐ **No**

If No, has this person ever received Supplemental Security Income/Social Security Disability Insurance? ☐ **Yes** ☐ **No**

If Yes, when did Supplemental Security Income/Social Security Disability Insurance end? (mm/dd/yyyy) _____

Reason Supplemental Security Income/Social Security Disability Insurance Ended:_____

SIGNATURE AND CERTIFICATION:

By signing this form I am giving my permission to the State of Colorado and its designers to make contacts to verify the information given within this form. Under penalty of perjury I certify all information I have given is true and correct. **I MUST ALSO SIGN PAGE 15 OF THIS APPLICATION.**

(Print Name) First	Middle	Last	Suffix	Signature	Date (mm/dd/yyyy)

Authorized Representative, Conservator, Guardian, or other Contact:

(Print Name) First	Middle	Last	Suffix	Signature	Date (mm/dd/yyyy)

Name of Person 1_____ **Date of Birth**_____

WORKSHEET C: Tell us About Household Member(s) Who Are **Non-Citizens**

1. Name:_____Date of Birth (mm/dd/yyyy): _____

If this person is not applying for benefits, you do not need to fill out this worksheet. Applying for Medicaid or CHP+ or getting help with health insurance costs in the Marketplace will not affect someone's chances of becoming a Lawful Permanent Resident or U.S. citizen. The information on this form will **not** *be used by or shared with the U.S. Immigration and Customs Enforcement agency.*

2. What is this person's non-Citizenship Status?

- ☐ Amerasian
- ☐ Cross Border Native American
- ☐ Parolee
- ☐ Afghani Special Immigrant
- ☐ Asylee
- ☐ Battered Alien
- ☐ Conditional Entry
- ☐ Cuban-Haitian
- ☐ CRSP Refugee
- ☐ Dependent Child of Hmong/Lao
- ☐ Disabled Child of Hmong/Lao
- ☐ Hmong/Laotian
- ☐ Iraqi Special Immigrant
- ☐ Legal Permanent Resident
- ☐ Refugee
- ☐ Deportation Withheld
- ☐ Spouse of Hmong/Lao
- ☐ Victim of Trafficking
- ☐ Unrem Surv Spouse of Hmong/Lao
- ☐ Other _____

---

3. Does this person have an eligible immigration status ⓘ? ☐ **Yes** ☐ **No**

If Yes, what is your Document Type?

- ☐ I-94
- ☐ Afghan passport
- ☐ Border Crossing Card
- ☐ Court Documents
- ☐ I-766 Empl Auth Card
- ☐ I-688 Empl Auth Card
- ☐ INS/CIS Original Letter
- ☐ Iraqi passport
- ☐ Other Federal Agency
- ☐ Other
- ☐ Prima Facie Doc
- ☐ Passport Only
- ☐ Passport W/I-181
- ☐ I-551 Resident Alien Card
- ☐ I-688B Empl Auth Card
- ☐ Self Declared
- ☐ Student Visa
- ☐ Stay of Deportation
- ☐ SAVE/unverified
- ☐ SAVE/verified
- ☐ Temp Resident Card
- ☐ Trafficking Letter
- ☐ T-VISA
- ☐ U-VISA
- ☐ Voluntary Departure Doc
- ☐ V-VISA

4. Non-Citizen Number: _____ 5. Document Number: _____

6. Document Expiration Date (mm/yyyy): _____ 7. Country of Issuance: _____

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8. Has this person lived in the U.S. since 1996? ☐ **Yes** ☐ **No**

9. Is this person, their spouse or parent an honorably discharged veteran or an active-duty member of the U.S. military? ☐ **Yes** ☐ **No**

I, _____ [Legal Name], am applying for or receiving Medical Assistance from the State of Colorado. As a condition of my eligibility for this assistance, I agree that, during the time I am receiving such assistance, I will not sign an Affidavit of Support to Sponsor a non-citizen who is seeking permission to enter or remain in the Unites States. I understand that any Affidavit of Support signed prior to July 1, 1997 does not affect my eligibility for assistance. If I do not agree, I may no longer be eligible for Medical Assistance from the State of Colorado.

☐ Yes, I agree ☐ No, I do not agree

Applicant's signature: _____ Date: _____

Name of Person 1_____ **Date of Birth**_____

WORKSHEET D: Tell us About Household Member(s) Who Have a **Claim**

TORT & CASUALTY CASE INFORMATION

Complete All Sections Related to Your Accident/ Incident

CLIENT INFORMATION:

1. Client Name: _____
2. Date of Birth:_____
3. State ID # or Social Security Number (SSN): _____
4. Date of Incident: _____
5. Type of Incident/ Accident (i.e., Auto Accident, Malpractice, etc.): _____
6. Nature of the injuries: _____

_____

ATTORNEY INFORMATION:

7. Attorney Name:_____
8. Law Firm Name:_____
9. Firm Mailing Address _____
10. City: _____ 11. State: _____ 12. ZIP Code _____
13. Email Address: _____
14. Phone: _____ 15. Fax: _____
16. Date Representation Began: _____
17. Firm File/Case #:_____

CRIMINAL CASE:

18. Name of defendant(s):_____
19. Charge (s):_____
20. Name of City or County Attorney's Office prosecuting case: _____
21. Court Case# _____

INSURANCE CARRIER INFORMATION:

22. Insurance Name: _____
23. Adjuster Name: _____
24. Insurance Mailing Address _____
25. City: _____ 26. State: _____ 27. ZIP Code _____
28. Email Address: _____
29. Phone: _____ 30. Fax: _____
31. Insured Name(s):_____
32. Claim #:_____
33. Name of person completing form: _____
34. Phone: _____

Name of Person 1_____ **Date of Birth**_____

WORKSHEET E: Tell us About Household Member(s) with Other Health Coverage

****If there is more than one person in your household that needs to fill out this worksheet, please make copies and fill out for each person.****

1. Name:_____Date of Birth (mm/dd/yyyy): _____

Section A (all): 2. Please fill out what you qualify for or are enrolled in.

☐ Qualify for Medicare ⓘ ☐ Enrolled in Medicare ⓘ

****If you qualify for or are enrolled in Medicare, fill out Section B below and Worksheet B.**

3. Qualify for: ☐ TRICARE ⓘ ☐ Peace Corps ☐ VA Health Care Program ⓘ
☐ Other State of Federal Health Benefit Program
Name of Program: _____

If you marked you qualify for any of the programs in Question 3, answer the following:

4. Will you qualify for or enroll in this health coverage in the coverage year ⓘ? ☐ **Yes** ☐ **No**

5. Who else in your household has access to this coverage? _____

_____

6. Who is currently enrolled in this health coverage? _____

If you selected VA Health Care Program, answer the following four questions:

8. Date you could start coverage (mm/yyyy) _____

9. Date the other member(s) of the household could start coverage (mm/yyyy) _____

10. Insurance Company Name:_____

11. Enrolled in: ☐ Railroad Retirement Insurance
☐ Other If **other**, answer the following questions:
12. Insurance Company Name: _____
13. Name of health plan and/or policy type: _____
14. Start Date of coverage or date the coverage could start (mm/dd/yyyy): _____
15. Policy number: _____

Section B: Medicare: Fill out this section if you qualify for or are enrolled in Medicare.

If you only get one type of Medicare, leave the other questions blank.

16. What is your Medicare Claim Number? You can find this number on the front of your Medicare card.

_____

MEDICARE PART A	MEDICARE PART B	MEDICARE PART C	MEDICARE PART D
17. Are you entitled to or receiving Medicare Part A? ☐ **Yes** ☐ **No**	22. Are you entitled to or receiving Medicare Part B? ☐ **Yes** ☐ **No**	26. Are you entitled to or are receiving Medicare Part C (Medicare Advantage) or will you be entitled or enrolled in the month in which you would like to purchase private health insurance? ☐ **Yes** ☐ **No**	28. Are you entitled to or receiving Medicare Part D? ☐ **Yes** ☐ **No**
18. Is your Medicare Part A Premium Free? ☐ **Yes** ☐ **No**	23. When did your Medicare Part B begin (mm/yyyy) _____ ☐ I don't know.	27. When did your Medicare Part C begin (mm/yyyy) _____	29. When did your Medicare Part D begin (mm/yyyy) _____ ☐ I don't know.
19. Are you currently enrolled? ☐ **Yes** ☐ **No**	24. How much is your Medicare Part B premium? _____ ☐ I don't know.		30. How much is your Medicare Part D premium? _____ ☐ I don't know.
20. When did your Medicare Part A begin (mm/yyyy) _____ ☐ I don't know.	25. Who pays for your Medicare Part B premium? _____		31. Who pays for your Medicare Part D premium? _____
21. Who pays for your Medicare Part A premium? _____			

Name of Person 1_____ **Date of Birth**_____

WORKSHEET F: Tell us About Household Member(s) who can get **Health Insurance** from an **Employer**

****If there is more than one person in your household that needs to fill out this worksheet, make copies and fill out for each person.****

1. Name:_____Date of Birth (mm/dd/yyyy): _____
2. Which type of coverage are you able to get from an employer?
☐ Current Employer-Sponsored Health Coverage ☐ COBRA ⓘ ☐ Retiree Health Plan

Section A (All Programs):

3. Employee Name (First) _____ (Middle) _____ (Last) _____ (Suffix)

4. Social Security Number (SSN) ☐☐☐ – ☐☐ – ☐☐☐☐
SSN is optional in this location. This may assist your employer in looking up your health insurance information if you ask for help from your employer in filling out this form.

****If you selected COBRA or Retiree Health Plan, please provide information about the <u>former</u> employer. If you selected <u>Current</u> Employer-Sponsored Health Coverage, please provide information about your <u>current</u> employer.****

5. Employer name: _____

6. Employer Identification Number (EIN): ☐☐ – ☐☐☐☐☐☐☐

7. Employer Address _____ 8. Apartment #/Suite _____ 9. City _____ 10. State _____ 11. ZIP code _____

12. Employer Phone _____ Ext. _____ Phone Type: ☐ Cell ☐ Work

13.Who at this employer can we contact about employee health coverage at this job?_____

14. Phone (if different than above) _____ Ext. _____ Phone Type: ☐ Cell ☐ Work

15. Date your coverage could start (mm/yyyy): _____

16. Who else in the household has access to this coverage?_____

Section B (Current Employer-Sponsored Health Coverage only):

17. Coverage is considered affordable if the portion of the premium that the employee must pay is less than 9.56% of the household's annual Modified Adjusted Gross Income. Do you think this coverage is affordable? See the information in Section C provided by your employer to answer this question. ☐ **Yes** ☐ **No**

Section C: Current **Employer to fill out**

(Information provided should be based on coverage year you are applying for)

18. Do you offer a health plan that covers an employee's spouse or dependent(s)? ☐ **Yes** ☐ **No**
If Yes, which people? ☐ Spouse ☐ Dependent

19. Do you offer an employee-only health plan that meets the minimum value standard health plan*?
☐ **Yes** ☐ **No** (**If No**, STOP and return form to employee.)

20. What is the name of the lowest-cost plan that meets the minimum value standard* offered only to the employee (do not include family plans): _____
☐ I don't know

21. How much would the employee have to pay in premiums for this plan?_____ ☐ I don't know

22. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
☐ Other:____ ☐ I don't know

*An employer-sponsored health plan meets the "minimum value standard" if the employer pays for 60% of the allowed health plan benefits.

Name of Person 1_____ **Date of Birth**_____

WORKSHEET G: Tell us About Household Member(s) Who are **American Indian** or **Alaska Native**

Complete this Worksheet if you or a household member are an American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs. If you qualify for a tax credit or other help with costs, the Marketplace will request proof of your status.

Tell us about your American Indian or Alaska Native household member(s).

American Indians and Alaska Natives can get services from the Indian Health Service, tribal health programs, or urban Indian health program or through a referral from one of these programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

Certain money received may not be counted as income for receiving insurance affordability programs ⓘ. List any income (type, amount, and how often) reported on your application that includes money from these sources).

NOTE: If you have money from selling things that have cultural significance, fill out Worksheet H	Member of a Federally-recognized Tribe?	Per capita payments from a Tribe that come from natural resources, usage rights, leases, or royalties	Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).
AI/AN Person A _____ 1. Legal First Name _____ Middle Name _____ Last Name _____ Suffix	2. ☐ **Yes** If yes, Tribe name: _____ State: _____ ☐ **No**	3. Type: _____ $:_____ How Often? _____	4. Type: _____ $:_____ How Often? _____
AI/AN Person B _____ 5. Legal First Name _____ Middle Name _____ Last Name _____ Suffix	6. ☐ **Yes** If yes, Tribe name: _____ State: _____ ☐ **No**	7. Type: _____ $:_____ How Often? _____	8. Type: _____ $:_____ How Often? _____

Name of Person 1_____ Date of Birth_____

WORKSHEET G: (Continued)

Certain money received may not be counted as income for receiving insurance affordability programs. List any income (type, amount, and how often) reported on your application that includes money from these sources).

NOTE: If you have money from selling things that have cultural significance, fill out Worksheet H	Member of a Federally-recognized Tribe?	Per capita payments from a Tribe that come from natural resources, usage rights, leases, or royalties	Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).
AI/AN Person C _____ 9. Legal First Name _____ Middle Name _____ Last Name _____ Suffix	10. ☐ **Yes** If yes, Tribe name: _____ State: _____ ☐ **No**	11. Type: _____ $:_____ How Often? _____	12. Type: _____ $:_____ How Often? _____
AI/AN Person D _____ 13. Legal First Name _____ Middle Name _____ Last Name _____ Suffix	14. ☐ **Yes** If yes, Tribe name: _____ State: _____ ☐ **No**	15. Type: _____ $:_____ How Often? _____	16. Type: _____ $:_____ How Often? _____

Indian Health Services	
17. Who in the household has ever received a service from the Indian Health Service, a Tribal health program, or urban Indian health program or through a referral from one of these programs? (Check all that apply)	☐ Person A ☐ Person C ☐ Person B ☐ Person D
18. If none, who in the household is eligible to receive services from Indian Health Service, Tribal health programs, or urban Indian health programs or through ha referral from one of these programs? (Check all that apply)	☐ Person A ☐ Person C ☐ Person B ☐ Person D

If you have more members of household to include, make a copy of this Worksheet and attach it.

Name of Person 1_____ **Date of Birth**_____

WORKSHEET H: Tell us About Household Member(s) Who Have Self-Employment

1. Name:_____2. Date of Birth (mm/dd/yyyy): _____

3. What type of self-employment do you have? ☐ Day Care ☐ Self Employment ☐ Self Employment Farming ☐ Sale of Livestock/Poultry ☐ Sale of Crops ☐ Sale of items of Indian cultural significance

4. What is the name of your self-employment business? _____

5. Are you the only owner of this business? ☐ **Yes** ☐ **No**

6. How many owners are there (including yourself)?_____

7. What percent of the business do you own?_____

8. Is this a home based business? ☐ **Yes** ☐ **No** **If Yes**, please answer the questions below. **If No**, skip to 9.
   a. How many total rooms are in your house? _____
   b. How many rooms in this house are used for this home based business? _____

9. When did you start your self-employment business (mm/dd/yyyy)? _____

10. If this self-employment has ended or will soon end, please tell us the self-employment end date (mm/dd/yyyy): _____

11. How many hours a week are you self-employed? If the hours are not regular, try to estimate the number of hours you work each week: _____

How much money does your self-employment business make? Give us the amount the business earns before any taxes, deductions, or expenses are taken out.

12. Does you self-employment income change from month to month? ☐ **Yes** ☐ **No**
If No, then only fill out the Current Gross Monthly Amount and skip the Actual Annual Amount.
If Yes, then fill out both the Current Gross Monthly Amount and the Actual Annual Amount.

a. Current Gross Monthly Amount _____ b. Actual Annual Amount _____

13. Do you have any monthly self-employment expenses? ☐ **Yes** ☐ **No**

If Yes, use the chart of Types of Expenses to tell us the type of self-employment expenses you have.

TYPES OF EXPENSES BY CATEGORY

Bad Debts	Business Equipment Cost	Home Owners Association Fee	Car and Truck Expenses	Cost of Goods Sold
• Bad Debts	• Clothing/Uniforms • Equipment • Equipment & Property Rentals • Upkeep of Equipment/Labor • Upkeep and Repairs	• Home Owners Association Fee	• Car Repairs • Car Loan Payments (Interest only, not Principle) • Transportation	• Livestock Purchase • Merchandise Wholesale –'Cost of Inventory' • Costs of Goods Sold
Depreciation	**Insurance**	**Interest**	**Salaries**	**Legal & Professional Fees (including Commissions & Fees)**
• Depreciation of Equipment • General Depreciation	• Deductibles • Insurance Premiums • Loan Insurance Premium • Self-employed Health Insurance Deduction	• Mortgage Interest • Interest on Capital Asset.Durable Goods & Loans • General Interest	• Labor/Employee Salaries	• Legal Conservator Fees • Loan Origination Fee • Mandatory Fees • Non-mandatory Fees • Professional Services • Trustee Fee • Legal and Professional Fees

Name of Person 1____ Date of Birth_______________

WORKSHEET H: (Continued)

Pension Plans	Rent or Lease	Reimbursing Your Employees for Expenses	Taxes & License	Travel, Meals & Entertainment
• Self-employed SEP, SIMPLE, and Qualified Plans • Pension Plans	• Rent	• Business Expense	• Federal Taxes • Self-Employment Adjustment • Property Taxes & Assessments • State Tax • Taxes-other • Education/ Licensing/ Certification	• Business Related Travel • Bus Tickets • Meals • Train Fares • Plane Tickets • Travel • Business Related Entertainment

Other (ex. Advertising, Supplies and Materials, Utilities)

- Books and Supplies
- Butane
- Miscellaneous Expenses
- Fertilizer
- Gasoline
- Laundry
- Livestock Feed
- Personals
- Phone
- Propane
- Prior Crop Loss
- Other Necessary and Required Expenses
- Sewer
- Utility Costs Tips Allocated But Not Received
- Vendor Payment
- Supplies
- Advertising
- Cremation/Burial
- Transportation of Body and Casket
- Embalming
- Purchase/Rent of Casket, Urn, or Receptacle
- Stage of Body Prior to Disposition
- Storage of Cremated remains No <120 Days

List all self-employment expenses below. If your self-employment expenses change month to month, please fill out both the Current Amount and the Actual Annual Amount. If your self-employment expenses do NOT change from month to month, you only need to fill out the current amount.

Type of Expense:____________________ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:

Type of Expense:____________________ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:

Type of Expense:____________________ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:

If you need more pages, make a copy of this page and submit it with your application.

Name of Person 1_____ **Date of Birth**_____

WORKSHEET I: Tell us About Your Household Member(s) Who Have Other Income

1. Name:_____Date of Birth (mm/dd/yyyy): _____

Section A: Grants, Scholarships, or Work Study

2. Does this person have any income from Grants, Scholarship, or Work Study? ☐ **Yes** ☐ **No**
If **Yes**, answer the following questions before going to Section B. If **No**, go to Section B.

3. What type of school this person attends? ☐ Community College ☐ University ☐ Trade School ☐ High School ☐ GED Program ☐ Middle School ☐ No GED/HS Required ☐ Certified Home Schooled

4. How much time is this person in school right now? ☐ Full time ☐ Half time ☐ Less than half time
If you receive Grants or Scholarships, fill out questions 5-6. If you receive Work Study, fill out questions 7-8.

5. Fill in the frequency and current amount you receive from **Grants or Scholarships**. If the amount changes month to month, fill in the actual annual amount in addition to the current amount.

Frequency:		Current Amount:	Actual Annual Amount:
☐ Annual	☐ Quarterly		
☐ Every 2 weeks	☐ Supplemental		
☐ Irregular/Variable	☐ Twice a Year		
☐ Monthly	☐ Twice a Month		
☐ One Time Only	☐ Weekly		

6. What amount ($) of your of grant or scholarship is used for living expenses each month? _____

7. Fill in the frequency and current amount you receive from **Work Study**. If the amount changes month to month, fill in the actual annual amount in addition to the current amount.

Frequency:		Current Amount:	Actual Annual Amount:
☐ Annual	☐ Quarterly		
☐ Every 2 weeks	☐ Supplemental		
☐ Irregular/Variable	☐ Twice a Year		
☐ Monthly	☐ Twice a Month		
☐ One Time Only	☐ Weekly		

8. What amount ($) of your of Work Study is used for living expenses each month? _____

Section B: Other Income

Please use the table below to find the type of Other Income you receive. For each type, please fill out a box on the next page. You do **not** need to report any money from the following items because they are not considered income: Supplemental Security Income (SSI), Veterans Benefits, Child Support Payments, Adoption Assistance Program, Worker's Compensation, or Gifts.

Social Security	Retirement	Loans, Annuities, Dividends	Payments for Family
• Social Security Disability (SSDI) • Social Security Survivor Adult • Social SecuritySurvivor Child • Social Security Dependent • Social Security Retirement • Social Security Disabled Adult Child	•Railroad Retirement •Other Government Retirement •Private Retirement	• Annuities • Dividends • Interest • Loan Repayment • Loans without Repayment • Agreement Loans with Repayment Agreements • Canceled Debts	• Spousal Maintenance Payments • Kinship Care Payments

Name of Person 1_____ Date of Birth_____

WORKSHEET I: (Continued)

Refugee	Private Disability	Unemployment Insurance Benefit	Other
• CO Refugee Services/VOLAG	• Private Disability	• Unemployment Insurance Benefit	• Cash Contributions Other • Other Unearned All • Capital Gains • Court Awards • Gambling/prizes/ awards • Room and Board • Rental Income*

*If you have Rental Income, please fill in the box at the bottom of the page.

10. Does your income change month to month? ☐ **Yes** ☐ **No**
If Yes, fill out the current amount **AND** actual annual amount columns for each type of deduction that applies to you. **If No**, you do **not** need to fill out the actual annual amount column.

Type: _____ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:
Type: _____ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:
Type: _____ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:

Rental Income

Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:
Business Expenses for Rental Income:	Current Amount:	Actual Annual Amount:
Do you spend 20 or more hours a week managing your rental properties? ☐ **Yes** ☐ **No**		

Name of Person 1_____ **Date of Birth**_____

WORKSHEET J: Tell us About Household Member(s) With **Past Annual Income**

Name:_____Date of Birth (mm/dd/yyyy): _____

*Only enter information below for past jobs, self-employments, or other income you got in the coverage year for which you are applying. Do **not** include income that you currently get. Once you get your results, enter it in the application to answer the question about past income.*

	1	Enter your taxable wages/salary/tips (before taxes are taken out) Note: that pre-tax contributions to dependent care accounts, health insurance premiums, flexible spending accounts, retirement accounts and commuter expenses are NOT included as income.	1	
	2	Enter your Self-employment (profit once business expenses are paid)	2	
	3	Enter your Social Security benefits (Taxable and non-taxable) SSDI is included here. SSI income is not included here. If you are receiving SSI, you are automatically eligible for Medicaid in the state of Colorado. You also do not need to include any veterans disability benefits you may receive.	3	
	4	Enter your Unemployment benefits	4	
	5	Enter your Alimony received	5	
+	6	Enter your Retirement benefits (taxable IRA distributions, pensions, and annuities)	6	
	7	Enter your Interest (including tax-exempt interest)	7	
	8	Enter your net capital gains (profit after subtracting capital losses)	8	
	9	Enter your Dividends	9	
	10	Enter your Rental or royalty income (profit after subtracting costs)	10	
	11	Enter Other taxable income, such as canceled debts, court awards, jury duty pay not given to an employer, cash support, and gambling, prizes, or awards or farm income. Also include taxable refunds, credits or offsets of local or state income taxes.	11	
	12	Enter your Foreign earned income	12	
	13	Combine the amounts in the columns for lines 1 through 12	13	
	14	Enter your Self-employment business expenses Most deductions for self-employed business expenses are included in net income (the profit once business expenses are paid) but additional deductions can be taken for the deductible part of self-employment tax, self-employed SEP, SIMPLE, and qualified plans, and the self-employed health insurance deductions. For additional information see IRS Publication 334, Tax Guide for Small Business.	14	

WORKSHEET J: (Continued)

	15	Enter your Portion of interest on student loans Households may be able to deduct a portion of the interest they expect to pay on a qualified student loan. Box 1 of the 1098-E Form shows the interest paid for the prior year, which may be helpful in projecting student loan interest that will be paid during the year.	15	
+	16	Enter your Alimony paid	16	
	17	Enter your IRA deduction	17	
	18	Enter your Adoption Benefits from an employer	18	
	19	Enter your Health savings account contributions	19	
	20	Enter your Penalties on the early withdrawal of savings	20	
	21	Enter your Certain business expenses of performing artists, reservists, and fee-basis government officials	21	
	22	Enter your Moving expenses related to a job change	22	
	23	Enter your Domestic Production Activities deduction	23	
	24	Combine the amounts in the columns for lines 14 through 23	24	
—	25	Subtract line 24 from line 13. This is your modified adjusted gross income.	25	

Name of Person 1_____ **Date of Birth**_____

WORKSHEET K: Tell us About **Additional Household Members**

PERSON #_____

Use this worksheet for additional household members by filling in the number of the person each page applies to (ex. PERSON 3, PERSON 4, etc.). Make additional copies and attach if necessary.

1. Legal Name (First) | (Middle) | (Last) | Suffix | 2. Relationship to you?

4. Date of Birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female

5. Home address (Leave blank if you do not have one.) | 6. Apartment #/Suite

7. City | 8. State | 9. ZIP code | 10. County

11. If you are 18 years or older, would you like to receive your own mail about to your health coverage?
☐ **Yes** ☐ **No**
If Yes, please fill out mailing address below.

12. Mailing address (If different from home address) | 13. Apartment #/Suite

14. In Care Of (If Applicable)

15. City | 16. State | 17. ZIP code | 18. County

19. Email address

20. Primary Phone | Ext. | Phone Type: ☐ Cell ☐ Home ☐ Work

21. Secondary Phone | Ext. | Phone Type: ☐ Cell ☐ Home ☐ Work

22. Preferred spoken language: ☐ English ☐ Spanish ☐ Other:_____ 23. Preferred written language: ☐ English ☐ Spanish

24. Is **THIS PERSON** a resident of Colorado? ☐ **Yes** ☐ **No**

25. Is **THIS PERSON** living outside of Colorado temporarily? ☐ **Yes** ☐ **No**

26. If **THIS PERSON** is living outside of Colorado temporarily, where will this person be living in Colorado when he/she returns?

City | ZIP code | County

Name of Person 1_____ **Date of Birth**_____

WORKSHEET K: (Continued)

PERSON #_____

27. Social Security Number (SSN) ☐☐☐ – ☐☐ – ☐☐☐☐

If THIS PERSON wants health coverage and has a SSN, we need this information. If they do not want health coverage, providing their SSN may help speed up the application process. We use SSNs to check income and other information to see what **THIS PERSON** may qualify for.

If no SSN and applying for coverage, tell us why: ☐ Has applied for SSN ☐ Illness
☐ Lawfully Present Non-citizen ☐ Religion

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28. **Does THIS PERSON plan to file a federal income tax return for the coverage year ⓘ? ☐ Yes ☐ No**
THIS PERSON can still apply for Medicaid, CHP+, or health insurance even if they do not file a federal income tax return. However, they must plan to file taxes for the coverage year to see if you could be eligible for tax credits and reduced out of pocket costs available through the Marketplace.

---

a. What is **THIS PERSON's** tax filing status? (Check all that apply)
☐ Single ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Head of Household

b. If **THIS PERSON** said that they are "Head of Household" or "Married Filling Separately", do exceptional circumstances ⓘ apply to their case? For more information, see the instructions ☐ **Yes** ☐ **No**

c. If **THIS PERSON** is filing jointly, please name his or her spouse: _____

d. Will **THIS PERSON** claim any dependents on his or her federal income tax return? ☐ **Yes** ☐ **No**
If Yes, list legal name(s) of dependents:_____

e. If **THIS PERSON** is a tax dependent, who will list them as a dependent? _____
Is this person listed on the application? ☐ **Yes** ☐ **No**
Is this person a non-custodial parent? ☐ **Yes** ☐ **No**

f. Is **THIS PERSON** living with both parents, but their parents do not expect to file a joint return? ☐ **Yes** ☐ **No**

The answers to questions with an (*) cannot be used to determine the availability or cost of the premium for any health insurance purchased through the Marketplace.

29. *Is **THIS PERSON** pregnant? ☐ **Yes** ☐ **No**
If Yes, how many babies are expected? _____ Due Date (mm/dd/yyyy)? _____

30. **Does THIS PERSON need health coverage?**

☐ **Yes**. **If Yes,** answer all of the following questions. ☐ **No**. **If No**, SKIP to question 40.

Name of Person 1_____ Date of Birth_____

WORKSHEET K: (Continued)

PERSON #_____

31. *Does **THIS PERSON** have a medical or developmental condition that has lasted, or is expected to last, more than 12 months, including blindness ? ☐ **Yes** ☐ **No**

32. *Does **THIS PERSON** regularly need help with some or all of their self-care activities (such as bathing, dressing, eating, using the bathroom)? ☐ **Yes** ☐ **No**

33. *Does **THIS PERSON** need to move to a nursing home, acute care, hospital, group home, mental health institution or long-term care facility within the next 30 days, or do they need in-home health care to stay in their home? ☐ **Yes** ☐ **No**

If you have answered '**Yes**' to any of the three questions above, fill out **Worksheet B**

34. Is **THIS PERSON** a U.S. citizen or U.S. national? ☐ **Yes** ☐ **No**
If No, fill out **Worksheet C**

Other Health Coverage

35. Does **THIS PERSON** want help paying for medical bills from the last 3 months? ☐ **Yes** ☐ **No**

If Yes, what is the date(s) of service (mm/dd/yyyy) _____

36. Is **THIS PERSON** being treated for an injury that they have or may bring a claim ? ☐ **Yes** ☐ **No**

If THIS PERSON answered "yes" to the above question, fill out Worksheet D

37. Does **THIS PERSON** qualify for or is enrolled in the following health care coverage?
If Yes, fill out **Worksheet E**
☐ Medicare ☐ TRICARE ☐ Peace Corps ☐ Other State or Federal Heath Benefit Program
☐ VA Health Care Program ☐ Railroad Retirement ☐ Other: _____

38. Does **THIS PERSON** qualify for or is enrolled in the following health care coverage?
If Yes, fill out **Worksheet F**
☐ Current Employer-Sponsored Health Coverage ☐ Retiree Health Plan ☐ COBRA

39. Is **THIS PERSON** currently incarcerated? ☐ **Yes** ☐ **No**

a. **If Yes,** where is **THIS PERSON** incarcerated? ☐ City/County Jail ☐ State/Federal Prison

b. **If Yes,** is **THIS PERSON** currently waiting for a decision on charges? ☐ **Yes** ☐ **No**

40. **Race (OPTIONAL—check all that apply.)**

☐ White or Caucasian	☐ Asian Indian	☐ Filipino	☐ Vietnamese	☐ Samoan
☐ Black or African American	☐ American Indian or Alaska Native (fill out **Worksheet G**)	☐ Japanese	☐ Other Asian	☐ Other Pacific Islander
☐ Hispanic/Latino		☐ Korean	☐ Native Hawaiian	☐ Other _____
		☐ Chinese	☐ Guamanian or Chamorro	

You may get additional benefits:
If THIS PERSONis an American Indian or Alaska Native, fill out Worksheet G.

41. Was **THIS PERSON** uninsured in the last six months? (optional) ☐ **Yes** ☐ **No**
Your answer to this question will not affect what you qualify for.

Name of Person 1_____ Date of Birth_____

WORKSHEET K: (Continued)

PERSON #_____

42. Current Job & Income Information (Check all that apply)

☐ **Does not have a job**
SKIP to question 71.

☐ **Has a job**
If **PERSON 2** is currently employed, tell us about their income. Start with question 43.

☐ **Is Self-employed**
fill out **Worksheet H** and return to question 71.

☐ **Has other income**
(including rental income) fill out **Worksheet I** and return to question 71.

CURRENT JOB 1 for THIS PERSON:

43. Employer Name

44. Employer Address | 45. Apartment/Suite # | 46. Employer Phone

47. City | 48. State | 49. ZIP code

50. Wages/tips (before taxes)
$_____

Pay Period:
☐ Daily ☐ Twice a month
☐ Weekly ☐ Monthly
☐ Every 2 weeks ☐ Yearly

51. Average hours worked each WEEK
_____

52. When did **THIS PERSON** start this job (mm/yyyy)? _____

53. When was**THIS PERSON's** most recent paycheck received for this job (mm/dd/yyyy)? _____

54. Tell us the total gross pay ⓘ that **THIS PERSON** got or will get this month as a one time payment from this employer. (This could be a bonus or other extra pay you got.) _____

55. Does **THIS PERSON's** income from this job change month to month? ☐ **Yes** ☐ **No**
If Yes, fill out the current amount **AND** annual amount for this job.
If No, only fill out the current amount. You do **not** need to fill out the annual amount.
56. Annual income ⓘ from this job: $ _____

CURRENT JOB 2 for THIS PERSON:

57. Employer Name

58. Employer Address | 59. Apartment/Suite # | 60. Employer Phone

61. City | 62. State | 63. ZIP code

64. Wages/tips (before taxes)
$_____

Pay Period:
☐ Daily ☐ Twice a month
☐ Weekly ☐ Monthly
☐ Every 2 weeks ☐ Yearly

65. Average hours worked each WEEK
_____

66. When did **THIS PERSON** start this job (mm/yyyy)? _____

67. When was **THIS PERSON's** most recent paycheck received for this job (mm/dd/yyyy)? _____

68. Tell us the total gross pay ⓘ that **THIS PERSON** got or will get this month as a one time payment from this employer. (This could be a bonus or other extra pay you got.) _____

69. Does **THIS PERSON's** income from this job change month to month? ☐ **Yes** ☐ **No**
If Yes, fill out the current amount **AND** annual amount for this job.
If No, only fill out the current amount. You do **not** need to fill out the annual amount.
70. Annual income ⓘ from this job: $ _____

Name of Person 1____ Date of Birth_______________

WORKSHEET K: (Continued)

PERSON #__________

71. **DEDUCTIONS** ⓘ**:** Check all that apply, and give the amount and how often **THIS PERSON** pays it. Telling us about these deductions could make the cost of your health insurance lower. You should not include a cost that **THIS PERSON** already considered in your answer to job income and net self-employment.

72. Do **THIS PERSON's** deductions change month to month? ☐ **Yes** ☐ **No**

If Yes, fill out the current Amount **AND** Actual Annual Amount columns for each type of deduction that applies to **THIS PERSON**. **If No,** only fill out the current Amount column. You do **not** need to fill out the Actual Annual Amount column.

Deduction Type:

- Alimony ⓘ
- Student Loan Interest ⓘ
- Contribution made to your Traditional IRA
- Capital Losses
- HSA Deduction
- Moving Expenses
- Penalty of Early Withdrawal of Savings
- Reimbursement of Expenses
- Domestic Production Activities

Type of Expense:____________________ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:
Type of Expense:____________________ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:
Type of Expense:____________________ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:
Type of Expense:____________________ Frequency: ☐ One time only ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Current Amount:	Actual Annual Amount:

73. Does **THIS PERSON** have income from a past job, self-employment, or other sources during the coverage year ⓘ which is not listed as current income that you will need to include on your tax return? ☐ **Yes** ☐ **No**

If Yes, fill out **Worksheet J**

74. After you submit this application, we will verify **THIS PERSON's** income. Please tell us if any of the following have happened to **THIS PERSON** in the past few months to help us with this verification process:

☐ Stopped working at a job ☐ Hours changed at a job ☐ Change in employment

☐ Married, Legal Separation, or Divorce ☐ Other: ______________________________

GLOSSARY ⓘ

Below are a list of terms and what they mean. These terms are used in this application.

For additional information, please see the separate Instruction Booklet available at Colorado.gov/hcpf/how-to-apply and ConnectforHealthCO.com/about-us/customer-resources/

Term	Definition
Agent	An agent represents a health insurer and offers their policies to consumers. They are generally either employed directly by an insurer or contracted by them to market their plans. Agents are familiar with the features of the plans their company sells and can provide expert and detailed answers to your questions about those policies.
Annual Income	Annual income is the total income you expect to make from your job in the coverage year. For example, if you are applying for 2014 coverage in 2014, you will provide job income for 2014. If you are applying for 2015 coverage in 2014, you will give estimated job income for 2015.
Alimony (Spousal Maintenance)	An allowance for support made under court order to a divorced person by the former spouse.
Appeal	A request for your health insurer or plan to review a decision or a grievance again.
Application Assistance Site	An agency or organization that assists individuals in completing their Application for Health Coverage & Help Paying Costs.
Authorized Representative	An Authorized Representative is either a person or an organization that you trust and let fill out your application, talk about this application with us, see your information, get information about your application, and sign your application on your behalf. An Authorized Representative also takes legal responsibility for the information provided in this application. If an Authorized Representative is a person, they must be 18 or older. An Authorized Representative is NOT an Agent/Broker, Health Coverage Guide, or a Certified Application Counselor.
Blindness	Blindness is the total lack of vision or vision in the better eye of 20/200 or less with the use of a correcting lens and/or tunnel vision to the extent that the field of vision is no greater than 20 degrees.
Broker	A broker offers policies from several insurers that they are contracted to represent. Brokers can provide assistance in comparing the rates and benefits of health plans from several companies. An experienced broker can provide expert and detailed information on plan specific features and limitations of various policies.
Child Health Plan *Plus* (CHP+)	CHP+ is public health insurance for children and pregnant women who earn too much to qualify for Medicaid, but cannot afford private health insurance. For more information on CHP+ go to CHPPlus.org.
Claim	A claim is a legal demand for money to pay for damages you have suffered due to an injury. Damages is the sum of money the law imposes to compensate the injured party for their loss or injury.

GLOSSARY (CONTINUED)

Term	Definition
	Example: Ron runs a red light and hits Joe's car, and Joe has to go to the ER. The court rules that Ron has to compensate Joe for his visit to the ER. Ron's compensation to Joe would be the damages awarded for the injury Joe suffered.
COBRA	A Federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or you experience another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.
Connect for Health Colorado	Also referred to as the Marketplace. Connect for Health Colorado™ offers individuals, families and small businesses an online marketplace for health insurance and exclusive access to up-front financial assistance, based on income, to reduce costs. Customers can shop through a website and get expert help in person and over the phone from a network of customer service professionals, including Customer Service Center Representatives, Health Coverage Guides and certified health insurance agents and brokers. The Marketplace is a non-profit entity established by a 2011 state law.
Coverage Year	The coverage year is the calendar year you are applying to get tax credits or help to lower your health care costs. For example, if you are applying in November of 2014 for 2015 health care coverage, the coverage year would be 2015. Or if you are applying in February of 2015 for 2015 health care coverage, the coverage year would be 2015.
Deductions	A deduction is an amount you can take off of the total amount you earn (gross income). Common deductions include alimony and student loan interest. We do not need you to tell us about things like charitable contributions or home mortgage interest. For additional information, see the Instruction Booklet or visit the IRS website at http://www.irs.gov/taxtopics/tc450.html
Department of Health Care Policy and Financing	The Department administers the Medicaid and Child Health Plan *Plus* (CHP+) programs as well as a variety of other programs for low-income Coloradans. For more information about the Department, go to Colorado.gov/hcpf.
Dependent	A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction.
Disability	Having a disability means you cannot do any substantial gainful activity or major activity to receive pay (or, in the case of a child having marked and severe functional limitations or have an easily recognized and extreme lack of ability to do everyday activities) because you have been medically determined to have a physical or mental impairment that will either result in death or which has lasted or is expected to last for 12 months in a row or more.

GLOSSARY (CONTINUED)

Term	Definition
Dividends/Interest	The charge for the use of borrowed money. Interest you get from a bank or dividends from a stock you own are examples of investment income, which you should tell us about if you apply for help paying for health coverage.
Division of Insurance	The Department of Regulatory Agencies' Division of Insurance regulates the insurance industry and assists consumers and other stakeholders with insurance issues. For more information go to HealthInsurance.Colorado.gov
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	The EPSDT benefit provides comprehensive and preventive health care services for children (ages 0-20) who qualify for Medicaid.
Eligible Immigration Status	An immigration status that's considered eligible for getting health coverage. The rules for eligible immigration status may be different in each insurance affordability program.
Exceptional Circumstances	If you have been a victim of domestic violence and are still married to the perpetrator but will not be able to file a joint tax return, please enter how you plan to file as either Head of Household or as Married Filing Separately. Also mark the Exceptional Circumstances checkbox in the application.
Federal income tax return	Income tax return is a document you file with the Internal Revenue Service or the state tax board reporting your income, profits and losses of your business and other deductions as well as details about your tax refund or tax liability. A 1040 form is an example of a federal income tax return.
Federally-recognized tribe	Any Indian or Alaska Native tribe, band, nation, pueblo, village or community that the Department of the Interior acknowledges to exist as an Indian tribe. Read the current list of federally recognized tribes at the Bureau of Indian Affairs bia.gov.
Gross pay/income	Profits before taxes, deductions, or expenses are paid.
Health Coverage	Legal entitlement to payment or reimbursement for your health care costs, generally under a contract with a health insurance company, a group health plan offered by an employer, or a government program like Medicare, Medicaid, TRICARE, or the Child Health Plan *Plus* (CHP+).
Health Coverage Guides	Health Coverage Guides are certified by Connect for Health Colorado to assist customers with applying for health coverage and financial assistance programs that help reduce health insurance costs. They also help customers to understand coverage options and provide unbiased assistance in shopping for and selecting health plans.
Health Insurance	A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.
Healthy Communities Program	Focuses on the activities necessary for you or your children to obtain coverage and access to coordinated health care services in Medical Homes.

GLOSSARY (CONTINUED)

Term	Definition
Individual Shared Responsibility Exemption	You may be exempt from having to buy coverage if any of the following apply: you are a legal resident of the United States with very low income but you do not qualify for Medicaid; you are part of a religion opposed to acceptance of benefits from a health insurance policy; you are American Indian or Alaska Native and a member of a Federally-recognized Tribe; or you qualify for a hardship exemption due to very low income.
Insurance Affordability Programs	Insurance affordability programs include Medicaid, Child Health Plan *Plus* (CHP+), and the tax credits and reduced out of pocket costs available through Connect for Health Colorado. Medicaid: Public health insurance for low-income Coloradans who qualify. More information is available at Colorado.gov/hcpf
Medicare	A Federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). For more information about Medicare, go to Medicare.gov.
Minimum Value Standard	A health plan meets this standard if it is designed to pay at least 60% of the total cost of medical services for a standard population. Starting in 2014, individuals offered employer-sponsored coverage that provides minimum value and that is affordable will not be eligible for a premium tax credit.
Outreach Specialist	An Outreach Specialist is an individual from either a Certified Application Assistance Site, Medical Assistance Site or a Presumptive Eligibility Site who can help you fill out this application.
PEAK Colorado Program Eligibility and Application Kit	Is an online benefits portal where Coloradans can apply and manage their public benefits including food, cash and medical assistance.
Premiums	The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.
Spouse	A marriage partner such as a husband or wife.
Student Loan Interest	If you took out a loan to pay for qualified higher education expenses, then you may deduct either the amount of interest you paid on that student loan OR $2,500 from your income, whichever one is less. Qualified education expenses are the total cost of attending an eligible educational institution and includes items such as tuition and fees, room and board (as determined by the educational institution), books, supplies, equipment, and other necessary expenses
TRICARE	A health care program for active-duty and retired uniformed services members and their families.
Unmarried Partner	A significant other to whom you are not legally married but with which you live.
Veterans Affairs (VA) Health Care Programs	Health care programs operated by the Department of Veterans Affairs for eligible veterans.