

**Care Card applications only accepted Monday through Friday 8:00 am – 11:00 am and
Wednesday 9:00 am – 11:00 am**

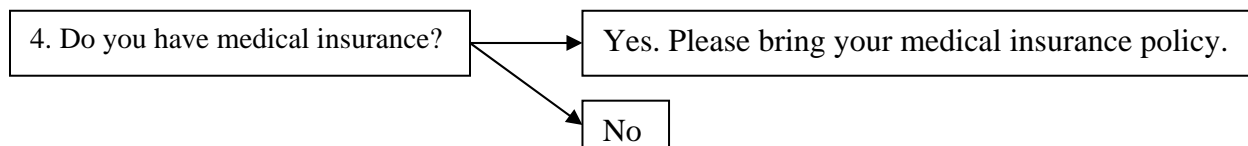
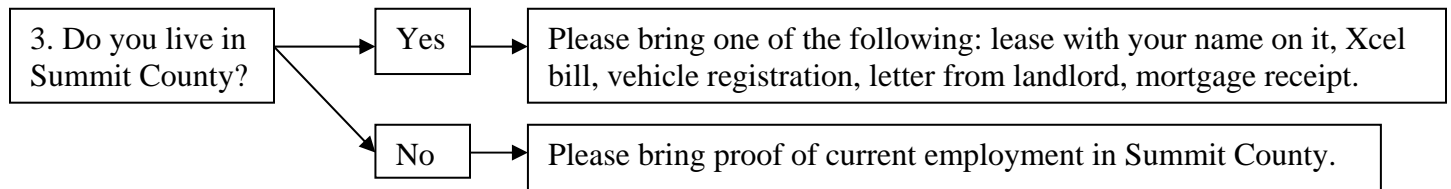
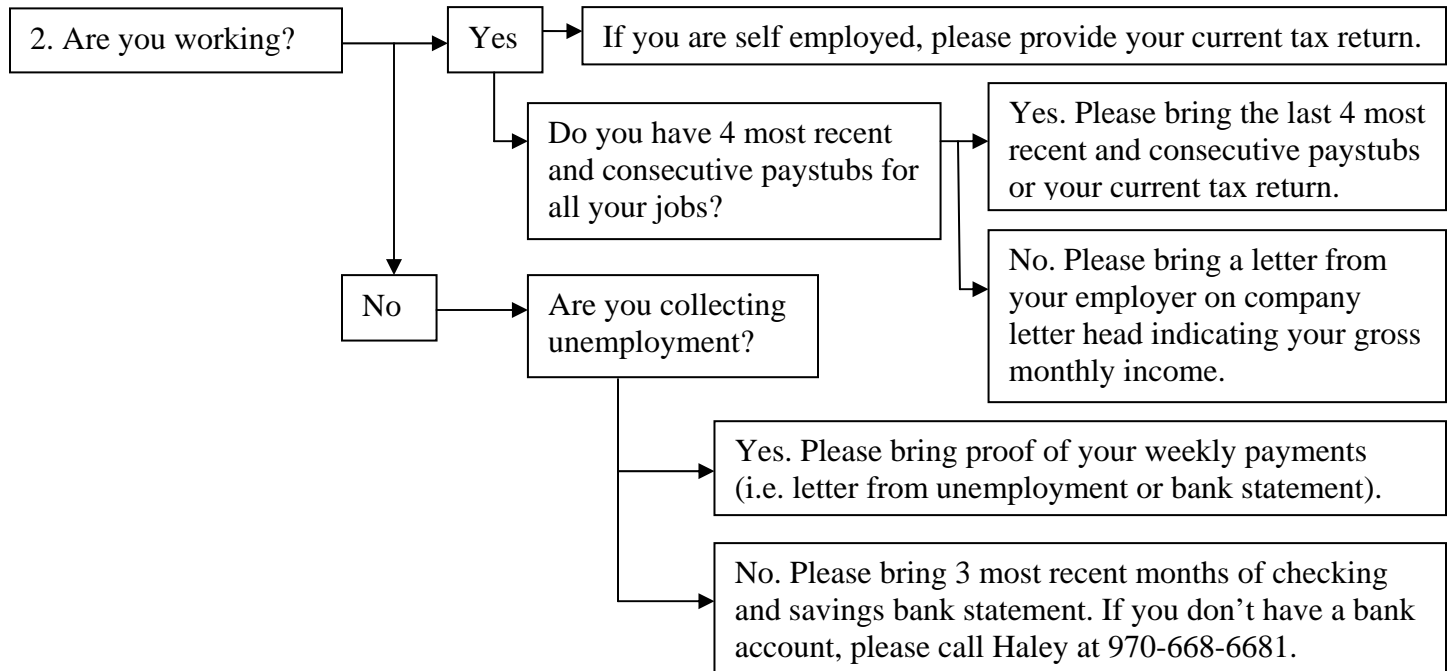
**If you have any questions regarding eligibility please feel free to call Haley
at (970) 668-6681 or email herickson@summitclinic.org**

Eligibility Checklist

If you are seeking medical care or dental services through the Care Clinic, you are required to provide the following information with your application.

If you do not bring all the required information, your application will not be complete and you will not receive a Care Card.

1. Please bring identification **for ALL household members, even if they are not applying for the care card.** Examples of approved identification: Colorado ID, passport, other state ID, ID from your country, birth certificate, green card, Medicaid **or** CHP+ card



5. If you pay child support, alimony, day care or elderly care: please bring proof of paid receipts for the most recent 90 days.

APPLICATION INFORMATION

DOB: ____ / ____ / ____ Sex: F ___ M ___ Last Name: _____ First Name: _____

PO Box: _____ City, State, and Zip: _____ Phone # (____) _____

Do you have a Social Security Number? Yes / No _____ - _____ - _____ Marital Status: _____

Physical Address: _____ City, State, and Zip: _____

Are you pregnant? Yes / No Due date: ____ / ____ / ____ Where do you work? _____

Do you have a second job? Yes / No _____ Are you self-employed? Yes / No _____

Other income (i.e.: food stamps, child support, unemployment): _____

RACE (CIRCLE AT LEAST ONE)	PRIMARY LANGUAGE (CIRCLE AT LEAST ONE)	ETHNICITY (CIRCLE ONE)
BLACK OR AFRICAN AMERICAN	AMERICAN SIGN LANGUAGE	HISPANIC ORIGIN
AMERICAN INDIAN OR ALASKA NATIVE	ENGLISH	NOT HISPANIC ORIGIN
ASIAN	FRENCH	UNKNOWN / NOT REPORTED
WHITE / LATINO	POLISH	
UNKNOWN	RUSSIAN	
OTHER	SPANISH	
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	NOT LISTED	

FAMILY GROSS INCOME \$ _____ WEEK / EVERY 2 WEEKS / SEMI-MONTHLY / MONTH / YEAR

NUMBER OF PEOPLE LIVING IN THE SAME HOUSEHOLD SUPPORTED BY THIS INCOME (INCLUDING YOUR SELF): _____

DO YOU HAVE INSURANCE THAT COVERS PRIMARY MEDICAL CARE? (your visits to the doctor)
 YES ___ NO ___ Deductible: \$ _____
 If YES does it cover Family Planning? YES ___ NO ___ DON'T KNOW ___

PRIMARY CARE PROVIDER _____

Please tell us who to contact in case of an emergency (parent or guardian if under 18): An emergency would be severe bleeding, unconsciousness, accident or a condition requiring ambulance transport or hospitalization. Family planning services DO NOT require parental permission; however, in an emergency situation, if you are under 18 years of age, we will notify a parent or guardian.
 Does the person listed below know that you are receiving services here? YES ___ NO ___

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____ PHONE NUMBER _____

I hereby consent to all treatment which the medical staff of Summit Community Care Clinic determines to be necessary. I certify that the above information is true, accurate, and complete to the best of my knowledge, (incorrect or false information will result in termination of services). I permit Summit Community Care Clinic representatives to contact any necessary person or agency to verify this information. If further information is needed, I must furnish it within 30 days.

I agree to notify Summit Community Care Clinic promptly of any change in household members, address, phone, income, insurance or other essential information. I understand that I must show my card at time of service.

I understand that I am responsible for any charges for service and I agree to pay for services at the time of service.

 Applicant Signature _____
 Date

FOR STAFF USE ONLY

CARE CARD DENTAL ONLY

ANNUAL INCOME \$ _____

FEE CODE _____ HH _____

EXPIRATION ____ / ____ / ____

Limited English Proficiency? YES NO

INITIALS _____

DATE ____ / ____ / ____

APPLICATION INFORMATION (continued)

Monthly Expenses

Rent / Mortgage _____	Auto Insurance _____
Utilities: _____	Auto Loan _____
Water/Trash _____	Grocery and Restaurant _____
Electricity _____	Telephone/Cell Phone _____
Gas/Propane _____	Cable/Internet _____

Allowable Deduction (Must have documentation)

Day Care _____
Child Support _____
Elderly Care _____
Alimony _____
Total Monthly _____

Please tell us about your spouse / significant other

Last Name: _____	First Name: _____	DOB: ____ / ____ / ____
How is this person related to you? _____	Is this person pregnant? Yes / No Due date: ____ / ____ / ____	
Is this person applying for a Care Card? Y / N	Sex: M ___ F ___	Does this person have health insurance? Y/N Deductible: \$ _____
Where does this person work? _____	Does this person have a second job? Yes / No _____	
Is he or she self-employed? Yes / No _____	Other income (i.e.: food stamps, child support): _____	

Please tell us about your child / children

Last Name: _____	First Name: _____	DOB: ____ / ____ / ____
How is this person related to you? _____	Is this person applying for a Care Card? Yes / No	Sex: M ___ F ___
Where was this person born? _____	Does this person have health insurance, Medicaid, CHP+? Y/N Deductible: \$ _____	

Last Name: _____	First Name: _____	DOB: ____ / ____ / ____
How is this person related to you? _____	Is this person applying for a Care Card? Yes / No	Sex: M ___ F ___
Where was this person born? _____	Does this person have health insurance, Medicaid, CHP+? Y/N Deductible: \$ _____	

Last Name: _____	First Name: _____	DOB: ____ / ____ / ____
How is this person related to you? _____	Is this person applying for a Care Card? Yes / No	Sex: M ___ F ___
Where was this person born? _____	Does this person have health insurance, Medicaid, CHP+? Y/N Deductible: \$ _____	

Last Name: _____	First Name: _____	DOB: ____ / ____ / ____
How is this person related to you? _____	Is this person applying for a Care Card? Yes / No	Sex: M ___ F ___
Where was this person born? _____	Does this person have health insurance, Medicaid, CHP+? Y/N Deductible: \$ _____	

For Staff Use

Total Annual Income _____	Total Annual expenses _____
HH _____	Fee Code _____
Eligibility Technician Signature: _____	Date _____

