summit community CARE CLINIC

Care Card and CICP Application
Eligibility Pre-screen Required Items – Rev 7/2/2018

To book an appointment please call the Front Desk (970)668-4040

Please, bring all applicable items listed below:

- ☐ Application entirely filled out.

- ☐ **Please bring any form of 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, school ID, Medicaid or CHP+ card.
- ☐ **Earned Income**: Please bring ONE of the following for all employed family members :
  - ☐ Last calendar month of pay stubs
  - ☐ Income verification letter from your employer (gross income, estimated tips if applicable, dated last calendar month, address and phone number of employer)
  - ☐ Taxes from previous year or W2's
  - ☐ or Self-employment income:
    - ☐ One month of gross bank business deposits
    - ☐ Year to date profit and loss statements or business ledgers
    - ☐ Self-employment worksheet
    - ☐ Or Taxes from previous year or W2's
- ☐ **Unearned Income:**
  - ☐ Unemployment
  - ☐ Worker's Compensation
  - ☐ Social Security or Supplemental Security Income (SSI)
  - ☐ Public Assistance
  - ☐ Veteran's Benefits
  - ☐ Survivor Benefits
  - ☐ Disability Benefits
  - ☐ Pensions or Retirement Income
  - ☐ Interest or Dividends
  - ☐ Rents, Royalties, estates and trusts
  - ☐ Alimony

- ☐ **If you are homeless please ask to speak to the Eligibility Coordinator**

If you have any questions regarding documentation required
or will like to talk to an Eligibility Coordinator please call (970)668-6681

FOR STAFF USE ONLY

Name: _____

Date: _____

CARE CARD APPLICATION

Self (1) /Dependents (Spouse/Civil Union partner(2)/Minor(3)/Senior(4)/Adult Student(5)/Other(6)

DOB: MM _____DD_____YYYY_____	Sex at Birth: **M / F** Marital Status: **Single / Married**
First Name:	Are you a veteran: **Yes / No**
Last Name: **Code:**	Are you pregnant: **Yes / No** Due Date:
PO Box: City: Zip:	Do you have health insurance: **Yes / No** **Medicare □ Private □ Medicaid □ CHP □**
Physical Address::	Does your insurance cover family planning: **Yes / No**
City, State, Zip: County:	Name of Employer:
Email:	Second job:
Home # : Cell # :	Are you self-employed: **Yes / No**
We give our patients reminder calls prior to their appointments Can leave a message for you? **Yes / No** If yes, what phone number do you prefer we call _____	Other sources of income:
Have you received a Medicaid/CHP+ Denial Letter : **Yes /No** **Ineligibility Code (A): _____**	**Only if applying for CICP:** Are you a Colorado Resident & US Citizen (1), Colorado Resident & Lawfully present for at least 5 years (2), Migrant Worker & US Citizen (3), Migrant Farm Worker & Lawfully present (4), Counted in household size only (5)? **Residency Code:** _____ **Ineligibility Code (B): _____** Do you have refugee status? Yes / No
Do you have Transitional Medical Benefits: **Yes/ No** **Ineligibility Code (C): _____**	Are you over income for Medicaid: **Yes/No/Have Not Applied** **Ineligibility Code (D): _____** **Cirle all that apply:** **A. I am a child** **B. I am pregnant** **C. I am disabled**
Do you have primary insurance? (if yes, not eligible for CHP+) **Yes/No** **Ineligibility Code (E): _____**	Social Security Number :_____ Are you homeless: Yes / No **Other – Provide a brief Explanation:** **Ineligibility Code (F): _____**

Please CIRCLE:

RACE (CIRCLE ONE)		**PRIMARY LANGUAGE (CIRCLE 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		POLISH	
NATIVE HAWAIIAN	OTHER PACIFIC ISLANDER	RUSSIAN	
NOT PROVIDED		SPANISH	

PLEASE CIRCLE:

GENDER IDENTITY (CIRCLE ONE)		**SEXUAL ORIENTATION (CIRCLE ONE)**	
MALE	FEMALE	STRAIGHT(NOT LESBIAN OR HOMOSEXUAL)	
TRANSGENDER FEMALE/MALE TO FEMALE		LESBIAN OR HOMESEXUAL	
TRANSGENDER MALE/FEMALE TO MALE		BISEXUAL	SOMETHING ELSE
CHOOSE NOT TO DISCLOSE	OTHER	DO NOT KNOW	CHOOSE NOT TO DISCLOSE

How did you hear about our services? __Facebook __Friend/Family __Newspaper __Radio __Website
Other: _____

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 # _____

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 PRENATAL TEMP

CICP

ANNUAL INCOME $ _____

FEE CODE _____ HH _____

DATE _____ /_____ /_____

APPLICATION INFORMATION (continued)

(Spouse/Civil Union partner(2)

Last Name:	First Name:	DOB:
Relation to you: **Code:**	Applying for card: **Y N**	Sex: **M F**
Employer:	Second job:	Self-employed: **Y N**
Pregnant: **Y N**	Due date:	Other forms of income:
This person has health insurance: Yes/No	Medicare□ Private □ Medicaid □ CHP+□ CICP □	**CICP eligible: YES ___ NO ____**

Has this person received a Medicaid/CHP+ Denial Letter : **Yes /No** **Ineligibility Code (A): _____**	**Only if applying for CICP:** Is this person a Colorado Resident & US Citizen (1), Colorado Resident & Lawfully present for at least 5 years (2), Migrant Worker & US Citizen (3), Migrant Farm Worker & Lawfully present (4), Counted in household size only (5)? **Residency Code:** _____ **Ineligibility Code (B): _____** Is this person have refugee status? Yes / No
Do this person have Transitional Medical Benefits: **Yes/ No** **Ineligibility Code (C): _____**	Is this person over income for Medicaid: **Yes/No/Have Not Applied** **Ineligibility Code (D): ___** **Cirle all that apply:** **A. Is this person a child** **B. Is this person pregnant** **C. Is this person disabled**
Do this person have primary insurance? (if yes, not eligible for CHP+) **Yes/No** **Ineligibility Code (E): _____**	Social Security Number :_____ Is this person homeless: Yes / No **Other – Provide a brief Explanation:** **Ineligibility Code (F): _____**

Dependents (Minor(3)/Senior(4)/Adult Student(5)/Other(6)

Last Name:	First Name:	DOB:
Relation to you: **Code:**	Applying for card: **Y N**	Sex: **M F**
Where they were born:	**Do they have health insurance** : Y N Medicaid □ CHP+□ Medicare□ Private □	
Has this person received a Medicaid/CHP+ Denial Letter : **Yes /No** **Ineligibility Code (A): _____**	**Only if applying for CICP:** Is this person a Colorado Resident & US Citizen (1), Colorado Resident & Lawfully present for at least 5 years (2), Migrant Worker & US Citizen (3), Migrant Farm Worker & Lawfully present (4), Counted in household size only (5)? **Residency Code:** _____ **Ineligibility Code (B): _____** Is this person have refugee status? Yes / No	
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Last Name:	First Name:	DOB:
Relation to you: **Code:**	Applying for card: **Y N**	Sex: **M F**
Where they were born:	**Do they have health insurance** : Y N Medicaid □ CHP+□ Medicare□ Private □	
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Last Name:	First Name:	DOB:
Relation to you: **Code:**	Applying for card: **Y N**	Sex: **M F**
Where they were born:	**Do they have health insurance** : Y N Medicaid □ CHP+□ Medicare□ Private □	

Has this person received a Medicaid/CHP+ Denial Letter : **Yes /No** **Ineligibility Code (A): _____**	**Only if applying for CICP:** Is this person a Colorado Resident & US Citizen (1), Colorado Resident & Lawfully present for at least 5 years (2), Migrant Worker & US Citizen (3), Migrant Farm Worker & Lawfully present (4), Counted in household size only (5)? **Residency Code:** _____ **Ineligibility Code (B): _____** Is this person have refugee status? Yes / No	
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Last Name:	First Name:	DOB:
Relation to you: **Code:**	Applying for card: **Y N**	Sex: **M F**
Where they were born:	**Do they have health insurance** : Y N Medicaid □ CHP+□ Medicare□ Private □	

Has this person received a Medicaid/CHP+ Denial Letter : **Yes /No** **Ineligibility Code (A): _____**	**Only if applying for CICP:** Is this person a Colorado Resident & US Citizen (1), Colorado Resident & Lawfully present for at least 5 years (2), Migrant Worker & US Citizen (3), Migrant Farm Worker & Lawfully present (4), Counted in household size only (5)? **Residency Code:** _____ **Ineligibility Code (B): _____** Is this person have refugee status? Yes / No	
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Do this person have primary insurance? (if yes, not eligible for CHP+) **Yes/No** **Ineligibility Code (E): _____**	Social Security Number :_____ Is this person homeless: Yes / No **Other – Provide a brief Explanation:** **Ineligibility Code (F): _____**	

FOR STAFF USE ONLY:

CARE CARD & CICP INCOME CALCULATION

Eligible for Medicaid/CHP+	YES	NO	Annual Income $_____
			Household #: _____
Eligible for WWC (21-64)	YES	NO	Fee code: $ _____
			CICP Client Annual Cap: $_____

Eligibility Technician name and signature:

Information entered in:

Aprima	YES
Dentrix	YES
Excel	YES

_____

Applicant Signature:

_____

NEW PATIENT or RENEWAL

Section for Calculating Income & Self-employment. **Patient Pay Schedule** Monthly/Twice A Month/Bi-weekly (every 2 weeks), Weekly/Hourly	**Section for Calculating Client Annual Copayment and Cap.** Annual income: $ _____ N or Z CICP rating _____ All other CICP rating _____ 10% calculation: $ _____ CICP Client Annual Cap: $ _____

Care Card / CICP card:

Revised: 7/2/2018 JG