Voter Registration Choice Form

For office use only

Date: _____

The applicant completed a voter registration form

☐ Yes ☐ No

The applicant requested and was given a voter registration form for later delivery

☐ Yes ☐ No

Employee Initials: _____

Instructions

Please read the following information and complete and sign the form below. This agency will keep the form for its records.

Important Notice

You may file a complaint with the Colorado Secretary of State if you believe that someone has interfered with your right to:

- register or decline to register to vote,
- privacy in deciding whether to register or in applying to register to vote, or
- choose your own political party or other political preference.

Send complaints to:

Colorado Secretary of State
1700 Broadway
Denver, CO 80290
Phone: (303) 894-2200

You may apply to register to vote or update your current registration today

- If you are not registered to vote where you live now, you may apply to register to vote here today.
- If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

Does filling out or not filling out the registration form affect services I am applying for?

No. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

How private is this process?

The name and location of the agency or public office where you received the voter registration application will not appear on your records. If you decide not to use this application to register to vote, that is also confidential.

Complete and sign below

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

Please check only one of the following boxes. *If you do not check either box, you will be considered to have decided not to register to vote at this time.*

☐ Yes, I want to apply to register to vote today. (Please fill out the Voter Registration Form)

You are eligible to register to vote if you:

- Are a United States citizen.
- Are or will be a resident of the state of Colorado for at least 22 days immediately before an election in which you intend to vote,
- Are at least 16 years of age but you must be 18 years of age or older on the date of an election in which you intend to vote,
- Are NOT serving a sentence (including parole) for a felony conviction.

☐ No, I do not want to apply to register to vote today.

_____
Your full name (please print)

_____ _____
Signature Today's date (MM/DD/YY)

Formulario de Elegir Registración de Votante

Para uso de la oficina solamente

Date: _____

The applicant completed a voter registration form

☐ Yes ☐ No

The applicant requested and was given a voter registration form for later delivery

☐ Yes ☐ No

Employee Initials: _____

Instrucciones

Por favor, lea la siguiente información y complete y firme el formulario abajo. Esta agencia mantendrá el formulario por su registro.

Aviso Importante

Usted puede presentar una queja con el Secretario de Estado de Colorado si usted cree que alguién ha interferido con su derecho a :

- registrarse o declinar la registración para votar,
- privacidad en la decisión de registrarse o en aplicar para registrarse para votar, o
- elegir su propio partido político y otras preferencias políticas.

Enviar quejas a:

Colorado Secretary of State
1700 Broadway
Denver, CO 80290
Phone: (303) 894-2200

Usted puede aplicar para registrarse para votar o actualizar su registro hoy

- Si usted no está registrado para votar en el lugar donde reside ahora, usted puede registrarse para votar aquí hoy.
- Si usted quisiera ayuda para llenar el formulario de registración de votante, le ayudaremos. Usted decide si desea o no buscar o aceptar ayuda. Usted puede llenar el formulario de registración en privado.

¿Afecta los servicios que estoy solicitando el hecho de que llene o no llene el formulario de registración?

No. Aplicar para registrarse o declinar la registración para votar no afectará la cantidad de ayuda que esta agencia le proporcionará.

¿Qué tan privado es este proceso?

El nombre y lugar de la agencia u oficina pública donde recibió la aplicación de registración de votante no aparecerá en sus expedientes. Si decide no usar esta aplicación para registrarse para votar, esto también es confidencial.

Complete y firme abajo

Si usted no está registrado para votar en el lugar donde reside ahora, ¿desea aplicar para registrarse para votar aquí hoy?

Por favor, sólo marque una de las casillas a continuación y firme abajo. Si no marca ninguna casilla, se considerará que ha decidido no registrarse para votar por el momento.

☐ Sí, deseo aplicar para registrarme para votar hoy. (Por favor llene el Formulario de Registración de Votante)

Usted es elegible para votar si:

- Es ciudadano de los Estados Unidos.
- Es o será un residente del estado de Colorado durante por lo menos 22 días inmediatamente antes de una elección en la que usted se propone votar,
- Tiene por lo menos 16 años de edad, pero usted debe tener 18 años de edad o mayor en la fecha de una elección en la que usted se propone votar.
- NO está cumpliendo una condena (inclusive libertad condicional) debido a una condena por delito.

☐ No, no deseo aplicar para registrarme para votar hoy.

_____
Su nombre completo (letra de imprenta)

_____ _____
Firma Fecha de hoy (MM/DD/AA)

Application for Public Assistance

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

Please remove pages A-F to keep for your records

You have the option to answer only those questions relevant to the program for which you are applying.

Food Assistance- *Known federally as the Supplemental Nutrition Assistance Program (SNAP)*

(Questions marked with a ■ are NOT required for Food Assistance.)

- You have the right to file your application today. **You can start the process by filling out your name, address and signature or that of an authorized representative on this form and turning it in to a county office.** You can give us your application in person, by fax, through the mail or you can apply through PEAK. **An interview will be required before receiving Food Assistance** and you may be required to provide proof of some information given on the application. ***Benefits will begin from the date any county office receives your signed application.***
- You may receive Food Assistance within 7 days if the household has less than $100 in assets and less than $150 income per month; OR if your monthly shelter costs are more than your monthly income plus any cash on hand or in the bank; OR if anyone in the home is a migrant or seasonal farm worker and the household has less than $100 in cash on hand and in the bank.
- If you do not qualify for expedited Food Assistance, benefits can begin within 30 days if all requested proof of information that was given on your application was provided. If expedited assistance is denied, you may ask for an informal hearing.

Cash Programs (Questions marked with a ♦ are NOT required for Cash Assistance.)

- **Colorado Works (CW),** known federally as Temporary Assistance for Needy Families (TANF) – For households with a child or a pregnant mother. Provides a cash benefit to families in need. With a few exceptions, parents must participate in work activities. A referral may be made to Child Support Services based on your household circumstances. If you feel this could cause hardship to you or your child(ren), you may request good cause for waiving this referral.
- **Colorado Supplement to SSI** – Provides an additional cash supplement to eligible persons not receiving the full SSI grant from the Social Security Administration.
- **Aid to the Needy Disabled (State AND)**– Provides a cash benefit for persons ages 18-59 who have been determined totally disabled for at least six months or persons under the age 59 who meet the definition of a person who is blind.
- **Old Age Pension (OAP)** – Provides a cash benefit for low income persons age 60 or over.
- **Home Care Allowance (HCA)**- For persons who need help on a regular basis with some or all of their daily self-care (such as bathing, dressing, eating, getting around, and using the bathroom). Provides a cash benefit that used must be to pay the provider for services. A functional assessment is required.

Medical Assistance (Questions marked with a ● are NOT required for Medical Assistance.)

Medical Assistance includes free or low-cost insurance from **Health First Colorado (Colorado's Medicaid Program)** or the **Child Health Plan *Plus* Program (CHP+).** It also includes affordable private health insurance plans that offer you comprehensive coverage through **Connect for Health Colorado (the Marketplace).** This includes tax credits that can immediately lower your premiums for health coverage. It also includes assistance for paying your Medicare Premiums.

Instructions:

List EVERYONE in your home and on your federal tax return, even if you are not applying for them. Use more paper if necessary. If you are a non-citizen who has a sponsor, you will list the sponsor's information in a question later in this application.

If you are applying for benefits and you have a Social Security Number (SSN), we need this information. If you provide your SSN, it may speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778. Providing a SSN or immigration status is optional for Food Assistance. If a SSN or immigration status is not provided for a person, that person will not receive benefits. Even though the person's SSN or proof of immigration status was not provided, they must provide any income and resource they have as well as any expenses they pay because that information will be used to determine eligibility and benefits for eligible household members.

What I Should Know

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

- I must tell the truth; it is a crime to lie on this application.
- I may have to give papers that show what I've told you is true.
- I may have to tell you of any changes to the information I gave you on my application. If I think you made a mistake, I can ask for an appeal or fair hearing.
- The department will not discriminate.
- The department will confirm citizenship and immigration status for everyone applying for benefits.
- The department will tell you if your benefits change.
- The department or relevant federal agency will take back any benefits you should not have received.

1. The Department of Health Care Policy and Financing (HCPF) is the state agency responsible for Medical Assistance Programs in Colorado. The Department of Human Services is the state agency responsible for the other public assistance programs. The County Departments of Human/Social Services and Medical Assistance Sites are the agencies that receive and process applications for all public assistance programs. In this statement, the term "department" is used to refer to all agencies.
2. I must give the department all needed proof and documents before qualifying for benefits.
3. **The information I give on the application and in the application interview is confidential. However, the department can use or share the information with other program(s) that any of my family and/or household members are getting or are applying for. The information can only be used for purposes of treatment, payment, determining eligibility, and other program and administrative operations, or other purposes permitted by law for my family and/or household members or me. Additionally, this information may be disclosed to other Federal and State agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. It will also be determined if the information is factual. If any information is incorrect, Food Assistance may be denied and the applicant may be subject to criminal prosecution for knowingly providing incorrect information.**
4. **It is a crime to lie on the application or to take benefits that I know that my family and I are not eligible to receive and I may be subject to criminal prosecution for knowingly providing false information. Giving false information may be punished by a fine of up to $250,000 or a jail term of up to 20 years, or both.**
5. **A person found to have intentionally given false information cannot get Food Assistance and/or Colorado Works/TANF for 12 months for the first offense, 24 months for the second offense, and permanently for the third offense. A court can also stop a person from getting Food Assistance for another eighteen months. This crime is subject to prosecution under other state and federal laws. Receiving duplicate benefits of Food Assistance by lying about identity or residence will result in a ten (10) year disqualification for the first offense, a ten (10) year disqualification for the second offense and a permanent disqualification for the third offense. If I omit or provide any information (other than lying about identity or residence) that leads to duplicate benefits being issued, I can be disqualified for 12 months for the 1st offense, 24 months for the 2nd offense and permanently for the 3rd offense. A person convicted by a court or whose disqualification was obtained through an Intentional Program Violation (IPV) waiver for misrepresenting their residence in order to obtain assistance in two states at the same time will have their Colorado Works assistance denied for ten (10) years.**
6. **The department will notify me in writing of how and when to tell the department of any changes.** If I am receiving financial assistance, I know that I must tell the organization providing the assistance if information I listed on this application changes. I am aware I have 10 calendar days to report any changes if I am enrolled in Health First Colorado or Child Health Plan Plus (CHP+). Changes are to be reported to my local county office for Health First Colorado or to CHP+. I am responsible for paying fees, premiums and co-payments for myself and my family if they are required for Medical Assistance benefits. I know I have 30 calendar days to report any change 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. If my family is enrolled in multiple insurance affordability programs, I must report changes to each organization in the appropriate time frame. I understand that a change in information could affect my eligibility and eligibility of member(s) of my household.
7. If I do not tell the truth on my application or if information is left off of the application, or if I do not report changes to the department, as required, I may lose my assistance, and I may have to pay back the department for the assistance received when I was not eligible. If I have to pay back money to the department, I understand that state or federal salaries, rebates, or tax refunds that would be received by me or another person on this application may be taken.
8. The law says the department must check the immigration status and citizenship for anyone who is applying. They will not check immigration status of family members who are not applying for benefits. I may be requested to give proof of non-citizen registration documentation received from the United States Citizen and Immigration Service (USCIS) for every non-citizen member in my house who is applying for benefits. The department will confirm information with USCIS and any information received from USCIS may affect my eligibility and benefits. Federal law (Public Law 97-98) requires me to give the department the Social Security number and/or alien registration number of all persons who are applying for public assistance. I must also provide the Social Security number and/or alien registration number for all sponsors. **For Adult Financial and Colorado Works programs, sponsor information will be confirmed with USCIS and the information received from USCIS may affect sponsor repayment for my eligibility and benefits. My sponsor and I may be responsible for reimbursing the state for benefits that I receive.**
9. **The following applies to all qualified non-citizens applying for Adult Financial and/or Colorado Works:** As a condition of my eligibility for financial assistance programs 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 United 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 will no longer be eligible for financial assistance from the State of Colorado.

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

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

12. 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 (SSN) and other information from my application to request and receive information or records to confirm the information in my application.** Food Assistance will be denied to individuals that do not provide a Social Security number, and Social Security numbers will be used and disclosed in the same manner for both eligible and ineligible members. **I release the department from all liability for sharing this information with other agencies for this purpose.** For example, the department may get and share information with any of the following agencies: Social Security Administration; Internal Revenue Service; United States Customs and Immigration Services; Colorado Department of Labor and Employment; financial institutions (banks, savings and loans, credit unions, insurance companies, landlords, leasing agents, etc.); child support services; 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.

13. If a Food Assistance, Colorado Works, and/or Adult Financial over-payment occurs against my household, the information on this application, including all Social Security numbers, may be referred to Federal and State agencies, as well as private claims collection agencies for claims collection action.

14. The EBT (or Quest) card is used to pay me most of my public assistance benefits. I cannot trade or sell EBT cards. The only people allowed to use my household's EBT card are members of my household, my authorized representative(s), and individuals outside my household that have my permission to use my EBT card to access benefits for the people in my household. I cannot use my EBT card to access my cash benefits at locations identified as prohibited locations including licensed gaming establishments, in-state simulcast facilities, tracks for racing, commercial bingo facilities, stores or establishments in which the principal business is the sale of firearms, retail establishment licensed to sell malt, vinous, or spirituous liquors, establishments licensed to sell medical marijuana or medical marijuana-infused products, or retail marijuana or retail marijuana products, establishments that provide adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment. **Continued misuse of my EBT card at prohibited locations will cause my cash benefits to be suspended on my EBT card and/or my cash benefits to be terminated for a period of 30 days requiring a new application.**

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

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

17. 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.

18. Colorado Works is not an entitlement program and benefits are not guaranteed. Each county has the authority to determine eligibility requirements and benefit levels. To remain eligible, I may be required to complete an assessment and develop a plan. Unless exempted, I will be required to participate in work readiness activities

19. As an applicant for Colorado Works, if I refuse to cooperate with Child Support Services at the time I apply or while receiving cash assistance through Colorado Works, without good cause, I will not receive assistance or a basic cash assistance grant for my family. Good cause for not working with Child Support can be, but is not limited to; potential physical or emotional harm to a child(ren), parent or caretaker relative; pregnancy or birth of a child related to incest or forcible rape; legal adoption before court or a parent receiving pre-adoption services; or other reasons determined to be in the best interest of the child. In order to cooperate with Child Support Services, I will be required to complete additional documentation concerning the child(ren), parentage of the child(ren) and provide all court documents that concern the child(ren).

20. If I am an adult between the ages of 18 and 49, with no children under the age of 18 in my Food Assistance house, I will only be eligible to receive Food Assistance benefits for three months, unless one of the following applies: I work in a job 80 hours each month and report my hours worked to my local Employment First office, or I meet the Workfare program requirements or work program requirements set by the Employment First office. Additionally, I may continue to receive my Food Assistance benefits if I am determined to be physically or mentally unable to work or if the Food Assistance office identifies other applicable exemptions. If I meet any of these criteria, I will be able to continue receiving Food Assistance as long as I remain eligible.

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

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

23. I cannot use Food Assistance benefits to buy nonfood items, such as alcohol or cigarettes. I can be disqualified for

using Food Assistance to pay for items purchased on credit. **If a court of law finds a person guilty of using Food Assistance benefits to illegally purchase or receive controlled substances that individual shall be disqualified for two years for a first offense and permanently for a second offense. Individuals found by a Federal, State, or local court to have used or received benefits in a transaction involving the sale of firearms, ammunition, or explosives shall be permanently ineligible to receive Food Assistance upon the first occasion of such violation. If a court of law finds a person guilty of having trafficked benefits for an aggregate amount of $500 or more, that individual will be permanently ineligible to receive Food Assistance upon the first occasion of such violation.**

24. The trafficking of benefits means:

a. The buying, selling, stealing, or otherwise effecting an exchange of Food Assistance benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signature, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone ; or,

b. The exchange of Food Assistance benefits or EBT cards for firearms, ammunition, explosives, or controlled substances; or,

c. A Food Assistance participant, including the participant's designated authorized representative, who knowingly transfers Food Assistance benefit to another who does not, or does not intend to, use the Food Assistance benefits for the Food Assistance household for whom the Food Assistance benefits were intended; or

d. The reselling of food that was purchased with Food Assistance benefits for cash; or

e. Obtaining a cash deposit when returning water or other containers that were purchased with Food Assistance benefits. Purchasing water containers is an eligible food item that can be paid for with Food Assistance benefits; however, when the container is returned, the deposit should be returned to the client's EBT card and not given to the client in cash.

f. Attempting to buy, sell, steal, or otherwise affect an exchange of SNAP benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signatures, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone.

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

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

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

28. IEVS refers to the Income Eligibility Verification System. IEVS reports discrepancies between the information you provide and information in the Department of Labor's system as well as Social Security Administration's various systems. Information available through IEVS will be requested, used, and may be verified through collateral contacts when discrepancies are found. This information may affect your eligibility and benefit level.

29. 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.

30. 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 behalf of Health First Colorado clients from the estates of deceased Health First Colorado clients who were permanently institutionalized. For Health First Colorado 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. There are certain exemptions to estate recovery. For further information, please contact your county and request the "Medical Assistance Estate Recovery Program" brochure.

CDHS Nondiscrimination Policy
This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact the USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Compliant Form, (AD-3027), found online at:
http://www.ascr.usda.gov/compliant_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Ave, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at:
http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

Medical Assistance Nondiscrimination Policy
The Department of Health Care Policy and Financing and Connect for Health Colorado do not discriminate on the basis of race, color, ethnic or national origin and expression, marital status, religion, creed, political beliefs, or disability in any of its programs, services and activities. For further information about the Department's policy, to request free disability and/or language aids and services, or to file a discriminating complain, contact: 504/ADA Coordinator, 1570 Grant St., Denver, CO 80203, Phone: 303-866-6010, Fax: 303-866-2828, State Relay: 711, Email: hcpf504ada@state.co.us. For information about Connect for Health Colorado's policy, aids and services or to file a discrimination complaint, contact: General Counsel, 3773 Cherry Creek N. Dr., Suite 1005, Phone: 303-590-9640, Fax: 303-322-4217. Complaints can also be filed with the U.S Department of Health and Human Services Office for Civil Rights at http://www.hhs.gov/ocr/filing-with-ocr/index.html.

For Other Programs: For information about the Colorado Department of Human Services policies, to request free disability and/or language aids and services, or to file a discrimination complaint, contact: 504/ADA Coordinator, 1575 Sherman St Denver, CO 80203, Phone: 303-866-7129, Fax: 303-866-6080, State Relay: 711, Email: CDHSCR@state.co.us. For additional information please visit www.colorado.gov/cdhs.

Civil rights complaints can also be filed with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf or by mail, phone, or fax at: 1961 Stout Street Room 08-148 Denver, CO 80294, Telephone: 800-368-1019, Fax: 202-619-3818, TDD: 800-537-7697. Complaint forms are available at http://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

Domestic violence information and services are available to me. If I ever feel I am in immediate danger I should call 911. If I would like to receive information regarding safety and services in Colorado, I will call the Colorado Coalition Against Domestic Violence at 303-831-9632 or toll free at 1-888-778-7091. I may also find the location of services near me by going to www.colorado.gov/cdhs/dvp. The National Domestic Violence Hotline at 1−800−799−SAFE (7233) or TTY 1−800−787−3224 or 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 physical address for use with state and local government agencies. I can find out more about the ACP at acp.colorado.gov. If I need or receive either of these services, I should tell my department worker.

CONNECT for HEALTH COLORADO

Application for Public Assistance

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

Check the box for each program you would like to apply for.

☐ **Food Assistance**- Known federally as the Supplemental Nutrition Assistance Program (SNAP)
Questions marked with a ■ are NOT required for Food Assistance.

☐ **Cash Programs**- **Questions marked with a ♦ are NOT required for Cash Assistance.**
- ☐ **Colorado Works**- Known federally as Temporary Assistance for Needy Families (TANF)
- ☐ **Adult Financial** – Includes Colorado Supplement to SSI, Aid to the Needy Disabled (State AND), Old Age Pension (OAP), and Home Care Allowance (HCA)

☐ **Medical Assistance**- Including Health First Colorado (Colorado's Medicaid Program), Child Health Plan *Plus* (CHP+), Tax Credits, and Cost Sharing Reductions
Questions marked with a ● are NOT required for Medical Assistance.

Your Legal Name (First, Middle Initial, Last)	Maiden Name	Social Security Number[1]		Date of Birth
Home address (Number, Street)	City	State	Zip	Phone number
Mailing address (if different)	City	State	Zip	Other phone number
Do you speak and read English? ☐Yes No☐ If no, what language do you speak?	Are you homeless? ☐Yes No☐	■Are you a resident of Colorado? ☐Yes No☐		Are you currently residing in a nursing home? ☐Yes No☐

[1] If you are applying for any program and have an SSN, we need this information. Even if you are not applying for benefits, providing your SSN will help us to quickly process your application. We use SSNs to check income and other information to see what you and your household may qualify for.

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

Your signature	Date	■● Spouse's/Co-Applicants signature, if applying (optional)	Date
Authorized Representative, Conservator, Guardian Printed Name		Authorized Representative, Conservator, Guardian Printed Name:	
■● Authorized Representative Signature	Date	■● Authorized Representative Signature	Date
Name, address and phone number of person who helped completed application			

We can send links that allow you to view electronic notices about your case. You may choose more than one option, but if you do not choose, you will receive paper notices by standard mail. I would prefer:
☐Paper notices ☐An email with a link to view your notices sent to _____@_____
(For Medical, if you would like to receive notices electronically, please see Instruction Booklet at Colorado.gov/HCPF/Apply or ConnectforHealthCO.com/About-Us/Customer-Resources)

Household Demographics

Legal Name (First, Middle, Last)	Relation to you	Birth Date	■Male/ Female (M/F)	Does this person want benefits ?	■Married, Civil Union, Domestic Partnership, Single, Divorced, Separated, Widowed	● Hispanic or Latino?[1]	● Race[1]	■● Social Security Number[2]	US Citizen or US National
	SELF	Page 1		❑Yes ❑No		❑Yes ❑No		Page 1	❑Yes ❑No
		__/__/__		❑Yes ❑No		❑Yes ❑No			❑Yes ❑No
		__/__/__		❑Yes ❑No		❑Yes ❑No			❑Yes ❑No
		__/__/__		❑Yes ❑No		❑Yes ❑No			❑Yes ❑No
		__/__/__		❑Yes ❑No		❑Yes ❑No			❑Yes ❑No

[1] Race and ethnicity information is optional, and will not affect eligibility; rather it is collected to ensure that benefits are provided to all eligible applicants regardless of race/color/national origin. **Race options include:** American Indian/Alaskan Native- **AI**; Asian - **A**; Black/African American- **B**; Native Hawaiian/ Other Pacific Islander- **NH**; White- **W**

[2] If you are applying for any program and have an SSN, we need this information. Even if you are not applying for benefits, providing your SSN will help us to quickly process your application. We use SSNs to check income and other information to see what you and your household may qualify for.

Is anyone in the home considered a roomer or boarder (they rent a room from you)?	❑Yes No❑ *If yes, list below*	
Name	Amount paid for rent	Are meals included with the rent?
	$	❑Yes No❑
	$	❑Yes No❑

Is there any household member temporarily out of the home in any type of facility or institution?			❑Yes No❑	*If yes, list below. Examples of types of institutions are listed be at the bottom of the table*	
Name	Date entered	Name of facility	Type of facility	Is this person pending disposition of charges?	Are meals provided?
				❑Yes No❑	❑Yes No❑
				❑Yes No❑	❑Yes No❑

Examples: Nursing home• Hospital • Mental health institution • Incarceration

Emergency Details

Including yourself, how many people in your home do you buy and prepare food for?		Is anyone in the home a migrant or seasonal farm worker?	❑ Yes No ❑
Total money my household expects to get this month (before deductions)	$	Total cash on hand and money in your checking/savings account	$
Amount you pay for rent or mortgage	$	Home insurance/Property Taxes/HOA fees	$
Utilities you pay for (check all that apply)	Heating/Cooling ❑ $_____ Electricity ❑ $_____ Water ❑ $_____ Phone ❑ $_____ Trash ❑ $_____ Sewer ❑ $_____ Other❑ $_____		

●**Did anyone in the home get any food or cash benefits in any other state in the last 30 days?**	❑Yes No❑ *If yes, list below*
■ **If you are applying for Colorado Works, have you received benefits from any other state since 1996?**	❑Yes No❑ *If yes, list below*

Name(s)	Date of receipt	City	County	State

Dependent Children

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

Do any of the children living in the home have a parent living outside the home?	❑Yes ❑No	If yes, have you tried to get medical support from the child's parent living outside the home?	❑Yes ❑No

Name of Parent	Address	Phone	For which child?

I would like to apply for good cause from pursuing Child Support Services Assistance allowable under the Family Violence Option Waiver (as described in the What I Should Know section) ❑Yes No❑

Is anyone in the home currently in foster care or has ever been in foster care?	❑Yes No❑ *If yes, list below*

Name	Age	Dates when in foster care

Pregnancy Details

Is anyone in the home pregnant?	❑Yes No❑ *If yes, list below*	
Name:	Due date:	Number of babies expected:
Name of the father, if known:		
Would you like to pursue good cause from pursuing Child Support Services Assistance? ❑Yes No❑		

Disability Details

Does anyone in your home have a disability?	❑Yes ❑No	Name:					
If yes, does this person need help with self-care activities (bathing, dressing, eating, using the bathroom, etc.)?	❑Yes No❑						
Does anyone have a medical or developmental condition that has lasted, or is expected to last more than 12 months?	❑Yes No❑ Name:						
Have you or anyone in the home applied for Supplemental Security Income (SSI) or other Social Security benefits?	❑Yes ❑No *If yes, list below*						
Name		What Program?	❑SSI ❑_____	Date of Application	___/___/___	Application Status	❑Pending ❑Approved ❑Denied ❑Appealed
Name		What Program?	❑SSI ❑_____	Date of Application	___/___/___	Application Status	❑Pending ❑Approved ❑Denied ❑Appealed
If no, has anyone who is disabled ever received SSI or SSDI?	❑Yes No❑	If yes, when did SSI or SSDI end?	___/___/___				

Non-Citizen Details

Is anyone who is applying for benefits a non-citizen?	❑Yes No❑	If yes, you may be asked to provide a copy of your U.S. Citizenship and Immigration Services card.	
Non-Citizen 1			
Name of Non-Citizen 1:		Non-Citizen Status:	
Alien or I-94 Number:		Card/Passport Number:	
Document Expiration Date:		Country of Issuance:	
Is the non-citizen's spouse or parent a veteran or active-duty member of the US military?	❑Yes ❑No	Has this person lived in the US since 1996?	❑Yes No❑
Non-Citizen 2			
Name of Non-Citizen 2:		Non-Citizen Status:	
Alien or I-94 Number:		Card/Passport Number:	
Document Expiration Date:		Country of Issuance:	
Is the non-citizen's spouse or parent a veteran or active-duty member of the US military?	❑Yes ❑No	Has this person lived in the US since 1996?	❑Yes ❑No

Are any of the non-citizens listed above sponsored to remain in this country?	❑Yes No❑ *If yes, list below*

Sponsor (please add additional pages if there is more than one sponsor)

Who is sponsored?			
Name of sponsor:		Name of sponsor's spouse:	
Sponsor's Social Security Number		● Sponsor's spouse's Social Security Number	
Sponsor's address:		Total number of people in sponsor's household?	

Does the sponsored individual live with the sponsor?	❑Yes No❑
Does the sponsored individual receive free room and board from the sponsor?	❑Yes No❑
Does the sponsored individual receive any support from their sponsor?	❑Yes No❑
Has the sponsored individual been abandoned, mistreated or abused by their sponsor?	❑Yes No❑

Earned Income

Does anyone work or is anyone starting a new job?	❑Yes No❑ *If yes, list below*

Job 1:	Name of person who is or will be working:		
Employer name and phone number:			
Monthly wages/tips (before taxes):	Hourly wage:	Average hours worked each week:	
How often is this person paid? ❑Hourly ❑Weekly ❑Every 2 weeks ❑Twice a month ❑Monthly ❑Yearly ❑Daily			
Is this job considered temporary and expected to last less than 3 months? ❑Yes No❑			
♦Is this income from? ❑ Seasonal Employment ❑ Commission-based Employment (including tip jobs)			

Job 2:	Name of person who is or will be working:		
Employer name and phone number:			
Monthly wages/tips (before taxes):	Hourly wage:	Average hours worked each week:	
How often is this person paid? ❑Hourly ❑Weekly ❑Every 2 weeks ❑Twice a month ❑Monthly ❑Yearly ❑Daily			
Is this job considered temporary and expected to last less than 3 months? ❑Yes No❑			
♦ Is this income from? ❑ Seasonal Employment ❑ Commission-based Employment (including tip jobs)			

Is anyone in the home considered self-employed? This includes, but is not limited to, earning money from babysitting, selling goods such as make-up or kitchenware, selling goods on the internet or selling homemade/homegrown food products?	❑Yes No❑ *If yes, list below*

Name of individual that is self-employed:		Business name (if applicable):	
One month's gross income $		Month of this income:	
Type of self-employment: ❑ Sole Proprietor ❑ LLC ❑ S-Corp ❑ Independent Contractor			
Utilities paid for business: $_____	Business taxes paid: $_____	Interest paid for business: $_____	Gross business labor costs: $_____
Cost of merchandise $_____	Other business cost: Type: $_____	Other business cost Type: $_____	Other business cost: Type: $_____
Total Net Income (Subtract your expenses from your gross income):			

Has anyone in the home quit a job, lost a job, or reduced their work hours in the past 30 days?	❑Yes No❑ *If yes, list below*

Name of person:		Employer name and phone number:
Start date of job:	End date of job:	Monthly wages/tips (before taxes):
Date and amount of last paycheck:		How often was this person paid? ❑Monthly ❑Yearly ❑Hourly ❑Weekly ❑Every two weeks ❑Twice a month

Unearned/Other Income

Does anyone have other types of income?	❑Yes No❑ *If yes, list below. Examples of other types of income are listed at the bottom of the table*

Name	Type of Money/Income	Monthly Amount

Examples include but are not limited to: Unemployment benefits • SSI • Veterans' benefits • Widow Benefits • Workers' Comp • Railroad Retirement • Child Support • Survivor's Benefits • Dividends/Interest • Rental income • Money from a boarder • Disability benefits • Retirement/pension • SSDI • Alimony • In-kind income (Working for rent) • Social Security benefits • Public Assistance • Plasma donations • Gifts • Loans • Foster Care payments • Tribal Benefits

Has anyone who is applying received (or expects to receive) a lump sum payment?	❑Yes No❑ *If yes, list below. Examples of types of lump sums are listed at the bottom of the table*

Name	Date Received	Type of Lump Sum	Amount

Examples: Lawsuit settlement • Insurance settlement • Social Security, SSI, SSDI Payment • Veterans • Inheritance • Surrender of Annuity • Life Insurance payout • Lottery/gambling winnings

Is anyone in the home on strike?	❑Yes No❑ *If yes, list below*
Name:	Date strike began:
Date of last check:	Amount of last paycheck:

Expenses

Does anyone pay child or adult daycare, legally-obligated child support, child support arrears, medical expenses[1], student loan interest and/or alimony?				❑Yes No❑ *If yes, list below*		
Expense	Who Pays	Is this person outside of the home?	Who is this expense for?	Month of expense	Amount Paid	Legally Obligated Amount
		❑Yes No❑			$	$
		❑Yes No❑			$	$
		❑Yes No❑			$	$

For Food Assistance, medical expenses are only allowed for persons disabled and/or 60 years old or over. Some examples of medical expenses include prescriptions, medical/dental/eye, co-pays, insurance premiums and in-patient care. Amounts which are reimbursed by a 3rd party are not to be claimed.

Student Details

Does anyone in the home attend high school, vocational, trade school or college?	❑Yes No❑ *If yes, list below*	*For Food Assistance, student information is only required for individuals between the ages of 18 and 49 unless a person under the age of 18 is the head of household.*

Name	Name of School	Last Grade Completed	Start date	Expected Graduation Date	Are you a full-time student?
					❑Yes No❑
					❑Yes No❑

Is anyone in the home receiving financial aid (grants or scholarships), work study income or income through a GI Bill?	❑Yes No❑ *If yes, list below*

Who:	
What is the amount ($) of Grants, Scholarships, and/or Work Study used for living expenses this month? $_____	
What is the taxable amount ($) of Grants, Scholarships, and/or Work Study this person received for the year? $_____ - If you need Medical Assistance, you will need this information	

Living Expenses Examples: Food • Clothing • Housing • Transportation • Utility Costs • Insurance • Other

Resources

INFORMATION ABOUT RESOURCES IS NOT REQUIRED FOR COLORADO WORKS

Does anyone in the home have any resources, including those that are jointly owned with someone else?	❑Yes No❑	*If yes, list below. Examples of types of resources are listed at the bottom of the table.*		
Name	Type of resources	Name of financial institution	Account number	Current value
				$
				$

Examples: Cash on-hand • Checking and Savings accounts • Stocks • Bonds • Mutual funds • 401Ks • IRAs • Trusts • CDs • Annuities • College funds • PASS accounts • IDAs • Promissory notes • Education accounts

Does anyone own a vehicle, including cars, trucks, motorcycles, trailers, boats, snowmobiles, and other recreational vehicles?		❑Yes No❑ *If yes, list below*
Name	Year, make and model	Current value
		$
		$

Does anyone have life insurance policies or burial insurance policies?		❑Yes No❑ *If yes, list below*		
Who	Company & Policy Number	Type	Revocable or Irrevocable?	Value
		❑Burial policy ❑Insurance policy	❑Revocable ❑Irrevocable	$
		❑Burial policy ❑Insurance policy	❑Revocable ❑Irrevocable	$

Does anyone in the home own any property (including your home)?			❑Yes No❑ *If yes, list below*	
Name/owner of property	Property type	Property address	Value	Primary use for this property (choose one)
			$	❑Primary Home ❑Rental income ❑Business/self-employment ❑Other:
			$	❑Primary Home ❑Rental income ❑Business/self-employment ❑Other:

Has anyone in the home sold, transferred or given away cash, property, or other assets within the last five years? [1]			❑Yes No❑ *If yes, list below*	
Name	Date of Transfer	What Asset?	Amount Received	Fair Market Value
			$	$
			$	$

[1] If you are only applying for Food Assistance; you only need to declare for the last 3 months. For AND, OAP, HCA and CS-SSI, you only need to declare for the last 36 months (3 years).

Prior Convictions

THESE QUESTIONS ARE ONLY REQUIRED FOR FOOD ASSISTANCE, COLORADO WORKS AND ADULT FINANCIAL If you are applying for Medical Assistance, please skip to the next section.	
1. Have you or any member of your home been convicted of, or disqualified for, fraudulently receiving duplicate Food Assistance benefits in any state after 9/22/1996?	❑Yes No❑ Who:
2. Are you or any member of your home hiding or running from the law to avoid prosecution, being taken into custody, or going to jail, for a felony crime or attempted felony crime, or violating a condition of parole or probation?	❑Yes No❑ Who:
3. Have you or any member of your home been convicted of a felony under federal or state law for possession, use, or distribution of a controlled drug substance (felony drug conviction) or for a crime while under the influence of a controlled drug substance after 8/ 22/1996?	❑Yes No❑ Who:
4. Have you or any member of your home been convicted of, or disqualified for, buying or selling, or attempting to buy or sell, Food Assistance benefits for more than $500 after 9/22/1996?	❑Yes No❑ Who:
5. Have you or any member of your home been convicted of trading Food Assistance benefits for guns, ammunitions, explosives, or drugs after 9/22/1996?	❑Yes No❑ Who:
6. Have you or any member of your home applying for assistance ever been disqualified for an Intentional Program Violation or been convicted of welfare fraud in a criminal case?	❑Yes No❑ Who:
7. Have you or any member of your home been convicted of aggravated sexual abuse, murder, sexual exploitation and abuse of children, sexual assault as defined in the Violence Against Women Act of 1994, or a similar state law, and is also not in compliance with the terms of their sentence?	❑Yes No❑ Who:

IF YOU ARE ONLY APPLYING FOR FOOD ASSISTANCE YOU MAY STOP HERE.

Has anyone in the home been in the military? ❑Yes No❑	If yes, who?

If you need help to pay your burial/funeral costs, would you prefer: ❑Cremation ❑Burial ❑No Preference

Lawful Presence Affidavit

AFFIDAVIT

for the Colorado Department of Human Services as Proof of Lawful Presence in the United States

I, _____, swear or affirm under penalty of or perjury under the laws of the State of Colorado that:

Check only one box

- ❑ **I am a United States citizen, or**
- ❑ **I am not a United States Citizen but am a legal Permanent Resident of the United States, or**
- ❑ **I am not a United States Citizen or a legal Permanent Resident but am lawfully present in the United States pursuant to federal law.**

I understand that this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Signature: Date:

AFFIDAVIT

for the Colorado Department of Human Services as Proof of Lawful Presence in the United States

I, _____, swear or affirm under penalty of or perjury under the laws of the State of Colorado that:

Check only one box

- ❑ **I am a United States citizen, or**
- ❑ **I am not a United States Citizen but am a legal Permanent Resident of the United States, or**
- ❑ **I am not a United States Citizen or a legal Permanent Resident but am lawfully present in the United States pursuant to federal law.**

I understand that this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received

Signature: Date:

IF YOU ARE ONLY APPLYING FOR COLORADO WORKS OR ADULT FINANCIAL ASSISTANCE YOU MAY STOP HERE.

Retroactive Medical Coverage

Does anyone want help paying for medical bills from the last 3 months?	❑Yes No❑	
Who	Month(s)	Household income in that month(s)

Tax Filer Information

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

Do you plan to file a Federal Income Tax Return NEXT YEAR?	❑Yes No❑ *If yes, list below*		
Filing jointly with a spouse?	❑Yes No❑	Name of spouse:	
Claiming dependent(s)?	❑Yes No❑	Name of dependent(s):	
Expects to be claimed as a dependent on someone else's tax return that does not live at your address? ❑Yes No❑ If yes, *list* below			
Claimed as a dependent?	*❑Yes No❑*	*Name of person claiming you:*	
Is this person listed on the application?	*❑Yes No❑*	*Is this person a non-custodial parent?*	*❑Yes No❑*
If you indicated that you are a tax filer and that you are Married, Filing Separately on your tax forms, do Exceptional Circumstances (that you have been a victim of domestic violence) apply to your case? ❑Yes No❑			

Does anyone else in the home plan to file a Federal Income Tax Return NEXT YEAR?	❑Yes No❑	Name:
Filing jointly with a spouse?	❑Yes No❑	Name of spouse:
Claiming dependent(s)?	❑Yes No❑	Name of dependent(s):
Expects to be claimed as a dependent on someone else's tax return that does not live at your address? ❑Yes No❑ If yes, list below		
Claimed as a dependent?	*❑Yes No❑*	*Name of person claiming them:*

Is this person listed on the application?	❑Yes No❑	*Is this person a non-custodial parent?*	❑Yes No❑
If they indicated that they are a tax filer and that they are Married, Filing Separately on your tax forms, do Exceptional Circumstances (that you have been a victim of domestic violence) apply to their case? ❑Yes No❑			

Does anyone else in the home plan to file a Federal Income Tax Return NEXT YEAR?	❑Yes No❑	Name:	
Filing jointly with a spouse?	❑Yes No❑	Name of spouse:	
Claiming dependent(s)?	❑Yes No❑	Name of dependent(s):	
Expects to be claimed as a dependent on someone's tax return that does not live at your address? ❑Yes No❑ If yes, list below:			
Claimed as a dependent?	❑Yes No❑	*Name of person claiming them:*	
Is this person listed on the application?	❑Yes No❑	*Is this person a non-custodial parent?*	❑Yes No❑
If you indicated that you are a tax filer and that you are Married, Filing Separately on your tax forms, do Exceptional Circumstances (that you have been a victim of domestic violence) apply to your case? ❑Yes No❑			

Health Insurance Coverage

Does anyone in your home qualify for or have health insurance/coverage?[1]			❑Yes No❑ *If yes, list below*
Name(s)	Type of Coverage	Coverage Dates	Is this person enrolled?
			❑Eligible ❑Enrolled
			❑Eligible ❑Enrolled
			❑Eligible ❑Enrolled
			❑Eligible ❑Enrolled

[1] *Types of coverage: Medicare •TRICARE • VA Health Care • Peace Corps • COBRA • Retiree Health Plan •Current Employer Sponsored Health Coverage • Railroad Retirement Insurance*

If you listed that someone in your home is enrolled in TRICARE, Peace Corps, VA Health Care Program, or other state or Federal Health Benefit Program, complete the table below.
Type/Name of Program:
Who is currently enrolled in this health coverage?
Insurance Company Name:
Policy number:

If you listed that someone in your home has access to health insurance from a job, complete the table below. This includes if the coverage is from someone else's job such as a parent or a spouse OR if you have COBRA or a Retiree Health Plan.	
Employer Name:	Employer Identification Number:
Employer Address:	
Employer Phone:	Who can we contact about your coverage?
Date you could start coverage:	Date you lost coverage:
Who else in the Household had access to this coverage?	Who else in the Household was enrolled in this coverage?
How much would you need to pay in premiums: $	❑I don't know
How often would you pay them? ❑Weekly ❑Every 2 Weeks ❑Twice a month ❑Monthly ❑Yearly	
Do you have access to an employee-only health plan that meets the minimum value standard[1] health plan? ❑Yes ❑No	
If Yes, what is the name of the lowest-cost plan that meets the minimum value standard offered only to the employee? ❑ I don't know ❑No plans meet the minimum value standard	
[1] An employer-sponsored health plan meets the "minimum value standard" if the employer pays for 60% of the allowed health plan benefits. You would pay 40%.	

If you or anyone in your household is enrolled in Medicare, complete the table below. For Part C coverage, please complete if you will be entitled or enrolled in the month in which you would like to purchase private health insurance.			
Medicare Part A	Medicare Part B	Medicare Part C	Medicare Part D
Are you entitled to or receiving Part A? ❑Yes No❑	Are you entitled to or receiving Part B? ❑Yes No❑	Are you entitled to or receiving Part C (Medicare Advantage) ❑Yes No❑	Are you entitled to or receiving Part D? ❑Yes No❑
When did your Part A begin?	When did your Part B begin?	When did you part C begin?	When did your Part D begin?
Are you currently enrolled ❑Yes No❑	How much is your Part B premium:$_____		How much is your Part D Premium $_____
Who pays for your Part A premium? _____	Who pays for your Part B premium? _____		Who pays for your Part D Premium? _____
Is your Part A Premium Free? ❑Yes No❑			

Are you or anyone in your home being treated for an injury that you have brought or may bring a legal claim? ❑Yes No❑
Name:

Individuals that are 18 years or older can get their own mail about their health coverage at a different address. Do any individuals that are over 18 want to receive their own mail?	❑Yes No❑ *If yes, list below*

Name	Address

Expected Income Change

Does the income in your household change from month to month?	❑Yes No❑ *If yes, list below*	
Name	Annual income from your job and employer name	Will the Annual income be the same or lower in the next calendar year?
	$	❑Yes No❑
	$	❑Yes No❑

Reasons for Income Differences

After you submit your 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 the verification process:

Name	What Happened?
	❑Stopped working a job ❑Hours changed at a job ❑Change in employment ❑Married, legal separation, or divorce ❑Other
	❑Stopped working a job ❑Hours changed at a job ❑Change in employment ❑Married, legal separation, or divorce ❑Other

Does anyone in your household have any job or non-job related deductions? Check all that apply. Provide 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 previous answer to job income and net self-employment.

Do the deductions change month to month? ❑Yes No❑	*If yes, fill out both the current amount and the actual annual amount*	
Deduction Type and How Often	Current Amount	Actual Annual Amount
Type_____ ❑One Time only ❑Weekly ❑Every 2 weeks ❑Twice a month ❑Monthly ❑Yearly	$	$
Type_____ ❑One Time only ❑Weekly ❑Every 2 weeks ❑Twice a month ❑Monthly ❑Yearly	$	$
Type_____ ❑One Time only ❑Weekly ❑Every 2 weeks ❑Twice a month ❑Monthly ❑Yearly	$	$

Example: • Alimony Paid • Capital Losses • Penalty on Early Withdrawal of Savings •Student Loan Interest • Domestic Production Activities • Reimbursement of Expenses • HSA deduction • Moving Expenses •Contribution made to your Traditional IRA •Certain Business Expenses of Reservists, Performing Artists, or Fee based Government Officials

Did anyone in your household have income and deductions 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, tell us the amount of the past income and deductions. ***Do not*** *include any ongoing or future income or deductions.*	
Amount of past Income: $_____	
Amount of past Deductions: $_____	

American Indian or Alaska Native Information

American Indians and Alaska Natives can get services from the Indian Health Service, tribal health programs, 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 that includes money from these sources:

•Per capital 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)

•Money from selling things that have cultural significance

Is anyone in your home an American Indian or Alaska Native?			❑Yes No❑ *If yes, list below*	
Name	Tribe Name	Tribe State	Type of Income Received	Frequency and Amount

Has anyone in the household ever received a service from the Indian Health Service, a Tribal health program, Urban Indian Health program or through a referral from one of these programs?	❑Yes No❑ *If yes, list below*
Name:	
Name:	

If none, who in the household is eligible to receive services from Indian Health Service, Tribal health programs, Urban Indian Health Programs or through a referral from one of these programs?	❑Yes No❑ *If yes, list below*
Name:	
Name:	

Permission to Validate Income

As part of the eligibility process, we are required to verify information that you have provided to us for this application. By checking the box below, you indicate that Connect for Health Colorado DOES NOT have permission to verify income information from tax returns. By not allowing the use of this data, you understand that Connect for Health Colorado will send you a letter requesting that you provide proof of information for your household, including your annual income. **If you do not provide the requested proof of your household's income tax return information within 90 days of the request, you will be determined ineligible for Advance Premium Tax Credits/Cost Sharing Reductions (APTC/CSR).**

❑ **I DO NOT give Connect for Health Colorado permission to validate my income data against federal sources.**

AUTHORIZED REPRESENTATIVE INFORMATION FOR MEDICAL ASSISTANCE

For Medical only you can choose an Authorized Representative. An Authorized Representative is a trusted person or organization who you choose to help you with your application. We need your permission in order for your Authorized Representative to talk with us about this application, see your information, and act for you on all issues related to your health coverage. If you ever want to change your Authorized Representative, or no longer want an Authorized Representative, contact Health First Colorado & CHP+ or Connect for Health Colorado.

Is your Authorized Representative an: ❑ Individual ❑ Organization:	
Authorized Individual/Organization Name:	
Company/Organization ID Number (is applicable):	
Authorized Individual/Organization's Address:	
In Care Of (If applicable):	
City, State, Zip Code, County:	
Telephone Number:	Email Address:
Do you want your Authorized Representative to receive copies of your notices/communications?	❑Yes No❑
By signing, you allow the Authorized Representative to sign your application, get information about the application, and act for you on all future matters with this agency and/or Connect for Health Colorado.	
Applicant's Signature	Date: (mm/dd/yyyy)

By signing, I agree to fulfill all responsibilities within the scope of the authorized representation that the individual who I represent is required to fulfill. I agree to maintain the confidentiality of any information regarding the applicant or client provided by the agency or Connect for Health Colorado in compliance with state, federal, and all other applicable laws.

If an Authorized Representative is an organization, the signature of an organizational contact who is either a provider, staff member, or volunteer of the organization is required.

As a provider, staff member or volunteer of an organizations which is an Authorized Representative, I affirm that I will adhere to the regulations in 42 CFR §431, Subpart F and to 45 CFR §155.260(f), and 42 CFR §447.10, as well as all other relevant state and federal laws concerning conflicts of interests and confidentiality of information.

If you have been given the legal authority to act as an Authorized Representative on the applicant or client's behalf through some means other than assignment through this Worksheet, you will need to affirm that you have that authority and provide the appropriate documents verifying that you have that authority.

I, affirm that I have legal authority to act on behalf of the applicant or client. (Please provide a copy 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 applicant or client.)

Authorized Representative/Organizational Contact Signature	Date: (mm/dd/yyyy)