

**REQUIREMENTS FOR CARE CARD APPLICATION**

1. **Care Card Application Form**
2. **Proof of Address**
3. **Proof of identification for ALL family members living in the SAME household. Photo ID for adults is preferred. Adult children over 18 in higher education MUST furnish student ID**
4. **Proof of income**

**Unearned Income:**

* Unemployment or Worker’s Compensation
* social security or Supplemental security income (SSI)
* Public assistance
* Veterans’ benefits
* Survivor benefits
* Disability benefits
* Pension or retirement income
* interest or dividends
* Rents, royalties, estates and trusts
* Alimony
* Child support
* Self-declaration of income

**Earned Income: Please bring ONE (1) of the following for all employed family members:**

* Last calendar month pay stubs
* Income Verification letter from your employer (**gross** income, estimated tips, if applicable, dated within the last 30 days, on company letterhead to include address, phone number, and contact for employer)
* Taxes from prior year, W2, Form 4506-T

**Self Employed:** **Please bring ONE (1) of the following:**

* Taxes
* Profit and Loss statement
* One month of gross bank business deposits or ledger
* Summit Community Care Clinic Self-employment worksheet

**If you are homeless, please ask to speak to the Eligibility Representative.** If you have any questions regarding documentation required, or would like to talk with an Eligibility Coordinator, please call (970)668-4040

**CARE CARD APPLICATION FORM**

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| Name of the applicant | Social Security # | Date of Birth |
| Physical Address | City, State, Zip Code | Phone # |
| PO Box # | City, State, Zip Code | Insurance:  **Y N** |

***Please list spouse and dependents under 18 years old who live with you:***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NAME** | **DATE OF BIRTH** | **SOCIAL SECURITY #** | **RELATIONSHIP WITH APPLICANT** | **PATIENT HAS INSURANCE** | **APPLYING FOR CARE CARD** |
|  |  |  |  | **Y N** | **Y N** |
|  |  |  |  | **Y N** | **Y N** |
|  |  |  |  | **Y N** | **Y N** |
|  |  |  |  | **Y N** | **Y N** |
|  |  |  |  | **Y N** | **Y N** |
|  |  |  |  | **Y N** | **Y N** |
|  |  |  |  | **Y N** | **Y N** |

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| **DECLARATION OF INCOME:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **INCOME SOURCE** | **SELF** | **SPOUSE** | **OTHER** | **TOTAL** |
| Earned , Unearned,  Self Employed Income |  |  |  |  |

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| **APPLICATION FOR MEDICAID/CHP+** |

I grant permission to Summit Community Care Clinic to apply for Medicaid/CHP+ on behalf of myself and/or family members as noted above

Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

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| **CERTIFICATION** |

I certify that the family size and income information above is correct

Name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

V: 11-16-2020



**CARE CARD APPLICATION CHECK LIST**

**For Internal Use Only**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Applicant Name** | | |  | | | | | | | | | | | |  |  | |
|  | | | | | | |  | |  |  | | |  | |  |  | |
|  |  |  | |  |  |  | |  |  | |  | | |  |  | |  | |
| Employee Initials |  | Date Received | |  |  |  | |  |  | |  | | |  |  | |  | |
|  |  |  | | Received Application complete and Sign with items provided marked and completed | | | | | | | | | | |  | |  | |
|  | | | | | | | | | | | | | | | | | | |
| **Please make copies of the following:** | | | | | | | | | | | | | | | | | | |
| Employee Initials |  | Date Received | |  | | | | | | | | | | | | | | |
|  |  |  | | **ALL FAMILY MEMBERS IDENTIFICATION:** | | | | | | | | | | | | | | |
|  |  |  | | \*Examples of approved identification: Colorado Driver’s License, Colorado Issued ID, Passport, Other state ID, | | | | | | | | | | | | | | |
|  |  |  | | ID from your country, ID from your employer, Green card, School ID | | | | | | | | | |  |  | |  | |
| Employee Initials |  | Date Received | |  | | | | | | | | | |  |  | |  | |
|  |  |  | | **PROOF OF INCOME**: | | | | | | | | | |  |  | |  | |
|  |  |  | | Examples of approved income:  \*Last 30 days of consecutive pay stubs | | | | |  | |  | | |  |  | |  | |
|  |  |  | | \*Income Verification letter from your employer (gross income, estimated tips, if applicable, dated within the last | | | | | | | | | | | | | | |
|  |  |  | | \*30 days, on company letterhead to include address, phone number, and contact for employer) | | | | | | | | | | | | |  | |
|  |  |  | | \*Taxes from prior year, or W2's | | | |  |  | |  | | |  |  | |  | |
|  |  |  | |  | | | | | | |  | | |  |  | |  | |
|  |  |  | | If Self Employed, one of the following will be required: | | | | | | |  | | |  |  | |  | |
|  |  |  | | \*Unemployment | |  | |  |  | |  | | |  |  | |  | |
|  |  |  | | \*Workers Compensation | | | |  |  | |  | | |  |  | |  | |
|  |  |  | | \*Social security or Supplemental | | | |  |  | |  | | |  |  | |  | |
|  |  |  | | \*Public Assistance | |  | |  |  | |  | | |  |  | |  | |
|  |  |  | | \*Veteran's Benefits | |  | |  |  | |  | | |  |  | |  | |
|  |  |  | | \*Survivor Benefits | |  | |  |  | |  | | |  |  | |  | |
| Employee  Initials |  | Date Received | |  | | | | | | |  | | |  |  | |  | |
|  |  |  | | **PROOF OF ADDRESS:** | | | | | | |  | | |  |  | |  | |
|  |  |  | | Examples of approved income:  \*Xcel bill (electricity) | | | | | | | |  | |  |  | |  | |
|  |  |  | | \*Dish or Comcast bill | | | | | | |  | | |  |  | |  | |
|  |  |  | | \*Lease showing | | | | |  | |  | | |  |  | |  | |
|  |  |  | | \*Mortgage Receipt | | | | |  | |  | | |  |  | |  | |
| Employee  Initials |  | Date Received | |  | | | | | | |
|  |  |  | | **AFFIDAVIT IF APPLICABLE FOR SENIOR DENTAL PLAN** | | | | | | |

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| **DO NOT RECEIVE APPLICATIONS WITH LACK OF INFORMATION, PLEASE RETURN TO THE PATIENT UNTIL THEY PROVIDE ALL THE REQUIREMENTS** |