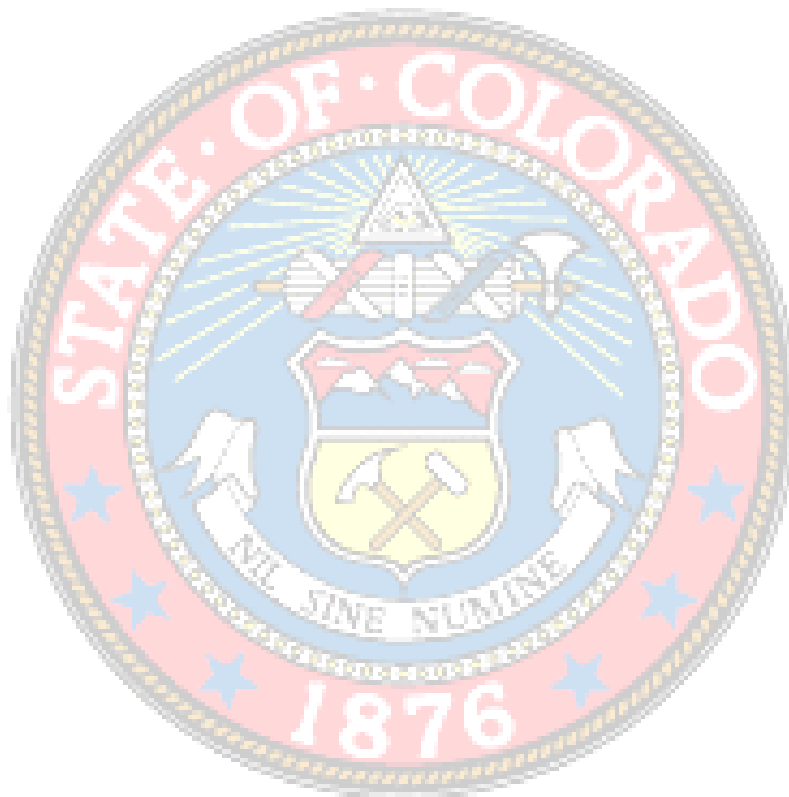

State of Colorado
Department of Human Services
Department of Health Care Policy and Financing

Information

You Need To Know



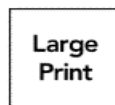
This application can be downloaded at:

www.cdhs.state.co.us or www.chcpf.state.co.us.

Available Services/accommodations



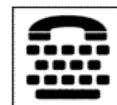
Handicap
Accessible



Vision Impaired



ASL TDDY



Language
Interpreters



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

Take this section with you.

You may use this application to apply for any of the programs listed below at the county Department of Social Services where you live.
Anyone has the right to apply for help at any time.

Do I have to be a U.S. citizen to apply for assistance?

Please do not let the fear of the U.S. Citizen and Immigration Services (U.S.C.I.S.) stop you from seeking benefits for your family. Receiving health coverage and food stamps for your eligible children will not stop you from gaining lawful permanent residence or U.S. citizenship, but receiving other types of aid may.

You do not have to provide a Social Security Number, nor will we contact U.S.C.I.S., for anyone not seeking benefits.

How do I apply for assistance?

To apply you must complete an application and turn it in at the county department where you live.

- You may mail, fax or drop it off in person.
- You may be required to attend an interview.
- You may have family, friends or the county help you complete this form.

What will I need to provide?

Sending copies or bringing the following items with your application may help you get your benefits quicker. (You may not need all these items to apply.) Tell your county worker if you cannot get these (he or she will help):

- Your identification, such as picture ID or drivers license;
- Social Security numbers or proof of application for everyone requesting benefits. If you state on the application that you have a Social Security Number, you will need to provide proof.
- Proof of current wages or income for your household, such as pay stubs, award letter, employer letter, Social Security, child support;
- Proof of resources (assets), such as checking, savings, vehicles, CD's, IRA's, stocks, life insurance, burial policies;
- Proof of status in this country such as Visa, Legal Permanent Resident Card, Passport, or Employment Authorization Card for everyone you are applying for;
- If someone is pregnant, proof of when the baby is due (letter or statement from a health care provider or doctor);
- Information on any parent(s) not living in the home of the children you are applying for;
- Health insurance card or policy; and/or
- Proof of expenses such as day care, rent, mortgage, utilities, child support or medical costs.



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The Programs We Offer



Food Assistance

This is a program to assist with the cost of food. Anyone may apply. If you are eligible for this assistance, you must receive your benefits within certain time frames (see page 4 under "Processing Time"). If you need food right away and you meet certain guidelines, you will be entitled to expedited food stamps.

For Food Stamps, you must provide proof of your alien status if you are not a United States citizen. Citizenship is only verified if it is questionable, If you are not applying but part of the household, no alien documentation or Social Security numbers are required.

You can immediately file an application with the applicant's name, address and signature of a responsible household member or household's authorized representative.

Benefits will be paid from the filing date. The filing date is different if the household is in an institution and applying for Food Stamps and SSI at the same time. In this case, the filing date is the date of release from the institution. The filing date is the date your application is received in the food stamp office.

The Food Stamp household must have an interview. You can leave the first page and take the application home to complete. You then can bring, mail or fax the application to the Food Stamp office.

You may claim actual expenses for your utilities or you may use the Standard Utility Allowance, which may be higher than your actual expenses. (Ask your worker to explain)

You may use an authorized representative to apply for Food Stamps and another, separate authorized representative to use your EBT card.

Title VI of the Civil Rights Act of 1964 allows the State to ask for racial/ethnic information. You do not have to state your racial/ethnic information and not giving the information will not affect the application. Your county worker will complete this information if it is not answered.

You have a right to request a fair hearing orally or in writing if you disagree with any action taken on the case.



Cash Assistance

- **Colorado Supplement to SSI (Supplemental Security Income)** This program is for persons who are receiving SSI but not receiving the full SSI amount.
- **Colorado Works/TANF (Temporary Assistance for Needy Families)** Through the Colorado Works Program, counties provide family stabilization assistance and other supportive services to enable eligible low-income families to find and retain employment and to provide for their children. Assistance and services provided include child care, housing and transportation, cash payments, counseling for those experiencing domestic violence, mental health or substance abuse problems, and services aimed to reduce the incidences of out-of-wedlock births and encourage the formation and maintenance of two parent families.
- **Old Age Pension (OAP)** This is a cash assistance program for low-income persons, ages 60 or over, and may include medical assistance.



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Cash Assistance-Continued

- **State Aid to the Blind (AB)** This program is for persons, ages birth–59, who are blind. This is a cash assistance program and does not include medical benefits.
- **State Aid to the Needy Disabled (AND)** This program is for persons, ages 18–59, who are totally disabled for at least 6-months. This is a cash assistance program and does not include medical benefits.
- **Home Care Allowance (HCA)** This is a cash assistance program for individuals that need assistance in daily living.



Medical Assistance

- **Child Health Plan *Plus* (CHP+)**
This program provides health insurance for low-income children up to age 19 and pregnant women.
- **Emergency Medicaid**
This program is for non-citizens who need help with an emergency medical expense. All persons are eligible to apply regardless of age.
- **Family Medical Assistance**
This program is for pregnant women, families and children up to the age 19.
- **Long Term Care**
This is a program for persons needing help to pay for services in their home or a medical facility for more than 30 days. These persons have to meet a medical assessment.
- **Medicare Cost Savings Programs (QMB, SLMB, QI-1)**
These programs may help persons receiving Medicare Part A. (Prescriptions are not a covered benefit.)
- **Supplement Security Income (SSI) Medicaid**
This program provides medical benefits for anyone receiving SSI. (No application needed for this program).
- **Old Age Pension –State Medical Program**
This program may help persons receiving Old Age Pension Financial Assistance.
- **Medicare Part D – Low Income Subsidy (LIS)**
This program may help persons receiving Medicare Part D with their premiums, co-pays and deductibles.



Processing Time

From the date the agency receives your completed application, they must act within:

- 7 days for Expedited Food Stamps, 30 days for Food Stamps
- 45 days for Colorado Works/TANF, Colorado Supplement, Old Age Pension (OAP), Medicaid, Old Age Pension –State Medical Program, and Child Health Plan *Plus* (CHP+)
- 60 days for State Aid to the Needy Disabled (AND), Aid to the Blind (AB)
- 90 days for Medicaid applications based on disability for Long Term Care



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Proof of Lawful Presence in the United States Please note: this is not required to apply for or receive Food Stamps and Medicaid programs that are subject to the Deficit Reduction Act of 2005. You must provide verification of your lawful presence in the United States for applicants 18 years and older for certain public benefits, with:

- A valid Colorado Driver's license or Colorado Identification card; or
- U.S. Military Card or Military Dependent's Identification Card; or
- United States Merchant Mariner Card; or
- Native American Tribal Document.

If you do not have the documents listed, you may contact your local county office for other acceptable documents. You must sign the **Affidavit of Proof of Lawful Presence in the United States** located on the last page of Part 1 of the application. Please see pages 6 and 7 for additional requirements for medical assistance programs.

FOR FOOD STAMPS: You must provide proof of your alien status if you are not a United States citizen. Aliens and alien household members who are not eligible to participate in the food stamp program will not be required to provide alien documentation or social security numbers.

OTHER ASSISTANCE
 (To apply you will need a separate application)

Colorado Child Care Assistance Program (CCCAP)

The Colorado Child Care Assistance Program provides financial assistance to low-income families who are working, searching for employment or are in training. Families that are enrolled in the Colorado Works Program and need child care services to support their efforts toward self-sufficiency are also eligible. The CCCAP is administered through individual county departments of social services.

Low Income Energy Assistance Program (LEAP)

LEAP may assist with a part of your winter heating costs. You may apply from November 1st through April 30th. To get an application call, 1-866-HEAT HELP (1-866-432-8435) or you may visit our web site at www.colorado.gov/LEAP.

For additional information about the programs listed, visit the following web sites: www.cdhs.state.co.us or www.chcpf.state.co.us.



How to receive your benefits:

Colorado's Electronic Benefits Transfer (EBT) QUEST Card Food stamp and cash benefits are issued on an EBT card. You can receive a card at your county department or have an EBT card mailed to you. You will need to select your Personal Identification Number (PIN) to access the benefits once they are put on the card. To contact QUEST customer service you may call toll free at 1-888-328-2656.



Medical Card

If you are found eligible for medical services, you will be mailed a Medical Identification Card. Present this card each and every time you receive medical services. If your card is lost or stolen, please contact your county department of social services. A separate medical card will be sent out to those who qualify for the CHP+ program.



If you are found eligible for cash assistance, you may request to have your cash benefits directly deposited into your bank account. Ask your county worker for details.

Deficit Reduction Act of 2005: Implemented July 1, 2006 (for Medical Assistance Programs Only)

<p>On February 8, 2006, the Deficit Reduction Act of 2005 was signed into law (Public Law 109-171). This new federal law requires Medicaid clients and applicants who declare that they are citizens of the United States to provide documentation to establish their US citizenship and their identity. For any determinations of initial eligibility and re-determinations of eligibility for medical assistance made on or after July 1, 2006, an individual who has declared that he or she is a citizen of the United States must provide evidence of his or her US citizenship and identity.</p>	<p>This federal law applies to all applicants or clients who receive or are seeking Medicaid benefits. The exceptions are as follows: presumptive eligibility, Supplemental Security Income (SSI), Social Security Disability Income, Medicare, Title IV-E or IV-B foster care, subsidized adoptions, refugees services, CHP+, CHP+ Prenatal, entitlement benefits for newborns of Medicaid eligible mothers and medical services through a State only program. <i>In addition to the required documents under the Deficit Reduction Act, you may want to provide the required documents for HB 06S-1023. This is not mandatory, but a request for your convenience so that if the documents are needed, they will be available and not delay the application or re-determination process.</i></p>
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Proof of BOTH Citizenship & Identification

<ul style="list-style-type: none"> • US Passport or a Certificate of Naturalization (N-550 or N-570) or a Certificate of Citizenship (N-560 or N-561) • If none of the above documents are available, a document from the proof of citizenship AND a document from the proof of identification lists must be provided.
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<p>Proof of Citizenship</p> <p>A document from the Proof of Identification list must be provided as well as ONE of the following:</p> <ul style="list-style-type: none"> • A US public birth record showing birth in: One of the 50 US States, District of Columbia, American Samoa, Swain's Island, Puerto Rico (if born on or after January 13, 1941), US Virgin Islands (if born on or after January 17, 1917), Northern Mariana Islands (if born on or after November 4, 1986), or Guam (if born on or after April 10, 1899); or • A Certification of Report of Birth (DS-1350); or • A Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); or • A Certification of Birth Abroad (FS-545); or • A United States Citizen Identification Card (I-197) or the prior version I-179; or • An American Indian Card (I-872); or • A Northern Mariana Card (I-873); or • A final adoption decree; or • Evidence of civil service employment by the US government before June 1, 1976; or • A U.S. Military record of service showing a US place of birth; or • An extract of hospital record on hospital letterhead established at the time of the person's birth that was created at least 5 years before the initial application date and indicates a US place of birth; or 	<ul style="list-style-type: none"> • A life or health or other insurance record showing a US place of birth that was created at least 5 years before the initial application date; or • A Federal or State census record showing US citizenship or a US place of birth (generally for persons born from 1900 through 1950); or • Other document that were created at least 5 years before the application for Medicaid: Seneca Indian tribal census record, or Bureau of Indian Affairs tribal census records of the Navajo Indians, or US State Vital Statistics official notification of birth registration, or an amended US public birth record that is amended more than 5 after the person's birth, or statement signed by the physician or midwife who was in attendance at the time of birth; or • An institutional admission papers from a nursing facility, skilled care facility, or other institution that indicates a US place of birth; or • A Medical (clinic, doctor, or hospital) record that was created at least 5 years before the initial application date and indicates a US place of birth; or • A Notarized Affidavit as Proof of Citizenship
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<p>Proof of Identification</p> <p>A document from the Proof of Citizenship list must be provided as well as ONE of the following:</p> <p>For Applicants of all ages</p> <ul style="list-style-type: none"> • A Certificate of Degree of Indian Blood or other US American Indian/Alaskan Native Tribal document, or • A driver's license issued by a State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight, or eye color, or • An identification card issued by the federal, state or local government, or • A school identification card with a photograph of the individual, or • A US military card or draft record, or 	<ul style="list-style-type: none"> • A Military dependent's identification card, or • A Native American Tribal document, or • A US Coast Guard Merchant Mariner card For Applicants under 16 years of age • School records, including nursery or daycare records, or • A written Affidavit as Proof of Identification <p><i>For Information and list of documents required for Northern Marina Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)), US Virgin Islands Naturalization Citizenship documents and Puerto Rico Naturalization citizenship documents please go to the state website: www.chcpf.state.co.us.</i></p>
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Congress created in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) a detailed document verification process for qualified aliens. "Notwithstanding any other law" individuals who do not have a status as a qualified alien as defined in 42 U.S.C. 1641 are not eligible for Medicaid. Qualified aliens under the act must provide specific Immigration and Naturalization Service documents to establish lawful immigration status (State Medicaid Manual §3212.2) and that status must be confirmed through the automated Systematic Alien Verification for Entitlement (SAVE) system. 42 U.S.C. 1320b-7(d). Under PRWORA there is no "waiver" alternative and the qualified alien must produce the specified immigration documents to become eligible for Medicaid. Therefore, the PRWORA requirements exclusively govern alien applicants' entitlement to Medicaid, including the entitlement of alien dual-eligibles.

For All Qualified Non-Citizens applying for Assistance: All of the following must be provided:

- The INS documents providing proof of lawful immigration status, **and**
- The documents must be verified through the Systematic Alien Verification for Entitlement (SAVE) system at the eligibility site.

Undocumented citizens may be entitled to emergency medical services if they meet all other Medicaid eligibility criteria with the exception of citizenship.

Photocopies

An individual may provide photocopies of his or her original citizenship and identity documents if the photocopies meet the following criteria:

- a) The photocopy is notarized. A notary public must have certified that he or she saw the original document and that the photocopy is a true copy of that original, **or**
- b) The photocopy is made by a county caseworker or medical assistance site worker who attests in writing on the photocopy that he or she saw the original document and that the photocopy is a true copy of that original.

Opportunity to provide documents for new applicant and at re-determination

- Applicant will be given 10 business days to supply requested verification after which period of time the application will be denied or the Medicaid benefits will be discontinued.
- Denials can be rescinded within 10 weeks of the date of the denial if proper documentation is supplied.

If an individual whose application was denied or benefits terminated on the basis of not having the required citizenship and/or identity documents provides the required documentation within 10 weeks of the date of the denial/termination, the denial/termination shall be reversed and the applicant/client found eligible based on the original application, provided the applicant/client meets all of the other eligibility requirements.

HB 06S-1023: Implemented August 1, 2006 (for Medical Assistance Programs Only)

During a special session, the Colorado General Assembly created House Bill (HB) 06S-1023, which requires applicants who are not subject to the Deficit Reduction Act of 2005 and are age 18 and older to provide specific identification documents and the completion of an affidavit as part of the required proof of lawful presence in the United States for certain individuals applying for state benefits. The Governor signed HB 06S-1023 into law on July 31, 2006. This new law, along with corresponding regulations approved by the Medical Services Board, is effective August 1, 2006.

This state law applies to all applicants or clients, who are 18 years of age and older, who receive or are seeking medical assistance benefits. The exceptions are as follows: all Medicaid programs that are subject to the Deficit Reduction Act of 2005. This law **does apply** to those who are seeking or are receiving benefits under the following programs: CHP+, CHP+ prenatal, Prenatal State Only and Old Age Pension State Only. ***In addition to the required documents under HB 06S-1023, you may want to provide the required documents for the Deficit Reduction Act. This is not mandatory, but a request for your convenience so that if the documents are needed, they will be available and not delay the application or re-determination process.***

Proof of Lawful Presence in the United States

A document from the Proof of Identification list must be provided as well **ONE** of the following:

- Written Affidavit of Proof of Lawful Presence in the United States, **or**
- Non-citizens must have their INS documentation verified through Systematic Alien Verification for Entitlement (SAVE) system.

Proof of Identification

A document from the Proof of Lawful Presence in the United States list must be provided as well as **ONE** of the following:

- A Valid Colorado Driver's License, **or**
- A Colorado Identification Card, **or**
- A US Military Card, **or**
- A Military Dependents' Identification card, **or**
- A US Coast Guard Merchant Mariner Card, **or**
- A Native American Tribal document, **or**
- **Under the Department of Revenue Waiver**
 1. Certificate verifying naturalized status Issued by an authorized agency of the United States bearing Applicant's intact photograph impressed with the raised embossed seal of the issuing agency; **or**
 2. Certificate verifying United States citizenship issued by an authorized agency of the United States bearing Applicant's intact photograph impressed with the raised embossed seal of the issuing agency, **or**
 3. Valid Driver's License or Identification Card bearing Applicant's photograph issued by one of the following: Alabama, Arizona, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Virginia, West Virginia, and Wyoming; **or** Valid Immigration Documents demonstrating Lawful Presence and verified through Systematic Alien Verification for Entitlement (SAVE) system.

Proof of Identification and Citizenship for Non-Citizen (Qualified Aliens)

Congress created in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) a detailed document verification process for qualified aliens. "Notwithstanding any other law" individuals who do not have a status as a qualified alien as defined in 42 U.S.C. 1641 are not eligible for Medicaid. Qualified aliens under the act must provide specific Immigration and Naturalization Service documents to establish lawful immigration status (State Medicaid Manual §3212.2) and that status must be confirmed through the automated Systematic Alien Verification for Entitlement (SAVE) system. 42 U.S.C. 1320b-7(d). Under PRWORA there is no "waiver" alternative and the qualified alien must produce the specified immigration documents to become eligible for Medicaid. Therefore, the PRWORA requirements exclusively govern alien applicants' entitlement to Medicaid, including the entitlement of alien dual-eligibles.

For All Qualified Non-Citizens applying for Assistance: All of the following must be provided:

- The INS documents providing proof of lawful immigration status, **and**
- The documents must be verified through the Systematic Alien Verification for Entitlement (SAVE) system at the eligibility site.

Undocumented citizens may be entitled to emergency medical services if they meet all other Medicaid eligibility criteria with the exception of citizenship.

Photocopies

An individual may provide photocopies of his or her original citizenship and identity documents if the photocopies meet the following criteria:

- a) The photocopy is notarized. A notary public must have certified that he or she saw the original document and that the photocopy is a true copy of that original, **or**
- b) The photocopy is made by a county caseworker or medical assistance site worker who attests in writing on the photocopy that he or she saw the original document and that the photocopy is a true copy of that original.

Opportunity to provide documents for new applicant and at re-determination

- Applicant will be given 10 business days to supply requested verification after which period of time the application will be denied or the Medicaid benefits will be discontinued.
- Denials can be rescinded within 10 weeks of the date of the denial if proper documentation is supplied.

If an individual whose application was denied or benefits terminated on the basis of not having the required citizenship and/or identity documents provides the required documentation within 10 weeks of the date of the denial/termination, the denial/termination shall be reversed and the applicant/client found eligible based on the original application, provided the applicant/client meets all of the other eligibility requirements.



State of Colorado
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Receipt

This receipt is proof that you have applied for assistance on the date below. Please keep this paper in a safe place.

Name of Applicant

Date Application Received by County or MA site

Signature of Person Who Received the Application

Please mark each program you are applying for.

Cash Assistance Programs

- Aid to the Blind (State AB)
- Aid to the Needy Disabled (State AND)
- Colorado Supplement to SSI
- Colorado Works (TANF)
- Food Stamps
- Home Care Allowance (HCA)
- Old Age Pension (OAP) Financial Assistance

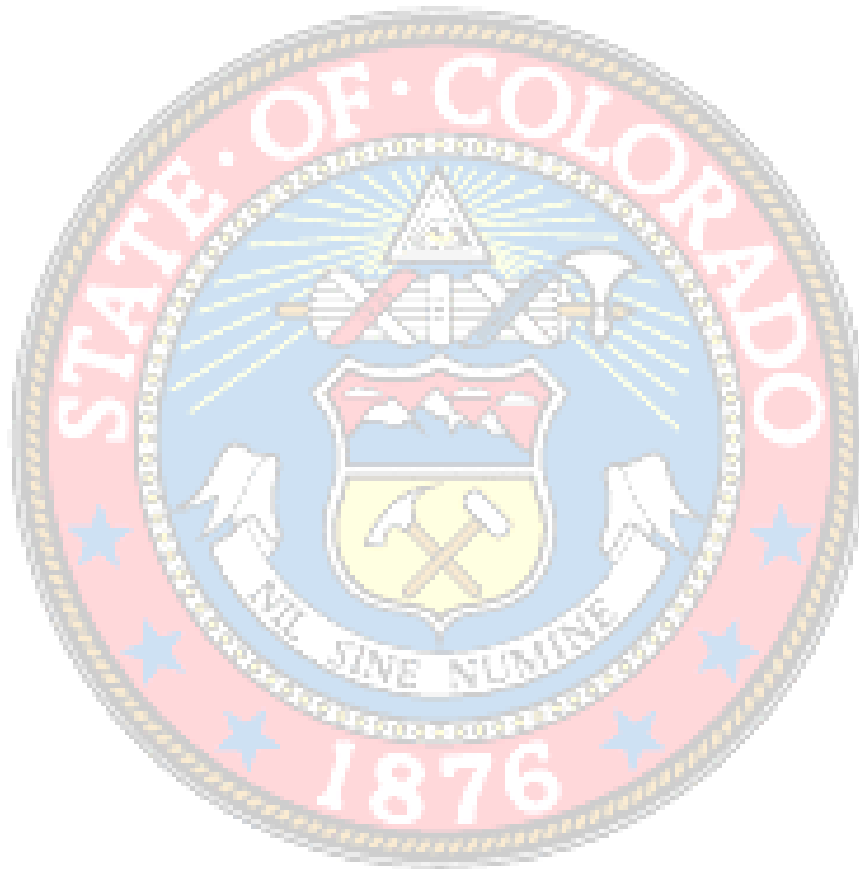
Medical Assistance Programs

- Adult Medicaid
- Child Health Plan Plus (CHP+)/Family Medical Assistance
- Emergency Medical Services (non-citizens)
- Medicaid Long Term Care (LTC)
- Medicare Part D – Low Income Subsidy
- Medicare Savings Program - Medicaid

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

Application for Assistance

Part 1 of 2



Complete this section

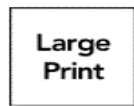
This application can be downloaded at:

www.cdhs.state.co.us or www.chcpf.state.co.us.

Available Services/accommodations



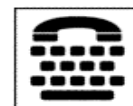
Handicap
Accessible



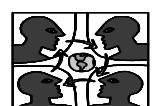
Vision Impaired



ASL



TDDY



Language
Interpreters

Language Information

English	If you need help completing this application, please contact your local county department of social services.
Spanish	Si necesita ayuda en completar esta solocitud, por favor comuniquese con su trabajador del condalo.
Hmong	Yog koj xav kom muaj tus pab sau koj daim ntawv thov nyiaj, koj yuav tsum hu mus rau lub chaw pab kev noj haus ntawm lub nroog koj nyob.
Vietnamese	Nếu bạn cần sự giúp đỡ trong vấn đề điền đơn, xin liên lạc cho số xã hội quán.
Ambaric/Ethopian	ይህንን ግመልዝኛ መሙላት ቢቻገሩ ለአካባቢው የካውንቲ ሰጣል ሰርቪስ ሙሉሪያ ቤት በመደወል ተክረክያን ያናገሩ።
Lao	ຖ້າທ່ານຊຽງປເກອບແບບພອມເອົາເຮງບໍ່ເຢັຍ, ກຊ່ຽນາ ອໍຄອາມດໍອຍຫຼືອນຳນັກວິຊາການຂອງເອດເມີອງ (County Technician)
Cambodian	បើលោក/អ្នក ត្រូវការ អ្នកជួយចំពោះពាក្យសុំមេហៅ អ្នកគាន់សំណុំរឿង តាមសង្កាត់ដែលលោក/អ្នកនៅ។
Russian	ЕСЛИ ВАМ НУЖНА ПОМОЩЬ В ЗАПОЛНЕНИИ АНКЕТ (APPLICATION), ПОЖАЛУЙСТА, ОБРАТИТЕСЬ ЗА ПОМОЩЬЮ К СВОЕМУ ВЕДУЩЕМУ (TECHNICIAN) В SOCIAL SERVICES ВАШЕГО РАЙОНА (COUNTY).
Arabic/Farsi	صحتی که برای کامل کردن این تقاضا نامه احتیاج به کمک داشته باشد می توانید از کلینیک حوزه خود درخواست کمک نمایید.

Nondiscrimination Statement

In accordance with Federal law and U.S. Department of Health and Human Services (HHS) and U.S. Department of Agriculture (USDA) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is also prohibited on the basis of marital status, familial status, parental status, religion, sexual orientation, genetic information, political beliefs, reprisal, or because all or part of an individual's income is derived from any public program. (Not all prohibited bases apply to all programs.)

If you think you have been discriminated against for any of these reasons, you can file a complaint with the County Client Civil Rights Contact Person. At any time, you may also file a complaint of discrimination with one of the following Federal agencies, without fear of retaliation:

For Financial Assistance issues contact:
 US Department of Health and Human Services (HHS)
 Director, Office for Civil Rights (OCR)
 Room 506-F, 200 Independence Ave. S.W.
 Washington, D.C. 20201
 (202) 619-0403 (voice) or (202) 619- 3257 (TDD)

For Food Stamp issues only contact:
 US Department of Agriculture (USDA)
 Director, Office for Civil Rights
 1400 Independence Ave., SW
 Washington DC, 20250-9410
 (800) 795-3272 (voice)

* Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape) should contact USDA's TARGET Center at 202-720-2600 (voice or TDD). We will make reasonable efforts to meet your special needs if you have a qualifying disability under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. Contact your county worker if you have special needs and want to request a reasonable accommodation under the ADA.



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

Application for Assistance Part 1 of 2
Tell us about you (Please Print)

Full Name (last, first, middle initial; include maiden or any other names used)

Phone Number

Signature

Message Number (or another number to contact you)

Home Address (street, PO Box, etc.)

Mailing Address (if different than home address)

City State ZIP Code

City State ZIP Code

1. What is your primary language? Spoken: _____ Written: _____

2. Are you a Colorado resident? Yes No

3. Are you receiving benefits from another State? Yes No

If yes, please provide the following information:

What benefits are you receiving?

Date last received

What state/county?

4. Are you receiving any benefits from another Colorado county? Yes No

5. Are you homeless? Yes No

6. For which programs are you applying (check all that apply)

Cash Assistance Programs

- Aid to the Blind (State AB)
- Aid to the Needy Disabled (State AND)
- Colorado Supplement to SSI
- Colorado Works (TANF)
- Food Stamps
- Home Care Allowance (HCA)
- Old Age Pension (OAP) Financial Assistance

Medical Assistance Programs

- Adult Medicaid
- Child Health Plan Plus (CHP+)/Family Medical Assistance
- Emergency Medical Services (non-citizens)
- Medicaid Long Term Care (LTC)
- Medicare Part D – Low Income Subsidy
- Medicare Savings Program - Medicaid



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

Application for Assistance Part 1 of 2

Expedited Services for Food Stamps

Your household may qualify for Expedited Service and receive food stamps within 7 days:

- If your gross monthly income is less than \$150 and liquid resources are \$100 or less; or
- Your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources; or
- Your household is a migrant or seasonal farm worker household with little or no income and resources.

Give The Information Below, So Your Eligibility For Expedited Service Can Be Determined.

How many people live with you?	
Total money expected this month before deductions	\$
Total cash, money in checking/savings accounts, CDs	\$
Total rent or mortgage for this month	\$
Total utilities for this month	\$

If you qualify for Expedited Food Stamps: You are to receive benefits within seven days of your application. If you are denied Expedited Food Stamps and you do not agree with the denial, you may request an informal conference at your Food Stamp office. This conference is to be held within two days of your request unless you ask for a later date.

Household Information *(information is not required for Food Stamps only)

SELF

_____ Name (last, first, middle initial)	_____ Relationship to You	_____ Social Security Number <input type="checkbox"/> Check if you do not have a SSN
	*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
_____ Date of Birth (mm-dd-yyyy)		_____ Place of Birth (City, State, Country)

*Pregnant?
 No Yes If yes ➤ *Due Date (mm-dd-yyyy) _____ *Number of Babies Expected _____

<p>*Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated</p>	<p>Race/National Origin/Ethnicity (Optional, check all that apply): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White</p>	<p>Student? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Last Grade Completed:</p>
--	---	--



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

Application for Assistance Part 1 of 2

Tell us about everyone in your household who is applying for assistance

Name (last, first, middle initial)		Relationship to You	Social Security Number <input type="checkbox"/> Check if you do not have a SSN
		*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth (mm-dd-yyyy)		Place of Birth (City, State, Country)	
*Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes		*Due Date (mm-dd-yyyy)	*Number of Babies Expected
*Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Race/National Origin/Ethnicity (Optional, check all that apply): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		Student? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Last Grade Completed:

Tell us about everyone in your household who is applying for assistance

Name (last, first, middle initial)		Relationship to You	Social Security Number <input type="checkbox"/> Check if you do not have a SSN
		*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth (mm-dd-yyyy)		Place of Birth (City, State, Country)	
*Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes		*Due Date (mm-dd-yyyy)	*Number of Babies Expected
*Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Race/National Origin/Ethnicity (Optional, check all that apply): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		Student? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Last Grade Completed:



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

Application for Assistance Part 1 of 2

Tell us about everyone in your household who is applying for assistance

Name (last, first, middle initial)	Relationship to You	Social Security Number <input type="checkbox"/> Check if you do not have a SSN
*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Date of Birth (mm-dd-yyyy)	Place of Birth (City, State, Country)	
*Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes	*Due Date (mm-dd-yyyy)	*Number of Babies Expected
*Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Race/National Origin/Ethnicity (Optional, check all that apply): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White	Student? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Last Grade Completed:

Tell us about everyone in your household who is applying for assistance

Name (last, first, middle initial)	Relationship to You	Social Security Number <input type="checkbox"/> Check if you do not have a SSN
*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Date of Birth (mm-dd-yyyy)	Place of Birth (City, State, Country)	
*Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes	*Due Date (mm-dd-yyyy)	*Number of Babies Expected
*Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Race/National Origin/Ethnicity (Optional, check all that apply): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White	Student? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Last Grade Completed:

If you have more people in your household, please use a blank sheet of paper.



State of Colorado
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Application for Assistance Part 1 of 2

7. Tell us about anyone else who lives with you (even if they are not applying for assistance).

Name	Relationship to You	Date of Birth	*Sex	Do they usually buy food, prepare food and eat with everyone in the house?
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No

8. Have you, or any member of your household, been convicted of fraudulently receiving duplicate Food Stamp benefits in any State after September 22, 1996? Yes No
9. Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, or going to jail, or violating a condition of parole or probation?
 Yes No *If yes, who?* _____
10. Have you or any member of your household 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 committed while under the influence of a controlled drug substance after August 22, 1996?
 Yes No *If yes, who?* _____
11. Have you or any member of your household been convicted of buying or selling Food Stamp benefits over \$500 after September 22, 1996? Yes No
12. Have you or any member of your household been convicted of trading Food Stamp benefits for guns, ammunitions, or explosives after September 22, 1996. Yes No
13. Have you or any member of your household been convicted of trading Food Stamp benefits for drugs after September 22, 1996? Yes No
14. Have you, or any member of your household, applying for assistance been convicted of Welfare Fraud? Yes No *If yes, who?* _____
15. The following services may be available to children and pregnant women and children who qualify for Medicaid. Would you like help getting any of these services? Yes No *Please check the services you would like to receive:*
- Medical Checkups
 - Pregnancy care
 - Eye Exams
 - Baby Shots
 - Medicine
 - WIC or supplemental food benefits
 - Sick Care
 - Dental Checkups
 - Hearing Exam



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

Rights, Responsibilities, and Penalties

For your protection, it is important to read the following carefully before you sign.

NOTICE TO MEDICAL ASSISTANCE CLIENTS – The Medical Assistance Estate Recovery Program

Under Federal law (Social Security Act, Title 19, Sec. 1917 [42 U.S.C 1396P]) and State law (**25.5-4-302, C.R.S.**), the Medical Assistance Estate Recovery Program authorizes the Department of Health Care Policy and Financing to make recovery from the estates of deceased Medicaid clients who were permanently institutionalized or were over the age of 55 when benefits were provided. The Federal and State laws provide for certain exemptions to the Medical Assistance Estate Recovery Program. For further information or questions about the Medical Assistance Estate Recovery you should contact your county worker and request “The Medical Assistance Estate Recovery Program” brochure.

I UNDERSTAND AND AGREE THAT:

It is a crime to lie on this application. Benefits will be denied if any information on this application is found not true or if requested information is left off the application.

If any information that I provide is incorrect, my application maybe denied and I may be subject to criminal prosecution for knowingly providing incorrect information. I must tell the agency if there are changes in the information I give on this application within the time frames explained to me at the interview with the county worker. For Colorado Works (TANF), medical assistance programs and adult financial cases, I must inform the agency within 10 days of any changes to my case.

I am allowing the agency to get records from financial institutions to show assets held for the person(s) named in this application. This includes banks, saving and loan companies, credit unions, insurance companies and other financial institutions. I am also allowing the agency to receive information from other persons or agencies to provide documentation or verify information in my application. I release these persons, agencies or institutions from all liability for supplying such information pertaining to myself or members of my household.

I will present proof of lawful presence in the United States (not required for Food Stamps), or alien registration documentation received from the United States Citizen and Immigration Service (USCIS), for every alien member in my household.

The agency will verify information with USCIS and that information received from USCIS may affect my eligibility and benefits. Federal law (Public Law 97-98) requires me to give the agency the Social Security number(s) and alien registration number(s) of persons who apply for public assistance.

The agency will confirm and share information with other state, local and federal agencies.

The agency will match information with the Social Security Administration, the Internal Revenue Service and the Colorado Department of Labor and Employment through the use of Social Security numbers(s). The agency will verify information that may affect eligibility and payment. The agency will contact employers and they may release information to this agency. The agency will verify information regarding child support payments with child support enforcement agencies or the courts. The agency may provide information to law enforcement agencies.



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

Rights, Responsibilities, and Penalties (Continued)

I UNDERSTAND AND AGREE THAT:

On approval of this application, I assign to the State all rights to payment for medical expenses and treatment. If I get Medicaid and receive money for the same medical bills that the State has paid, I will give the money to the State. The State may collect from any insurance company or court settlement for medical bills that the State has paid. I will immediately notify the State of any claim or lawsuit that I have and will cooperate with the State in collecting the medical bills that the State has paid.

If I get cash assistance under Colorado Works, I will give the agency all rights to current support and past due support owed on an existing court order. I also know that I give the agency rights to medical support to reimburse medical costs paid by Medicaid. I know I must give the agency all child support, medical support, and spousal maintenance paid directly to me while my children and I receive cash assistance under Colorado Works and Medicaid. While my children and I receive cash assistance under Colorado Works and Medicaid, the agency will try to collect current and overdue support. When we no longer receive cash assistance under Colorado Works or Medicaid, the agency will continue to collect past due support and medical support amounts that accrued while I received benefits. The current child support, spousal maintenance and medical support will be sent to me.

I must identify health insurance that is available to any person who is included in this application for Medicaid or medical assistance. I know that I may be required to enroll in an employer-based group health insurance if it is less expensive than Medicaid. In that case, Medicaid will pay the insurance cost.

My household will not be eligible for Food Stamps if I refuse to cooperate with any review of my case, including a quality control review. If my household gets benefits for which we are not eligible for, we may be required to repay those benefits. Any past due claims may be collected by taking an income tax refund that my household may be entitled to.

A person found to have intentionally given false information cannot get Colorado Works or Food Stamps 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 Stamps for another eighteen months. This crime is also subject to prosecution under other federal laws. Receiving duplicate benefits of Food Stamps or Colorado Works by misrepresenting identity or residence will be a 10-year disqualification.

It is a crime to knowingly receive money or benefits for which I am not eligible. This crime is punishable by a fine of up to \$250,000 or a jail term of up to 20 years, or both. A person found guilty of using Food Stamps to illegally purchase controlled substances shall be disqualified for 2 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 participate in the Program upon the first occasion of such violation.

An individual convicted by a Federal, State or local court of having trafficked benefits for an aggregate amount of \$500 or more shall be permanently ineligible to participate in the Program upon the first occasion of such violation.



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

Rights, Responsibilities, and Penalties (Continued)

To receive Food Stamps, certain members of the household need to register for work. This means that certain members of the household must:

- Report to the Employment First (work program) when the Food Stamp office schedules you for an appointment.
- Comply with the instructions the Employment First (work program) gives you, including reporting for all scheduled appointments and following through on the written agreements you sign.
- Provide information to the Food Stamp office or the Employment First (work program) about any jobs you get while you are on food stamps.
- Tell the Food Stamp office or Employment First (work program) if you are not able to work – you will be asked to provide verification; work any *Workfare Hours* you are assigned; go to job interviews arranged for you.

If you do not do what you are assigned to do, you may be disqualified from receiving Food Stamp benefits. If you are an adult between the ages of 18 and 49, with no children under the age of 18 in your Food Stamp household, you will only be able to get Food Stamp benefits for three months during the next three years unless: You work in a job 80 hours each month and report that information to Employment First (work program); or you work your assigned hours in your county's Employment First (work program), including *Workfare*; or The Employment First (work program), or you are determined to be physically or mentally unable to work, or the Food Stamp office tells you that you are exempt. **As long as you do one of these activities each month, you will be able to receive Food Stamp benefits if you are otherwise eligible.**

Your Signature

By signing this form, I certify that I have reviewed this application; I understand and agree to the Rights, Responsibilities and Penalties and under penalty of perjury I certify the information I have given is true including the information concerning citizenship and alien status. I have received information on how to apply, what information is available and what I may need to give the county to help me with getting benefits.

Signature of Applicant

Date (mm-dd-yyyy)

Applicant's Printed Name

Signature of person who helped complete this form

Authorized Representative, Conservator, or
Guardian's Signature

Date (mm-dd-yyyy)



State of Colorado
Department of Human Services
Department of Health Care Policy and Financing
These extra signature forms are for Family Med

By signing this form, I certify that I have reviewed this application; I understand and agree to the Rights, Responsibilities and Penalties and under penalty of perjury I certify the information I have given is true including the information concerning citizenship and alien status. I have received information on how to apply, what information is available and what I may need to give the county to help me with getting benefits. **For medical assistance applications, anyone 18 or older must sign the application in addition to the person completing the application.**

Signature of Applicant

Date (mm-dd-yyyy)

Applicant's Printed Name

Signature of person who helped complete this form

Authorized Representative, Conservator, or
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Signature of Applicant

Date (mm-dd-yyyy)

Applicant's Printed Name

Signature of person who helped complete this form

Authorized Representative, Conservator, or
Guardian's Signature

Date (mm-dd-yyyy)



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

An Affidavit of Proof of Lawful Presence is required for each individual (age 18 or older) that is applying for benefits or for adults applying for their children.

Affidavit of Proof of Lawful Presence in the United States

***Please Note, this affidavit is not required to apply for or receive food stamps and Medicaid programs that are subject to the Deficit Reduction Act of 2005.** Every applicant in your household 18 years of age and older must sign an Affidavit of Proof of Lawful Presence in the United States.

I swear or affirm under penalty of perjury under the laws of the state of Colorado (Check one):

- I am a United States citizen; or
- I am a legal Permanent Resident of the United States; or
- I am lawfully present in the United States pursuant to federal law

I understand 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 of Proof of Lawful Presence in the United States

***Please Note, this affidavit is not required to apply for or receive food stamps and Medicaid programs that are subject to the Deficit Reduction Act of 2005.** Every applicant in your household 18 years of age and older must sign an Affidavit of Proof of Lawful Presence in the United States.

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Signature

Date



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

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- I am lawfully present in the United States pursuant to federal law

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Signature

Date

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I swear or affirm under penalty of perjury under the laws of the state of Colorado (Check one):

- I am a United States citizen or
- I am a legal Permanent Resident of the United States or
- I am lawfully present in the United States pursuant to federal law

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Signature

Date

If you need additional affidavits, please ask your county worker.



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

Application for Assistance Part 2 of 2

Please read and answer each question carefully.

This application is to help us collect information we need to determine whether you are eligible for public assistance programs. The information contained in this application and the information received from third-party resources will be used to determine your eligibility and benefit amount.

This application can be downloaded at:

www.cdhs.state.co.us or www.chcpf.state.co.us.

Full Name (last, first, middle initial; include maiden or any other names used)

Social Security Number

Check if you do not have a SSN

Phone Number

Message Number (or another number to contact you)

Home Address (street, PO Box, etc.)

Mailing Address (if different than home address)

City State ZIP Code

City State ZIP Code



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

Section 2: Application for Assistance

Please tell us about your living arrangement and shelter expenses: This section will collect information about your shelter expenses. Some programs will consider these costs when determining how much your benefits should be.

- 1. What is your current living arrangement?** *Check all boxes that apply to your situation.*
- Own/Buying a home
 Renting
 Living with relatives
 Living on an Indian reservation
 Living with friends
 Living in subsidized housing
 Migrant/seasonal farm worker
 No permanent home
 Living in a group home
 Staying at a shelter

- 2. Are you applying for benefits for anyone in a Medical Facility?** *(Hospital, Nursing Home, Mental Health Institution)* Yes No *If yes, please complete the following:*

a.

Name	Name of Facility	Medical Facility Address	Date Entered
_____	_____	_____	_____

b.

Name	Name of Facility	Medical Facility Address	Date Entered
_____	_____	_____	_____

- 3. Are you asked to pay or are you billed for rent or a mortgage?** Yes No

_____	\$	\$	_____	_____
Rent Payment(s)	Amount Billed	Amount Paid	How Often	Landlord Name/Address/Phone
_____	\$	\$	_____	_____
Mortgage Payment	Amount Billed	Amount Paid	How Often	Mortgage Company Name/Address/Phone
_____	\$	\$	_____	_____
2 nd Mortgage Payment	Amount Billed	Amount Paid	How Often	Mortgage Company Name/Address/Phone

- 4. Are your homeowner taxes, insurance, and homeowners' association (HOA) fees billed separately from the above house payment?** Yes No *If yes, please complete:*

_____	\$	\$	_____	_____
HOA	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent
_____	\$	\$	_____	_____
Insurance	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent
_____	\$	\$	_____	_____
Taxes	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent

Expenses

5. Are you billed for any of the following: heating, cooling, water, trash, sewage or phone expenses? Yes No *If yes, please complete the following:*

Heating	\$	\$		
Type	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent
Cooling	\$	\$		
Type	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent
Water	\$	\$		
Type	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent
Trash	\$	\$		
Type	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent
Sewer	\$	\$		
Type	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent
Phone	\$	\$		
Type	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent

6. Does anyone outside of the household help pay any shelter costs? Yes No

7. Do you, or anyone in your household, pay legally obligated support to someone outside of your household? Yes No *If yes, please complete the following:*

Child Support			
Type of Support	Name(s) of Child(ren)	Person paying child support	
\$	\$		
Legally obligated amount of child support	Amount Actually Paid	How Often	
		\$	
Date of Last Payment	County/State of Court Order	Amount of Arrearages	

Child Support			
Type of Support	Name(s) of Child(ren)	Person paying child support	
\$	\$		
Legally obligated amount of child support	Amount Actually Paid	How often	
Date of Last Payment	County/State of Court Order	Amount of Arrearages	

Alimony	\$		
Type of Support	Amount Paid	How Often	
Date of Last Payment	County/State of Court Order		

8. Do you provide support to an individual not living in your household? Yes No
 If yes, do you also claim them on your Federal Income Tax? Yes No

Expenses

9. Is anyone in your household billed for child care? Yes No *If yes, please complete:*

a.

Name of Child Receiving Care Care Facility/Provider Name/Address

\$ _____ \$ _____
Amount Billed Amount Paid How Often

Are you receiving help with these costs? Yes No

b.

Name of Child Receiving Care Care Facility/Provider Name/Address

\$ _____ \$ _____
Amount Billed Amount Paid How Often

Are you receiving help with these costs? Yes No

10. Are you, or anyone in your household, disabled? Yes No

a.

Name of the Person with the Disability

Are you currently receiving treatment? Yes No

b.

Name of the Person with the Disability

Are you currently receiving treatment? Yes No

11. Has a medical provider told you, or anyone in your household, to cut back or limit activities? Yes No

Name of Person with Limitations

Limitations

12. Are you, or is anyone in your household, billed for care of an adult or disabled person? Yes No *If yes, please complete:*

a.

Name of Person Receiving Care Care Facility/Provider Name and Address

\$ _____ \$ _____
Amount Billed Amount Paid How Often

Are you receiving help with these costs?

Yes No

b.

Name of Person Receiving Care Care Facility/Provider Name and Address

\$ _____ \$ _____
Amount Billed Amount Paid How Often

Are you receiving help with these costs?

Yes No

12. Do you, or anyone in your household, have an injury? Yes No *If yes, please complete:*

Name of Injured Person

Date of Injury

12a. Was this injury work related? Yes No

12b. Have you filed a Workers' Compensation claim for this injury? Yes No

12c. Do you, or does anyone in your household, have a lawsuit or claim for any injuries?
 Yes No *If yes, which household member and filing date of claim (if known)?*

Name

Date

Expenses

13. Do you have an attorney? Yes No N/A *If yes, please complete the following:*

Attorney Name			
Address	City	State	ZIP Code
Phone	Fax		

14. Are you, or anyone in your household, paying medical expenses? (such as prescriptions, co-pays, health insurance premiums, insurance deductibles) Yes No *If yes, please complete:*

a.			
Name of Person with Expense	Name of Provider of the Service	Type of Medical Expense	
\$			
Amount Paid	Date of Service	How Often	
b.			
Name of Person with Expense	Name of Provider of the Service	Type of Medical Expense	
\$			
Amount Paid	Date of Service	How Often	
c.			
Name of Person with Expense	Name of Provider of the Service	Type of Medical Expense	
\$			
Amount Paid	Date of Service	How Often	

Does anyone outside the household help pay medical costs? Yes No

15. Do you, or anyone in your household, have Medicare? Yes No *If yes, please complete:*

Name of Person Receiving Medicare	Which Part of Medicare?	Effective Date	Claim Number
	Part A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/>		
	Part A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/>		
	Part A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/>		
	Part A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/>		

16. Do you, or anyone in your household, have health insurance/medical coverage? Yes No

a			
Name of Person Covered	Name of Policy Holder	Policy Number	
\$			
Amount Paid Monthly	Date of Coverage	Insurance Company Name, Address, and Phone Number	
b			
Name of Person Covered	Name of Policy Holder	Policy Number	
\$			
Amount Paid Monthly	Date of Coverage	Insurance Company Name, Address, and Phone Number	

If you have more insurance companies, please use a blank sheet of paper.

Expenses

You can request retroactive Medicaid coverage for three months prior to this application date.

17. In the past three months did you, or anyone in your household, have any medical expenses? Yes No

You will be required to provide verification of income and resources for this benefit.

18. Do you (if under age 21) or your children, need medical services? Yes No Please check:

- Baby Shots Dental Check-Ups Eye Exams
- Hearing Tests Medical Check-Ups Pregnancy Care
- Sick Care/Medicine Supplemental Nutritional Program for Women, Infants and Children (WIC)

Please complete for children 18 and under and anyone in the household who is pregnant

19. Does a parent of the child(ren) applying for health insurance have access to health insurance benefits? Yes No

If yes, is he/she a State of Colorado government employee? Yes No

19a. Has any applicant had health insurance coverage through an employer plan in the last 3 months? Yes No If yes complete the following:

\$ _____	\$ _____
Amount of Premium (What you paid)	Employer's Contribution (What your employer paid)

19b. Choose an HMO for persons applying for health insurance coverage.

_____ HMO

For information on choosing an HMO call CHP+ customer service 1-800-359-1991 or visit www.chpplus.org

If you are not a U.S. Citizen, please complete this section

20. Do you, your spouse or child(ren), have **Work Quarters** in the United States? (A work quarter is equal to three months of work income recognized by Social Security). Yes No

a.			
Name	Relationship to Applicant	Social Security Number (optional)	
Date of Entry (mm-dd-yyyy)	Alien Registration Number	<input type="checkbox"/> Check if you do not have a SSN	
b.			
Name	Relationship to Applicant	Social Security Number (optional)	
Date of Entry (mm-dd-yyyy)	Alien Registration Number	<input type="checkbox"/> Check if you do not have a SSN	
20a. Do you, or anyone in your household, have a sponsor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
a.			
Sponsor's Name	Sponsor's Complete Address	Relationship to Applicant	
Sponsor's Phone Number	Gross Monthly Income	Resources/Assets	Number in Sponsor's Family
b.			
Sponsor's Name	Sponsor's Complete Address	Relationship to Applicant	
Sponsor's Phone Number	Gross Monthly Income	Resources/Assets	Number in Sponsor's Family

Income Tell us about the income in your household

21. Do you, or anyone in your household, have a job? Yes No *If yes, please complete the following for each person in the household who is working:*

a. Name of Employed Person		Employer's Name, Address, and Phone Number		
	\$	\$		
Date Started	Hourly Wage and Tips	Gross Monthly Income	How Often Paid	What Day?

b. Name of Employed Person		Employer's Name, Address, and Phone Number		
	\$	\$		
Date Started	Hourly Wage and Tips	Gross Monthly Income	How Often Paid	What Day?

c. Name of Employed Person		Employer's Name, Address, and Phone Number		
	\$	\$		
Date Started	Hourly Wage and Tips	Gross Monthly Income	How Often Paid	What Day?

22. Are you, or anyone in your household, self-employed? Yes No *If yes, please complete:*
 Are there other owners or partners? Yes No

Name of Self-Employed Person			You will be asked to provide proof of your business earnings and expenses.
\$			
Average Monthly Income	Number of Hours Worked Per Week	Business Name, Address, and Phone Number	

23. Did you, or anyone in the household, leave or lose a job or reduce the number of hours per week worked, in the past 60 days? Yes No

Name of person who lost job		Reason for Leaving	Last Date Worked
\$			
Gross Amount of Last Paycheck	Date of Last Paycheck	Former Employer Name, Address, and Phone Number	

24. Are you, or anyone in the household, on strike? Yes No *If yes, please complete:*

Name		Employer Name, Address, and Phone Number	
\$			
Gross Income Before Strike	Date Person Began Strike	Union Name, Address, and Phone Number	

25. Have you, or anyone in the household, applied for unemployment benefits? Yes No

a. Name of Person Who Applied		Date Applied for Unemployment
b. Name of Person Who Applied		Date Applied for Unemployment

Income

26. Do you, or anyone in your household, receive any type of money other than income from work? Yes No *If yes, please complete:*

Type of Income	Name of Person Receiving Income	Gross Amount Received	How Often Received?	Claim or Account Number
Alimony, Maintenance, Income from Spouse		\$		
Annuity		\$		
Cash Contributions		\$		
Child Support		\$		
		\$		
Dividends/Interest		\$		
Income from Trust		\$		
Insurance/Lawsuit Settlement		\$		
Loans		\$		
Public Assistance (OAP, AND, AB Colorado Works—TANF)		\$		
Railroad Retirement Benefits		\$		
Rental Income		\$		
Retirement /Pension		\$		
Social Security Benefits		\$		
Unemployment Benefits		\$		
Veterans Benefits		\$		
Workers' Compensation		\$		
Other Income: (Please describe)		\$		
		\$		

Income

27. Does anyone pay you or any member of your household for meals, a room or both?

Yes No *If yes, please complete:*

a. _____ Room Only Room and Meals \$ _____
 Name of Person Receiving Payment Amount Received How Often?

b. _____ Room Only Room and Meals \$ _____
 Name of Person Receiving Payment Amount Received How Often?

27a. Do you, or anyone in your household, have expenses for providing meals, a room or both? Yes No *If yes, you will be asked to provide proof of your business earnings and expenses.*

a. _____ \$ _____
 Who Is Paying the Expense Type of Expense Amount of Expense Hours Spent Providing Meals, a Room, or Both

b. _____ \$ _____
 Who Is Paying the Expense Type of Expense Amount of Expense Hours Spent Providing Meals, a Room, or Both

28. Do you, or anyone in your household, attend college, technical school or trade school?

Yes No *If yes, please complete:*

a. _____ Enrollment Status Full Time Part-time _____
 Name of Person Attending School Expected Graduation Date Name of School

b. _____ Enrollment Status Full Time Part-time _____
 Name of Person Attending School Expected Graduation Date Name of School

29. Do you, or anyone in your household, receive financial aid? Yes No

a. _____
 Name of Person Type of Expense (books, transportation, lab fees): Type of Grants/Loans Received (Pell Grants, Stafford Loan, Perkins Loan, work study)

b. _____
 Name of Person Type of Expense (books, transportation, lab fees): Type of Grants/Loans Received (Pell Grants, Stafford Loan, Perkins Loan, work study)

30. Have you or anyone in your household applied for Social Security Benefits or Supplemental Security Income (SSI)? Yes No *If yes, please complete:*

a. _____
 Name of Person Date of Application Status of Application (pending, approved, denied)

b. _____
 Name of Person Date of Application Status of Application (pending, approved, denied)

Resources

31. Have you, or anyone in your household received a lump sum payment? (such as a lawsuit, settlement, insurance settlement or SSI settlement) Yes No *If yes, please complete:*

_____	_____	\$ _____	_____
Name of Person Who Received the Lump Sum	Type of Lump Sum	Amount Received	Date Received
_____	_____	\$ _____	_____
Name of Person Who Received the Lump Sum	Type of Lump Sum	Amount Received	Date Received

Tell us about the resources in your household

32. Do you or anyone in your household have the following? Yes No

Type	Owner	Account Number	Amount / balance	Name/Address of institution	Jointly owned
Annuity					<input type="checkbox"/> Yes <input type="checkbox"/> No
Cash					<input type="checkbox"/> Yes <input type="checkbox"/> No
Certificate of Deposit (CD)					<input type="checkbox"/> Yes <input type="checkbox"/> No
Checking Account					<input type="checkbox"/> Yes <input type="checkbox"/> No
Savings Account					<input type="checkbox"/> Yes <input type="checkbox"/> No
College Fund/ Educational Accounts					<input type="checkbox"/> Yes <input type="checkbox"/> No
Inheritance					<input type="checkbox"/> Yes <input type="checkbox"/> No
Investments, Mutual Funds					<input type="checkbox"/> Yes <input type="checkbox"/> No
PASS Account or Individual Development Account					<input type="checkbox"/> Yes <input type="checkbox"/> No
Proceeds from Sale of a home or other assets					<input type="checkbox"/> Yes <input type="checkbox"/> No
Promissory Note					<input type="checkbox"/> Yes <input type="checkbox"/> No
Retirement Account: IRA, Keogh, 401(k)					<input type="checkbox"/> Yes <input type="checkbox"/> No
Reverse Mortgage					<input type="checkbox"/> Yes <input type="checkbox"/> No
Safe Deposit Box					<input type="checkbox"/> Yes <input type="checkbox"/> No
Stocks/ Bonds					<input type="checkbox"/> Yes <input type="checkbox"/> No
Trusts					<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (Please describe)					<input type="checkbox"/> Yes <input type="checkbox"/> No

Resources

33. Do you, or anyone in your household, have a vehicle that you are buying, have registered or own? (such as: car, van, motorcycle, truck, RV, boat, trailer) Yes No

a.	Jointly Owned?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
_____	_____	_____	_____	_____
Name of Person with Vehicle			Vehicle Year	Vehicle Type
	\$	\$		
_____	_____	_____	_____	_____
What Is Vehicle Used for (work, medical, school)	Value	Amount Owed	Vehicle Make	Vehicle Model
b.	Jointly Owned?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
_____	_____	_____	_____	_____
Name of Person with Vehicle			Vehicle Year	Vehicle Type
	\$	\$		
_____	_____	_____	_____	_____
What Is Vehicle Used for (work, medical, school)	Value	Amount Owed	Vehicle Make	Vehicle Model
c.	Jointly Owned?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
_____	_____	_____	_____	_____
Name of Person with Vehicle			Vehicle Year	Vehicle Type
	\$	\$		
_____	_____	_____	_____	_____
What Is Vehicle Used for (work, medical, school)	Value	Amount Owed	Vehicle Make	Vehicle Model

34. Do you, or anyone in your household, have any life insurance? Yes No

a.			
_____	_____	_____	_____
Name of Insured Person	Name of Insurance Company	Insurance Company Address/phone	
_____	_____	_____	_____
Name of Policy Owner	Policy Number	Date Purchased Loan Against this Policy	
_____	_____	_____	_____
Type of Life Insurance (whole, term)	\$ Face Value	\$ Cash Surrender Value	
b.			
_____	_____	_____	_____
Name of Insured Person	Name of Insurance Company	Insurance Company Address/phone	
_____	_____	_____	_____
Name of Policy Owner	Policy Number	Date Purchased Loan Against this Policy	
_____	_____	_____	_____
Type of Life Insurance (whole, term)	\$ Face Value	\$ Cash Surrender Value	
c.			
_____	_____	_____	_____
Name of Insured Person	Name of Insurance Company	Insurance Company Address and phone	
_____	_____	_____	_____
Name of Policy Owner	Policy Number	Date Purchased Loan Against this Policy	
_____	_____	_____	_____
Type of Life Insurance (whole, term)	\$ Face Value	\$ Cash Surrender Value	

Resources

35. Do you or anyone in your household have a burial policy or any money set aside to be used for burial, cremation or other funeral expenses? Yes No

a. _____
 Name of Person the Money Is Being Held for Mortuary, Bank, Insurance Company or Person

\$ _____
 Amount Being held Mortuary, Bank, Insurance Company, or Person Address and Phone Number

_____ Yes No
 If you have a burial policy, is it irrevocable?

b. _____
 Name of Person the Money Is Being Held for Mortuary, Bank, Insurance Company or Person

\$ _____
 Amount Being held Mortuary, Bank, Insurance Company, or Person Address and Phone Number

_____ Yes No
 If you have a burial policy, is it irrevocable?

36. There may be help with funeral expenses for some recipients. If your family should need such help, what would you prefer? Cremation Burial No Preference

37. Did you, or anyone in your household, give away anything of value within the last 5 years or 3 months for Food Stamps? (land, home, money, buildings, cars, boats) Yes No

a. _____	_____	_____	\$ _____	\$ _____
Name of Person Who Gave Away Item	Item Given Away	Date Given Away	Value of Item	Amount Owed
b. _____	_____	_____	\$ _____	\$ _____
Name of Person Who Gave Away Item	Item Given Away	Date Given Away	Value of Item	Amount Owed
c. _____	_____	_____	\$ _____	\$ _____
Name of Person Who Gave Away Item	Item Given Away	Date Given Away	Value of Item	Amount Owed

38. Are you or anyone in your household buying or the owner of any real estate other than the property where you live? (Example: rental property, Timeshare, warehouse, empty lot) Yes No If yes, please complete the following for each piece of real estate:

a. _____	Jointly Owned? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Name of Owner(s)		Type of Real Estate
_____	\$ _____	\$ _____
Location (street, city, state, and country)	Value	Amount Owed
b. _____	Jointly Owned? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Name of Owner(s)		Type of Real Estate
_____	\$ _____	\$ _____
Location (street, city, state, and country)	Value	Amount Owed

Veteran's Information

39. Have you, or anyone in your household, ever been in the military? Yes No

39a. Are you the widow(er) or a survivor of anyone that has been in the military? Yes No

If Yes to either of the above questions, please complete the following:

- a. Veteran's name, address & phone number _____
- b. Veteran's date of birth and place _____
- c. If Deceased, Veteran's date and place of death _____
- d. Your Relationship to Veteran _____
- e. Dates of Service _____
- f. Branch of Service _____
- g. Date of last VA benefit application or receipt of VA benefits _____
- h. Serial Number _____

39b. If spouse of Veteran, what was the maiden name, date & place of marriage:

40. If we are in need of additional information regarding your application and are unable to contact you, whom may we contact?

Name of person, address and phone

Relationship to You

Your Signature

By signing this form, I certify that I have reviewed this application; I understand and agree to the Rights, Responsibilities and Penalties and that the information I have given is true.

Signature of Applicant

Date (mm-dd-yyyy)

Applicant's Printed Name

Signature of person who helped complete this form

Authorized Representative, Conservator, or Guardian's Signature

Date (mm-dd-yyyy)

Authorized Representative, Conservator, or Guardian's Printed Name



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

Application for Assistance Part 2A

Child Support Information

Complete *Only If*:

- You have a parent absent from your home and
- You are applying for:
 - Colorado Works
 - Family Medicaid
 - Adult Medicaid with SSI Children

Please read and answer each question carefully.

This application is to help us collect information needed to determine whether you are eligible for public assistance programs. The information contained in this application will help determine your eligibility and benefit amount.

Are there any children in your household who have a parent(s) not living in the home?

Yes No **If yes, please complete the following pages:**



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

Child Support Services for Colorado Works and Medicaid Applicants

Child Support/Absent Parent Information

Applicant's Full Name (last, first, middle initial; include maiden or any other names used)

Social Security Number

Phone Number

Message Number

Home Address (street, PO Box, etc.)

Mailing Address (if different than home address)

City State ZIP Code

City State ZIP Code

IMPORTANT:

For information about Child Support Enforcement (CSE), please read the tear off section entitled "Required Child Support Services for Recipients of Colorado Works and/or Medicaid" at the back of this section.

If cooperation with child support could result in serious physical or emotional harm to you or your child(ren), you may apply for good cause. If good cause due to possible harm to you or your child(ren) is approved then child support enforcement services would be stopped.

Do you wish to request good cause? **Yes** **No**

The section on the next page collects needed information about your child(ren) and the parent(s) who are not included in your household but who may have a responsibility to children in your household. Please complete this section only if you are applying for Colorado Works and/or Medicaid benefits (recipients of 1931 Medicaid are required referrals to child support, other Medicaid types can voluntarily apply for child support services).

CHILD(REN)'S INFORMATION

	Child 1	Child 2	Child 3
Full legal Name			
Gender (M or F)			
Date of Birth			
Social Security Number*			
State or County of Conception			
Who is listed as the father on the birth certificate?			
	Child 4	Child 5	Child 6
Full legal Name			
Gender (M or F)			
Date of Birth			
Social Security Number*			
State or County of Conception			
Who is listed as the father on the birth certificate?			

*Social Security Numbers are used by the CSE Program to locate individuals or to establish paternity and support obligations. Also the Social Security Number assists to modify and enforce support obligations and to distribute child support payments. However, if the your child(ren) or absent parent's SSN is unknown, the CSE unit will not deny your request for assistance. The CSE unit may request more information at a later date, as needed, in their effort to get child and medical support for your family.

Legal Name of Absent Parent	1 st Absent Parent	2 nd Absent Parent	3 rd Absent Parent
Is there a court order for this Absent Parent to pay Child Support?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, for which child? 1 2 3 4 5 6 PLEASE CIRCLE	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, for which child? 1 2 3 4 5 6 PLEASE CIRCLE	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, for which child? 1 2 3 4 5 6 PLEASE CIRCLE
<ul style="list-style-type: none"> If yes, enter the Court case number. 			
<ul style="list-style-type: none"> If yes, enter the date of the order. 			
<ul style="list-style-type: none"> If yes, enter court's city and state. 			
<ul style="list-style-type: none"> If yes, enter the amount of child support order and how often to be paid (example: \$200 a month). 			
<ul style="list-style-type: none"> If yes, was medical support a part of the order? 	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Last known address of Absent Parent:			
Last known phone number:			
*Social Security Number of Absent Parent, date and place of birth (if neither is known, approximate age of absent parent).	SSN Dob Or approximate age Place of birth	SSN Dob Or approximate age Place of birth	SSN Dob Or approximate age Place of birth
Is there any other information about the absent parent? i.e. (absent parent's physical description, name, address and phone of Absent Parent's parents, siblings or friends)			
Name of Absent Parent's most recent employer and address or phone number of this employer			
Last known date Absent Parent was employed:			
If this absent parent has died, enter the date and city and state of death:			
If the absent parent is disabled or incarcerated, describe the disability or where they are incarcerated:			



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

Required Child Support Services for Recipients of Colorado Works and Medicaid

About Child Support and your Cooperation

The Colorado Child Support Enforcement (CSE) Program assists you in getting child support for your children from the absent parent (parent not living in your home). Also the CSE unit can assist in obtaining spousal maintenance. Such assistance includes locating the absent parent, establishing paternity if needed and a child support order. The CSE unit also modifies child support orders when appropriate.

As a condition of your Colorado Works and/or 1931 Medicaid eligibility *you must cooperate with the CSE unit*. Cooperating means giving information about the absent parent to the CSE unit needed to proceed.

Failure to cooperate with the CSE unit could cause you to lose all or part of your Colorado Works benefits or 1931 Medicaid for yourself. Also by cooperating the absent parent is held to their responsibility for your child or children.

You will receive a periodic notice of support payments collected by the CSE unit. When you are no longer receiving Colorado Works or 1931 Medicaid, the CSE Office will continue to provide child support services unless you tell them in writing to stop. At that time, the money collected for current child support will go directly to you. Should the money collected be un-funded (a bad check for example), it is possible you would be responsible for returning the money.

Good Cause

If cooperation could result in serious physical or emotional harm to you or the child(ren) due to the absent parent becoming angry about paying child support or providing health insurance, you may apply for good cause. For good cause to be approved you must provide the county department with evidence within 20 days of your good cause claim. If you need more time you may request it. Examples of such evidence includes:

- Court, criminal, child protective services, social services, psychological or law enforcement records that indicate that the alleged non-custodial parent might inflict physical or emotional harm on you or the children,
- The child was born after forcible rape or incest. Evidence include medical or law enforcement records indicating incest or forcible rape occurred, or sworn statement from persons who have knowledge of the basis of claim,
- The child is in the process of being adopted. Evidence includes court documents or a written statement from the public or private agency handling the adoption.

If it is decided, with your evidence that good cause is granted, your benefits will not be affected. If you do not have good cause you will receive notice from the county department to cooperate with the CSE unit, unless you appeal the decision.