For agency use only:	CBMS case number	
Tech number	Date of Face to Face Interview	
Technician name	County household number	

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

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		Medical Assistance Programs
❑	Aid to the Blind (State AB)	❑	Child Health Plan Plus (CHP+)/Family Medical Assistance
❑	Aid to the Needy Disabled (State AND)	❑	Emergency Medical Services (non-qualifying citizen)
❑	Colorado Supplement to SSI	❑	Medicaid Long Term Care (Nursing Home)
❑	Colorado Works (TANF)	❑	Medicaid Long Term Care (Home and Community Based Services)
❑	Food Assistance	❑	Medicare Part D – Low Income Subsidy
❑	Home Care Allowance (HCA)	❑	Medicare Savings Program - Medicaid
❑	Old Age Pension (OAP) Financial		

Language Information

English: If you need help completing this application, please contact your local county department of social services.

Spanish: Si usted necesita ayuda a completar esta aplicación, contacta por favor su departamento local de condado de servicios sociales.

Russian: Если Вы нуждаетесь в помощи, заканчивая это заявление, пожалуйста свяжитесь с вашим местным отделом социального обеспечения графства.

Arabic: إذا كنت تحتاج مساعدة لملء هذا التطبيق، يرجى الاتصال بمكتب خدمات المجتمع المحلي.

Farsi: اگر شما احتیاج دارید که کسی به شما در پر کردن این درخواست کمک کند، لطفا با ادارات محلی خدمات اجتماعی تماس بگیرید.

Vietnamese: Chương trình chưa dịch được câu này. Câu của bạn sẽ được chuyển đến những người sử dụng khác dưới dạng bài tập. Nếu bạn dịch được ngay câu này, hãy nhấn nút.

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

Application for Assistance

Important Information for Food Assistance (formerly called Food Stamps) applicants: Please complete and sign page 1 of this application to begin the process to apply for benefits. The information requested on the additional pages is needed to determine your eligibility.

Important Information for Nursing Home applicants: If you are applying for Medicaid Long-Term Care Nursing Home and need to secure your application date for Medicaid billing, copy pages 1 through 5, sign page 21, and submit them to your local Human Services office. You must submit the entire application within 10 business days from the date you submitted the pages. Please identify your nursing home here: _____

Household Information

Tell us about you

Last Name	First Name	Middle Initial	Maiden or other name you have used

Sex: ☐Male Female☐ (Answer to this question is not required by Food Assistance.)

Date of Birth (mm-dd-yyyy)

Place of Birth (City, State, Country)

Social Security Number (SSN)

☐ Check if you do not have a SSN

			-			-				

Phone number

Message Number (or another number to contact you or where message can be left)

Home Address (Street, PO Box, etc.)	Mailing Address (if different than home address)
City State ZIP Code	City State ZIP Code
Signature	Date

Available Services/accommodations

Handicap Accessible

Vision Impaired

ASL

TDDY

Language Interpreters

Household Information

Tell us more about you

Race/National Origin/Ethnicity (Optional, check all that apply):
❑ Asian ❑ American Indian or Alaska Native ❑ Black or African American
❑ Hispanic or Latino ❑ Native Hawaiian/Other Pacific Islander ❑ White ❑ Other

Student? ❑Yes No ❑
If yes, please complete Last Grade Completed _____ Name of school _____

Answers to the following questions are not required by Food Assistance:

Pregnant? ❑Yes No❑ *If yes, please complete:* ➢ Due Date (mm-dd-yyyy) _____ Number of Babies Expected _____

Marital Status: ❑ Married ❑ Never Married ❑ Divorced ❑ Widowed ❑ Separated

1. **What is your primary language?** Spoken: _____ Written: _____
2. **Are you a Colorado resident?** ❑Yes No❑
3. **Are you receiving benefits from another State, or have you received benefits from another state?** ❑Yes No❑ *If yes, please complete*:

   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❑

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 Assistance 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 Assistance issues, 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.

Expedited Services for Food Assistance. Your household may qualify for Expedited Service and receive food Assistance within 7 days. If you would like to apply for expedited Food Assistance, complete this box. You must meet one of the following criteria:

- ❑ 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 us 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 utilities for this month _____

Total rent or mortgage for this month _____

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

6. **Have you, or any member of your household, been convicted of fraudulently receiving duplicate Food Assistance benefits in any State after September 22, 1996?** ❑Yes No❑

7. **Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, going to jail, or violating a condition of parole or probation?** ❑Yes No❑ *If yes, who?* _____

8. **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?*_____

9. **Have you or any member of your household been convicted of buying or selling Food Assistance benefits over $500 after September 22, 1996?** ❑Yes No❑

10. **Have you or any member of your household been convicted of trading Food Assistance benefits for guns, ammunitions, or explosives after September 22, 1996?** ❑Yes No❑

11. **Have you or any member of your household been convicted of trading Food Assistance benefits for drugs after September 22, 1996?** ❑Yes No❑

12. **Have you, or any member of your household, applying for assistance been convicted of Welfare Fraud?** ❑ Yes No❑ *If yes, who?*_____

Household Information

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

Name (last, first, middle initial) | Relationship to You | SSN ❑Check if you do not have a SSN

Date of Birth (mm-dd-yyyy) | Place of Birth (City, State, Country)

Student? ❑Yes No❑ *If yes, please complete:* Last Grade Completed | Name of school

Race/National Origin/Ethnicity (Optional, check all that apply):

❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑Hispanic or Latino
❑ Native Hawaiian or Other Pacific Islander ❑White ❑Other

Answers to the following questions are not required by Food Assistance:

Pregnant? ❑Yes No❑
If yes, please complete ➢ Due Date (mm-dd-yyyy) | Number of Babies Expected

Marital Status: ❑Married ❑Never Married ❑Divorced ❑Widowed ❑Separated | Sex: ❑Male Female❑

Name (last, first, middle initial) | Relationship to You | SSN ❑Check if you do not have a SSN

Date of Birth (mm-dd-yyyy) | Place of Birth (City, State, Country)

Student? ❑Yes No❑ *If yes, please complete:* Last Grade Completed | Name of school

Race/National Origin/Ethnicity (Optional, check all that apply):

❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑Hispanic or Latino
❑ Native Hawaiian or Other Pacific Islander ❑White ❑Other

Answers to the following questions are not required by Food Assistance:

Pregnant? ❑Yes No❑
If yes, please complete ➢ Due Date (mm-dd-yyyy) | Number of Babies Expected

Marital Status: ❑Married ❑Never Married ❑Divorced ❑Widowed ❑Separated | Sex: ❑Male Female❑

Household Information

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

Name (last, first, middle initial) | Relationship to You | SSN ❑Check if you do not have a SSN

Date of Birth (mm-dd-yyyy) | Place of Birth (City, State, Country)

Student? ❑Yes No❑ *If yes, please complete:* Last Grade Completed | Name of school

Race/National Origin/Ethnicity (Optional, check all that apply):

❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑Hispanic or Latino
❑ Native Hawaiian or Other Pacific Islander ❑White ❑Other

Answers to the following questions are not required by Food Assistance:

Pregnant? ❑Yes No❑
If yes, please complete ➢ Due Date (mm-dd-yyyy) | Number of Babies Expected

Marital Status: ❑Married ❑Never Married ❑Divorced ❑Widowed ❑Separated | Sex: ❑Male Female❑

Name (last, first, middle initial) | Relationship to You | SSN ❑Check if you do not have a SSN

Date of Birth (mm-dd-yyyy) | Place of Birth (City, State, Country)

Student? ❑Yes No❑ *If yes, please complete:* Last Grade Completed | Name of school

Race/National Origin/Ethnicity (Optional, check all that apply):

❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑Hispanic or Latino
❑ Native Hawaiian or Other Pacific Islander ❑White ❑Other

Answers to the following questions are not required by Food Assistance:

Pregnant? ❑Yes No❑
If yes, please complete ➢ Due Date (mm-dd-yyyy) | Number of Babies Expected

Marital Status: ❑Married ❑Never Married ❑Divorced ❑Widowed ❑Separated | Sex: ❑Male Female❑

Household Information Tell us about anyone else who lives with you (even if they are not applying for assistance). You must list everyone who lives with you even if they are not applying. If you have already listed them in the previous section you do not need to list them here.

Name	Relationship to You	Date of Birth	Sex (Answer to this question is not required for Food Assistance.)	Do they usually buy food, prepare food, and eat with everyone in the house?
			❑ Male Female❑	❑ Yes No❑
			❑ Male Female❑	❑ Yes No❑
			❑ Male Female❑	❑ Yes No❑
			❑ Male Female❑	❑ Yes No❑
			❑ Male Female❑	❑ Yes No❑

Expenses Tell us about the expenses of your household. This section will collect information about your shelter expenses. Some programs will consider these costs when determining how much your benefits should be.

13. 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

14. Are you applying for benefits for anyone in a Medical Facility? *(For Example: Hospital, Nursing Home, Mental Health Institution)* ❑Yes No❑ *If yes, please complete::*

Name	Name of Facility	Medical Facility Address	Date Entered
1.			
2.			
3.			

15. Does anyone outside of the household help pay any shelter costs? ❑Yes No❑ *If yes, please complete:*

Who helps pay: _____

How much do they pay per month? **$** _____

Expenses Tell us about the expenses of your household.

16. 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❑

17. Are you asked to pay, or are you billed, for rent or a mortgage? ❑Yes No❑ *If yes, please complete:*

	Amount Paid	Amount Billed	How Often	Landlord/Mortgage Name/Address/Phone
Rent	$	$		
Mortgage	$	$		
2nd Mortgage	$	$		
3rd Mortgage	$	$		

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

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

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

Child Support or Spousal Maintenance Paid							
Name(s) of persons receiving support	**Person paying support**	**Legally obligated amount**	**Amount Actually Paid**	**Date of Last Payment**	**How Often Paid**	**County/State of Court Order**	**Amount of Arrearages**
1.							
2.							

Expenses Tell us about the expenses of your household.

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

	Amount Billed	Amount Paid	How Often	Name and Address where Payment is Sent
Heating	$	$		
Air Conditioning	$	$		
Electricity	$	$		
Water	$	$		
Trash	$	$		
Sewer	$	$		
Phone/Cell phone	$	$		

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

Name of child Receiving Care	Care Facility/Provider Name and Address	Amount Billed	Amount Paid	How Often Paid	Are you receiving help with these costs?
1.					❑Yes No❑
2.					❑Yes No❑

22. Are you, or anyone in your household, disabled? ❑Yes No❑ *If yes, please complete:*

Name of the Person with the Disability	Currently receiving treatment?
1.	❑Yes No❑
2.	❑Yes No❑
3.	❑Yes No❑

23. Has a medical provider told you, or anyone in your household, to cut back or limit activities? ❑Yes No❑ *If yes, please complete:*

Name of Person with Limitations _____ Limitations _____

Expenses Tell us about the expenses of your household.

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

Name of Person Receiving Care	Care Facility/Provider Name and Address	Amount Billed	Amount Paid	How Often Paid	Receiving help with these costs?
1.					❑Yes No❑
2.					❑Yes No❑
3.					❑Yes No❑

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

Name of Injured Person _____ Date of Injury _____

25a. Was this injury work related? ❑Yes No❑

25b. Have you filed a Workers' Compensation claim for this injury? ❑Yes No❑

25c. 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 _____

26. Do you have an attorney? ❑Yes No❑ *If yes, please complete*:

Attorney Name _____ Address _____

Phone/ FAX _____ City _____ State ZIP Code

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

28. 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
1.	Part A ❑ B ❑ C ❑ D ❑		
2.	Part A ❑ B ❑ C ❑ D ❑		
3.	Part A ❑ B ❑ C ❑ D ❑		
4.	Part A ❑ B ❑ C ❑ D ❑		

Expenses Tell us about the expenses of your household.

CHP+ provides health insurance for low-income children up to age 19 and pregnant women (19 and older). If you are interested in applying for CHP+, please complete this box.

29. Does anyone who is applying (up to age 19, or pregnant and over 19) have health insurance now? ❑Yes No❑ *If yes, please complete: (Include a copy of the front/back of the insurance card).* Name(s) of person(s) covered:

Policyholder's name: Last name | First Name | Middle Initial

Policy /Group number | Name and address of insurance company

29a. Has anyone in the household who is applying for CHP+ had health insurance through an employer's group in the last three (3) months? ❑Yes No❑ *If yes, please complete:*

Why did the person lose this insurance? | When did this insurance end? (m/dd/yy)

Policyholder's name | Phone number of insurance company | Name of employer's insurance company

Name(s) of person(s) covered | Amount paid monthly | Amount employer paid each month

29b. Do you, or any member of your household, have access to group health insurance and would like help paying the monthly premiums? ❑Yes No❑

29c. Does either parent or legal guardian of this child work for a Colorado state government agency and have access to State health benefits? ❑Yes No❑ *(Some children of Colorado State agency employees may not be eligible for CHP+ due to federal law.)*

To receive health insurance by CHP+, you must choose an Health Maintenance Organization (HMO) for the child applying. You can find information about HMOs at colorado.gov/hcpf. Please list your HMO here:

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

Name of Person with Expense	Name of Provider of the Service	Type of Medical Expense	Amount Paid	Date of Service	How Often
1.			$		
2.			$		
3.			$		
4.			$		
5.			$		

31. If you are under 21, do you or your children, need medical services? ❑Yes No❑ *If yes, please check the medical services you need?*

❑ 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)

Expenses Tell us about the expenses of your household.

RETROACTIVE MEDICAID You can request Medicaid coverage for three months prior to this application date. If you wish to apply for Retroactive Medicaid, complete this box.

32. Did you, or anyone in your household, have medical expenses in the past three months? ☐Yes No☐ *If yes, please complete:*

Name of person with Medical Expenses in the Past 3 Months	Dates of Service

You will be required to provide verification of income and resources for these 3 months.

33. Do you, or anyone in your household, have health insurance/medical coverage other than Medicaid? ☐Yes No☐ *If yes, please complete:*

Name of Person Covered	Name of Policy Holder	Policy Number	Monthly Payment	Date of Coverage	Insurance Company Name, Address, and Phone Number

Not a U.S. Citizen? If you are not a U.S. citizen please complete this box.

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

First Person's Name	Relationship to Applicant	SSN (optional)
Date of Entry (mm-dd-yyyy)	Alien Registration Number	☐ Check if you do not have a SSN
Second Person's Name	Relationship to Applicant	SSN (optional)
Date of Entry (mm-dd-yyyy)	Alien Registration Number	☐ Check if you do not have a SSN

34a. Do you, or anyone in your household, have a sponsor? ☐Yes No☐ *If yes, please complete:*

First Sponsor's Name	First Sponsor's Complete Address		Relationship to Applicant
Sponsor's Phone Number	Gross Monthly Income $	Resources/ Assets $	Number in Sponsor's Family
Second Sponsor's Name	Second Sponsor's Complete Address		Relationship to Applicant
Sponsor's Phone Number	Gross Monthly Income $	Resources/ Assets $	Number in Sponsor's Family

Income This section will collect all income including wages or any other money received by you or anyone in your household.

35. Do you, or anyone in your household, have a job? ❑Yes No❑ *If yes, please complete:*

Name of Employed Person in your Household	Employer's Name, Address, and Phone Number	Date Started	Hourly Wage/ Tips	Gross Monthly Income	How Often Paid	What day is payday?
1.			$	$		
2.			$	$		
3.			$	$		
4.			$	$		

36. Did you, or anyone in your household, leave or lose a job in the past 60 days? ❑Yes No❑
If yes, please complete:

First person

Name of person who lost job	Reason for Leaving	Last Date Worked
$ Gross Amount of Last Paycheck	Date of Last Paycheck	Employer Name, Address, Phone:
Check if this was your final paycheck. ❑		

Second person

Name of person who lost job	Reason for Leaving	Last Date Worked
$ Gross Amount of Last Paycheck	Date of Last Paycheck	Employer Name, Address, Phone:
Check if this was your final paycheck. ❑		

36a. Did you, or anyone in your household, reduce the number of hours per week worked, in the past 60 days? ❑Yes No❑

Name of person whose hours were reduced	Reason for reduced hours	Number of hours worked before reduction	Number of current hours worked

Income Tell us about the income in your household.

37. 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

$ _____ Average Monthly Income

_____ Number of Hours Worked Per Week

_____ Business Name, Address, and Phone Number

You will be asked to provide proof of your business earnings and expenses.

38. 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

39. Have you, or anyone in the household, applied for Unemployment benefits? ❑Yes No❑ *If yes, please complete*:

Name of Person Who Applied for Unemployment	Date Applied for Unemployment
1.	
2.	
3.	

40. Does anyone pay you or any member of your household for meals, a room or both? ❑Yes No❑ *If yes, please complete*:

_____ Name of Person Receiving Payment

Room Only ❑ Room and Meals ❑

$ _____ Amount Received

_____ How Often?

_____ Name of Person Receiving Payment

Room Only ❑ Room and Meals ❑

$ _____ Amount Received

_____ How Often?

40a. 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/ expenses.*

Person Who Is Paying the Expense	Type of Expense	Amount of Expense	Hours Spent Providing Meals, a Room, or Both
1.		$	
2.		$	

Income Tell us about the income in your household.

41. Do you, or anyone in your household, attend college, technical school or trade school?
❑Yes No❑ *If yes, please complete*:

Name of Person Attending School	Enrollment Status	Expected Graduation Date	Name of School
1.	❑ Full-Time Part-Time ❑		
2.	❑ Full-Time Part-Time ❑		

42. Do you, or anyone in your household, receive student financial aid? ❑Yes No❑

Name of Student Receiving Financial Aid	Type of Expense (books, transportation, lab fees):	Type of Grants/Loans Received (Pell Grants, Stafford Loan, Perkins Loan, Work Study)
1.		
2.		

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

Name of Person(s) Who Applied	Date of Application	Status of Application (pending, approved, denied)
1.		
2.		
3.		
4.		

44. Have you, or anyone in your household received a lump sum payment? (For Example: a lawsuit settlement, insurance settlement, inheritance, proceeds from surrender of life insurance or annuity, or SSI or Social Security settlement) ❑Yes No❑ *If yes, please complete*:

Name of Person Who Received the Lump Sum	Type of Lump Sum	Amount Received	Date Received
1.		$	
2.		$	
3.		$	
4.		$	

Income Tell us about the income in your household.

45. 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 Ex-Spouse		$		
Annuity		$		
Cash Contributions/Gifts		$		
Child Support		$		
		$		
Dividends/Interest		$		
Income from Trust		$		
Insurance/Lawsuit Payments		$		
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)		$		
		$		

Resources Tell us about what you own, or are buying (For Example: vehicles, bank accounts, personal property or insurance for anyone in your household.)

46. Do you or anyone in your household have the following? ❑Yes No❑ *If yes, please complete:*

Type	Owner	Account Number	Amount/ balance	Name/Address of institution	Jointly owned
Annuity			$		❑Yes No❑
Cash			$		❑Yes No❑
Certificate of Deposit (CD)			$		❑Yes No❑
Checking Account			$		❑Yes No❑
Savings Account			$		❑Yes No❑
College Fund/Educational Accounts			$		❑Yes No❑
Inheritance			$		❑Yes No❑
Investments, Mutual Funds			$		❑Yes No❑
PASS Account or Individual Development Account			$		❑Yes No❑
Proceeds from Sale of a Home or Other Assets			$		❑Yes No❑
Promissory Note(s) owed to you			$		❑Yes No❑
Retirement Account: IRA, Keogh, 401(k)			$		❑Yes No❑
Reverse Mortgage			$		❑Yes No❑
Safe Deposit Box			$		❑Yes No❑
Stocks/Bonds			$		❑Yes No❑
Trusts			$		❑Yes No❑
Other (Please describe)					❑Yes No❑

Resources Tell us about the resources in your household.

47. Do you, or anyone in your household, have a vehicle that you are buying, have registered, or own? (For Example: car, van, motorcycle, truck, RV, boat, trailer) ❑Yes No❑ *If yes, please complete*:

	First Vehicle	Second Vehicle	Third Vehicle	Fourth Vehicle	Fifth Vehicle
Name of Person on Title and Registration					
Name of Person with Vehicle					
Jointly Owned?	❑Yes No❑	❑Yes No❑	❑Yes No❑	❑Yes No❑	❑Yes No❑
Vehicle Make					
Vehicle Model					
Vehicle Year					
What Is Vehicle Used for (work, medical, school)					
Value	$	$	$	$	$
Amount Owed	$	$	$	$	$

48. Do you, or anyone in your household, have any life insurance? ❑Yes No❑ *If yes, please complete*:

	First Policy	Second Policy	Third Policy	Fourth Policy
Name of Insured Person				
Name of Insurance Company				
Insurance Company Address/phone				
Name of Policy Owner				
Policy Number				
Date Purchased				
Loan Against Policy	$	$	$	$
Type of Life Insurance (whole, term)				
Face Value	$	$	$	$
Cash Surrender Value	$	$	$	$

49. 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❑ *If yes, please complete*:

Name of Person the Money Is Being Held for	Amount Being held	Is it irrevocable?	Name, address, and phone number of Mortuary, Bank, Insurance Company or Person holding money
	$	❑Yes No❑	
	$	❑Yes No❑	
	$	❑Yes No❑	

Resources Tell us about the resources in your household.

50. Did you, or anyone in your household, give away anything of value within the last 5 years or 3 months for Food Assistance? (For Example: land, home, money, buildings, cars, boats, cash) ❑Yes No❑ *If yes, please complete:*

Name of Person Who Gave Item Away	Item Given Away	Date Given Away	Value of Item	Amount Owed
1.			$	$
2.			$	$
3.			$	$

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

Name of First Owner(s) or Buyer(s)	Jointly Owned? ❑Yes No❑	Type of Real Estate
Address of Where Property is Located (Street, city, state, and country)	$ Value	$ Amount Owed
Name of Second Owner(s) or Buyer(s)	Jointly Owned? ❑Yes No❑	Type of Real Estate
Address of Where Property is Located (Street, city, state, and country)	$ Value	$ Amount Owed

Veteran, or entitled to Veteran Benefits? Tell us about your veteran information in this box.

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

52a. 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:*

Veteran's name, address & phone number

Veteran's date of birth and place

If deceased, Veteran's date and place of death

Your Relationship to Veteran

Dates of Service

Branch of Service

Date of last VA benefit application or receipt of VA benefits

Serial Number

52b. If spouse of Veteran, what was the maiden name, date & place of marriage:

53. 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

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 recover all medical assistance benefits paid on behalf of Medicaid clients, including capitation payments, 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 may be 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 Assistance), 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 SSN(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 SSNs. 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.

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 (TANF), I will give the agency all rights to current support and past due support owed on an existing court order. I know that I must 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 (TANF) and Medicaid. While my children and I receive cash assistance under Colorado Works (TANF) and Medicaid, the agency will try to collect current and overdue support. When we no longer receive cash assistance under Colorado Works (TANF) 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 Assistance 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, 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 (TANF) or Food Assistance for 12 months for the first offense, 24 months for the second offense, and permanently for the third offense. A court can also stop a person from getting Food Assistance for another eighteen months. This crime is subject to prosecution under other federal laws. Receiving duplicate benefits of Food Assistance or Colorado Works (TANF) 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 Assistance 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.

To receive Food Assistance, certain members of the household need to register for work. This means that certain members of the household must: 1) Report to the Employment First (work program) when the Food Assistance office schedules you for an appointment. 2) 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. 3) Provide information to the Food Assistance office or the Employment First (work program) about any jobs you get while you are on food Assistance. 4) Tell the Food Assistance 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.

Rights, Responsibilities, and Penalties (continued)

I UNDERSTAND AND AGREE THAT:

If you do not do what you are assigned to do, you may be disqualified from receiving Food Assistance benefits. If you are an adult between the ages of 18 and 49, with no children under the age of 18 in your Food Assistance household, you will only be able to get Food Assistance 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 Assistance 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 Assistance 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 application
Authorized Representative, Conservator, POA, or Guardian Signature	Date (mm-dd-yyyy)
Authorized Representative, Conservator, POA, or Guardian Printed Name	Guardian or person who helped complete application address/phone

If you are applying for Medicaid You need to send proof of U.S. Citizenship and Identity. You can send ONE of these to prove **both** Citizenship and Identity:

- U.S. passport **OR**
- Certificate of Naturalization (DHS Forms N-550 or N-570) **OR**
- Certificate of US Citizenship (DHS Forms N-560 or N-561)

If you don't have any of those, send one paper proving Citizenship AND one paper proving identity for any person applying for Medicaid from the list below.

Citizenship	**Identity**
▪ U.S. Birth Certificate	▪ Driver's license or state ID card with photo
▪ Certificate of birth abroad (Form FS 545)	▪ ID card issued by a federal, state, or local government agency
▪ U.S. National ID card (Form I-197 or I-179)	▪ U.S. military card or draft record or U.S. Coast Guard Merchant Mariner Card
▪ Native American Tribal Document	▪ School ID card with a photo
▪ Final adoption decree	
▪ Official military record of service showing a U.S. place of birth	▪ Verified School, Nursery or Daycare records (for children under 16)
▪ Religious/School records	▪ Clinic, Doctor or Hospital records (for children under 16)

Copies of the original documents may be accepted **ONLY** after documentation has been viewed and certified by a site approved by the State of Colorado. A list of approved sites is available at: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1217412405165 under "List of Locations that can Verify Documents" If you need help or more information regarding additional documentation, ask your county technician or visit colorado.gov/hcpf

This form is required for Family Medicaid, CHP+ and Adult Medicaid

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 Guardian's Signature	Date (mm-dd-yyyy)

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 Guardian's Signature	Date (mm-dd-yyyy)

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 Guardian's Signature	Date (mm-dd-yyyy)

This form is required for cash assistance. 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 Assistance 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 Assistance 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 _____

Child Support Information. This section must be completed if you have a parent absent from your home and you are applying for Colorado Works (TANF) or Adult Medicaid with SSI Children. You may complete this section if you would like assistance with child support.

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:*

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

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 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.

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

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 (TANF) and/or 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 (TANF) benefits or Medicaid for yourself. 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 (TANF) or 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 unfunded (a bad check for example), it is possible you would be responsible for returning the money.

Child Support Information. **This section must be completed if you have a parent absent from your home and you are applying for Colorado Works (TANF) or Adult Medicaid with SSI Children. You may complete this section if you voluntarily would like assistance with child support.**

This section 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 (TANF) and/or Adult Medicaid with SSI children** (recipients of other Medicaid types may apply for child support services).

	First Child	Second Child	Third Child
Full Legal Name			
Gender (M or F)			
Date of Birth			
SSN*			
State or County of Conception			
Who is listed as the father on the birth certificate?			

	Fourth Child	Fifth Child	Sixth Child
Full Legal Name			
Gender (M or F)			
Date of Birth			
SSN*			
State or County of Conception			
Who is listed as the father on the birth certificate?			

*SSNs are used by the CSE Program to locate individuals or to establish paternity and support obligations. Also, the SSN assists to modify and enforce support obligations and to distribute child support payments. However, if your child(ren) or the 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	1st Absent Parent	2nd Absent Parent	3rd Absent Parent
Is there a court order for this Absent Parent to pay Child Support?	❑Yes No❑ If yes, for which child? 1 2 3 4 5 6 PLEASE CIRCLE	❑Yes No❑ If yes, for which child? 1 2 3 4 5 6 PLEASE CIRCLE	❑Yes No❑ If yes, for which child? 1 2 3 4 5 6 PLEASE CIRCLE
If yes, enter the Court case number.			
If yes, enter the date of the order.			
If yes, enter court's city and state.			
If yes, enter the amount of child support order and how often to be paid (example: $200 a month).			
If yes, was medical support a part of the order?	❑Yes No❑	❑Yes No❑	❑Yes No❑
Last known address of Absent Parent:			
Last known phone number:			
*SSN 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:			