STATE OF COLORADO

Redetermination/Recertification Form

Date:

Case #

Please return your information to me at:

In order to determine your continued eligibility and benefits, you must complete and return this form. Please answer the questions below by selecting "Yes" or "No" and tell us about the change. Please attach a separate piece of paper if you have more than one change for each question. You may be required to give information verifying your answers. ***Please note: Not all programs require all verifications. Please refer to the Verification of Information Sheet included in this packet.***

1. **Are there any new members in your household?** ☐ Yes ☐ No
   If yes, please provide the following:

   New Members Name:_____ DOB:_____

   Relationship:_____ Date Entered the Home:_____

   Are they a US Citizen or a Non-Citizen? (Please circle one)

   If non-citizen, do they have a sponsor? ☐ Yes ☐ No

2. **Has any member of your household left the home?** ☐ Yes ☐ No
   If yes, please provide the following:

   Name:_____ Relationship:_____ Date Left the Home:_____

3. (For Adult Financial Clients Only) **Have you or has any member of your household left the US for more than 30 consecutive days?** ☐ Yes ☐ No
   If yes, please provide the following:

   Name:_____Date(s) Left the US:_____ Date(s) Returned to the US:_____

Are you or are any members of your household:

4. **Pregnant?** ☐ Yes ☐ No
   If yes, please provide the following:

   Name:_____ Due Date:_____ Number of Babies Expected:_____

5. **Incarcerated?** (such as jail or prison) ☐ Yes ☐ No
   If yes, please provide the following:

   Name:_____ Date of Incarceration:_____

6. **Institutionalized?** (such as hospital, treatment center or nursing home) ☐ Yes ☐ No
   If yes, please provide the following:

   Name:_____Date Institutionalized:_____Date Released: _____

7. (For Colorado Works Children Only) **Is each child current on his/her immunizations?** ☐ Yes ☐ No
   If No, please provide the following:

   Child's Name:_____

8. (For Colorado Works Clients Only) **A convicted felon?** ☐ Yes ☐ No
   If yes, please provide the following:

   Name:_____ Date of Conviction:_____

9. (For Food Assistance and Colorado Works Clients Only) **A fleeing felon?** ☐ Yes ☐ No
   If yes, please provide the following:

   Name:_____

10. **On Strike?** ☐ Yes ☐ No
    If yes, please provide the following:

    Name:_____

Do you or does any member of your household:

11. **Have a new home or mailing address?** ☐ Yes ☐ No
    If yes, please provide the following:

    Name:_____ Phone Number(s): _____

    New Home Address: _____

    New Mailing Address: _____

12. **Have medical expenses?** ☐ Yes ☐ No
    If yes, please provide the following:

    Name:_____ Date of Expense(s):_____Amount of Expense(s): _____

13. **Have dependent/elder care or child care expenses?** ☐ Yes ☐ No
    If yes, please provide the following:

    Name:_____Amount of Expense(s):_____

14. **Have child support expenses?** ☐ Yes ☐ No
    If yes, please provide the following:

    Name:_____Amount of Expense(s):_____

15. Have work income? ☐ Yes ☐ No
If yes, please provide the following:

Name:_____ Employer Name:_____

Monthly amount:_____ How often are you paid?_____

16. Have non-work income? ☐ Yes ☐ No
If yes, please provide the following:

Name:_____

Monthly amount:_____ How often are you paid?_____

17. Have self employment income? ☐ Yes ☐ No
If yes, please provide the following:

Name:_____

Monthly amount before taxes:_____

18. Have any other income? ☐ Yes ☐ No
If yes, please provide the following:

Name:_____ Date Received:_____Type of Income Received:_____

19. (For Food Assistance and Colorado Works Clients Only) **Have utility expenses?** ☐ Yes ☐ No
If yes, please provide the following:

List the monthly amount for each of the following:

Gas:_____ Electric:_____ Water:_____ Phone:_____ Other:_____

20. (For Food Assistance and Colorado Works Clients Only)
Ever received LEAP for your current address? ☐ Yes ☐ No

21. (For Adult Financial, Colorado Works and Food Assistance Clients Only)
Pay rent or mortgage? ☐ Yes ☐ No
If yes, please provide the following:

Monthly amount of rent or mortgage:_____

22. (For Adult Financial, Colorado Works, Food Assistance and Long Term Care Clients Only)
Own any vehicles? ☐ Yes ☐ No
If yes, please provide the following:

Owners Name:_____ Make:_____ Year:_____ Value:_____

23. (For Adult Financial, Colorado Works, Food Assistance and Long Term Care Clients Only)
Have any resources? ☐ Yes ☐ No
If yes, please provide the following:

Name:_____ What type:_____ Dollar value:_____

24. Sold or Given away any resources? ☐ Yes ☐ No
If yes, please provide the following:

Name:_____ Date:_____ Type:_____ Value:_____

25. (For CHP+ Clients Only) **Have a child with a parent or legal guardian who works for a Colorado State Government Agency and has access to State Health Benefits?** ☐ Yes ☐ No

If yes, please provide the following:

Name of Child:_____

26. Have other health insurance? ☐ Yes ☐ No

If yes, please provide the following:

Name of Policy Holder:_____ Name of Insured:_____

Name of Insurance Company:_____ Effective Date of Coverage:_____

Group #:_____ Policy #:_____

27. Have all Social Security Numbers (SSN) been reported for all members of your household who are requesting assistance? ☐ Yes ☐ No

If no, please provide the following:

Name:_____ SSN #: _____

28. Attend School? ☐ Yes ☐ No

If yes, please provide the following:

Name:_____Age:_____

Will this person graduate on or before age of 19? ☐ Yes ☐ No

Other Information:

29. (For CHP+ Clients Only)
Please provide a Health Maintenance Organization (HMO) choice:_____

For information on HMOs visit: **www.chpplus.org or call 1-800-359-1991**

30. By checking (x) this box:
I confirm that I have no changes or additions to report. ☐

Case #

PENALTY WARNING - FOR FOOD ASSISTANCE AND COLORADO WORKS ONLY

DO NOT give false information, or hide information, to continue receiving food assistance and/or Colorado Works.
DO NOT trade or sell food assistance benefits to anyone who is not authorized to use them for your household.
DO NOT use food assistance benefits to buy ineligible items, such as alcohol drinks, tobacco, or lottery tickets.
DO NOT use someone else's food assistance benefits for your household.

Anyone in your household who intentionally breaks any of these rules can be disqualified from the food assistance and/or Colorado Works program for 12 months, 24 months, or permanently. Anyone found to have received multiple benefits by misrepresenting his/her identity or residence can be disqualified for 10 years. You may also be fined up to $250,000, imprisoned up to 20 years, or both and subject to prosecution under other applicable federal laws.

PENALTY WARNING - FOR ALL MEDICAL PROGRAMS

By completing this Redetermination/Recertification Form you understand that the information you have provided is truthful under penalty of perjury.

PLEASE READ THE FOLLOWING AND SIGN BELOW

I understand the penalty for hiding or giving false information. I also understand I will owe the value of any benefits I receive because I have not fully reported changes in my household. I agree to prove any changes I report. My answers on this form are correct and complete to the best of my knowledge.

I understand and agree that to receive Food Assistance, certain members of the household need to register for work. This means that certain members of the household must: 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.

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.

I understand that my signature authorizes Federal, State, and Local officials to contact other persons or organizations to verify the information I have provided.

Your Signature Today's Date

IF YOUR BENEFITS CHANGE

We'll use your answers on this form to see if your household benefits will change. If your benefits change, you will be notified. If you don't agree with our decision, you can have a fair hearing. A hearing official will decide if you are right.

For Food Assistance:
In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability. To file a complaint of discrimination write USDA, Director, Office of Civil rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

For Colorado Works:
If you believe that you have been treated unfairly because of race, color, sex, age, religion, political belief, national origin, mental or physical disability, you have a right to complain to your County Department of Human Services or the Colorado Department of Human Services (Colorado Works). You can also write a letter of complaint to the Federal government at the following addresses:

U.S Department of Health and Human Services
Office for Civil Rights
Regional Program Manager
Federal Office Building
1961 Stout Street, 14th Floor, Rm. 1426
Denver, CO 80294

OR

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Ave., SW
Room 509F
Washington, DC 20201
(800) 368-1019

Case #

Statement of Rights and Responsibilities

I understand that by signing below, I acknowledge that I received the following information about my rights and responsibilities:

Client Rights

I have the right to apply for any category of public and/or medical assistance and to have my eligibility for such assistance determined.

This application will be reviewed without regard to race, color, sex, age, disability, religion, national origin, or political belief.

I have the right to request assistance from my worker in securing documentation needed to determine my eligibility for public and/or medical assistance, when I am unable to secure such documentation.

I do **NOT** have to give information on citizenship or immigration status of family members who are **NOT** applying for health care benefits or public assistance.

The information I have given is confidential. However, it can be released only if needed by the program(s) in which I am or my family members are enrolled or participating. The information given on my application may be reviewed and verified by my County Department of Social Services, the Department of Health Care Policy and Financing or its designees.

I may request a Fair Hearing if I disagree with any action taken when the application is processed. Information on how to request a Fair Hearing is printed on the back of all notices of action.

I may request an appeal if I disagree with my rating for CHP+. Information on this process is included in all notices of action sent by CHP+.

Client Responsibilities

I must show proof that my family is eligible for benefits.

If I give false information on purpose so that my family member(s) can get public assistance or health care, I must pay the program(s) back for any benefits received. It is a crime punished by fines and/or jail time to take benefits that I know I am not eligible to get.

I must cooperate fully with State and Federal staff if my case is reviewed.

My responsibilities include reporting changes in my or my household's circumstances to my worker. For Medical and Financial programs I must report changes **within 10 days** from the day I know about the change**.** For Food Assistance I must report changes **within the first ten days following the month that the change occurred. If you are only participating in the Food Assistance program and are certified as a Simplified Reporting household**, the following reporting requirements do not apply to you. Your worker should have explained what changes you need to report for the Food Assistance Program.

I must report the following kinds of changes:

- If someone moves in or out of the home in which I live.
- If any income of any person in my household changes.
- If I move or my rent or utilities amount changes or I begin to receive a LEAP payment.
- If my cash, money in bank accounts, value of stocks or bonds or vehicle ownership changes.
- If I apply for unemployment insurance.
- If I begin a job or leave a job.
- If legally obligated child support payments change.
- If you or any household members start receiving other health insurance.

On approval of my application for Medical Assistance, I give the State the right to collect for medical expenses it pays for anyone listed on my application that should have been paid by someone else.

I am responsible for paying medical fees and co-payments for myself and my family if they are required. If my family is enrolled in Medical Assistance and other insurance is paying for their medical care, my Medical Assistance program will pay last.

VERIFICATION OF INFORMATION

Please provide as much of the following information as you can. All bills and proof of information must be current. We will tell you if we need any other information at the time your application is processed or at the time of interview. *If you have a Sponsor, you may need to provide proof of your Sponsor's income and resources*.

1. PROOF OF ALL INCOME RECEIVED BY YOU OR OTHER MEMBERS OF YOUR HOUSEHOLD.
Income is any money your household receives. Proof of income may include but is not limited to:

Wages/Tips	Retirement Pension	Gifts/Allowances/Contributions
Self Employment	Veterans Benefits	Interest from savings, cd, etc.
Child Support	Military Allotment	Educational Loan/Grant
Unemployment	Rental Income	
Social Security	Roomer/Boarder	
Alimony/Maintenance	Colorado Works Cash	

2. SOCIAL SECURITY NUMBERS (SSN).
The SSN or proof of applying for an SSN should be provided for each member unless the member does not wish to apply for benefits or does not have one.

3. PROOF OF AGE AND IDENTITY.
You *may* be required to provide identification for yourself and all household members applying for benefits such as a:

Birth Certificate	ID for Health Benefits
Baptismal Record	Work ID
US Passport	Other Documents
Drivers License	

Identification Cards for US Citizens (CIS-I-179 or CIS-I-197)
Certificate of US Citizenship (CIS form N-560 or NH-561)
Certificate of Naturalization (CIS form N-550 or N-570)
Certificate of birth abroad of a citizen in the US (Department of State forms FS-545 or DS-1350)

4. PROOF OF CITIZENSHIP AND RESIDENCE.
You *may* be required to provide proof of citizenship and residence.

<u>If you are a US citizen, you may be required to provide proof, such as a</u>:

Birth Certificate	ID for Health Benefits
Client Statement	Work ID
US Passport	Baptismal Record
Drivers License	Other Documents

Drivers License
Other Documents
Forms from Citizenship and Immigration Services (CIS) such as:

Identification Cards for US Citizens (CIS-I-179 or CIS-I-197)
Certificate of US Citizenship (CIS form N-560 or NH-561)
Certificate of Naturalization (CIS form N-550 or N-570)
Certificate of birth abroad of a citizen in the US (Department of State forms FS-545 or DS-1350)

<u>If you are a legal non-citizen, you may be required to provide proof of your status, such as:</u>

CIS Documents
I-551 Resident Alien Card
I-94 Arrival/Departure Record
I-688B or I-766 Employment Authorization Document
A letter from CIS indicating a person's status

5. PROOF OF RESOURCES. (Not required for Family Medical and CHP+ programs)
You *may* be required to provide proof of resources. Proof of resources may include, but are not limited to:

Vehicles	Trust Funds	Checking/Savings Accounts
Real Estate	Life Insurance	Other
Stock and Bonds	Burial Insurance	
Retirement Funds	Home you do not live in	

6. PROOF OF EXPENSES.
You *may* be required to provide proof of expenses. Proof of expenses may include, but are not limited to:

Utilities	Child support payments
Medical expenses	Child dependent care costs
Rent or mortgage costs	Expenses for care of disabled household members

7. LIVING ARRANGEMENTS. (For Food Assistance Only)
If you are living with other people in the same house, an explanation of your living arrangements will be helpful. It should include how you buy and prepare food and how rent/ mortgage and utilities are paid.

8. CHILD SUPPORT INFORMATION. (For Food Assistance and Colorado Works Only)
If a parent to your child(ren) is out of the home, you must bring copies of any court orders. These court orders include orders involving a divorce, child support or paternity establishment. In addition to social security numbers for you and your children, please provide social security number(s) for the absent parent(s), if available.