Application for Public Assistance
State of Colorado Departments of Health Care Policy and Financing and Human Services

Please check the programs you want.

Food	**Food Assistance –** Helps you buy food. **You have the right to file your application today. You can complete your name, address, and signature and turn this form into the office where you live.** An interview is required, and even if you are not a U.S. citizen, you may apply for persons in your home who are citizens. **Benefits begin from the date the office received your signed application.** A decision will be made as quickly as possible, but no later than 30 days from the date the office receives your signed application. If expedited assistance is denied, you may ask for an informal hearing.	
Cash Programs	**Colorado Works** – For households with a child or a pregnant mother with no other children. Provides a cash benefit to families in need. With a few exceptions, parents must participate in work activities. You will be required to apply for Child Support Services, please complete Schedule A.	
	Colorado Supplement to SSI – For persons not receiving the full SSI grant. Colorado Supplement provides a cash supplement.	
	Aid to the Needy Disabled (State AND) and **Aid to the Blind (State AB)** – For persons ages 18-59 who are totally disabled for at least six months or persons under age 59 who meet the definition of blindness. Provides a cash benefit. These programs do not include medical benefits.	
	Old Age Pension (OAP) – For low income persons age 60 or over. Provides a cash benefit and includes medical assistance. If you check this box, also check Adult Medical Assistance below.	

	Home Care Services – For persons who need help on a regular basis with some or all of their daily self-care (such as bathing, dressing, eating, getting around, and using the bathroom). Provides a cash benefit to pay the provider for home care services. A functional assessment is required.	
Medical Assistance Programs	**Family Medical Assistance (FM)** and **Child Health Plan *Plus* (CHP+)** – For children under 19, families, and pregnant women. Immediate, temporary coverage may be available for children and pregnant women through the Presumptive Eligibility Program.	
	Long-Term Care Medical Assistance (LTC) (Nursing Facility or Home and Community Based Services) – For persons needing help to pay for services received in their homes or in a medical facility for stays longer than 30 days. A medical and functional assessment is required.	
	• **Personal Needs Allowance (PNA) –** For persons residing in a nursing home who have income less than $50 per month for personal needs.	
	Medicare Savings Program (MSP) – For persons who need help to pay for some of their Medicare costs, such as premiums, deductibles, and co-insurance.	
	Adult Medical Assistance (AM) – For persons who are disabled, blind, or age 19 and older.	
	Low Income Subsidy (LIS) – For persons needing help to pay for some of their Medicare Part D prescription costs, such as premiums, deductibles, and co-insurance. Before you apply for this program, please call 1-800-772-1213 to find out if you are already enrolled.	

Use another sheet of paper, if there is not enough room for your answers on this application.

Your **FIRST** Name	Middle Initial	**LAST** Name	Social Security Number*

Home Address (Number, Street)	City	State	ZIP	Telephone Number

Mailing Address (If Different From Home Address)	City	State	ZIP	Message Phone

Facility Name /Address (Nursing Home, Assisted Living)	Facility Telephone Number

Email Address	Are You Homeless?	Is Colorado Your Home?	Do You Want a Phone Interview?
	❑Yes No❑	❑Yes No❑	❑Yes No❑

*Optional for Medical Assistance Programs if not applying.

Under penalties of perjury, I state that I have examined this application, and to the best of my knowledge and belief my answers are true, including household composition, citizenship and non-citizenship information, and I have listed all amounts and sources of income and property I receive/own. I understand and agree to "What I Should Know".

Your Signature	Date	Spouses/ Co-Applicant Signature, If Applying (Not Required For Food Assistance)	Date
Authorized Representative, Conservator, Guardian Printed Name	Date	Person Who Helped Complete Application Address/Phone	Date

Instructions: List everyone living in your home, even if you are not applying for them. (For Adult Medical, LTC, and MSP programs, be sure to include information about the applicant living outside of the home and information about the spouse.)

Relation to You	Name (First, Middle, Last)	Birth Date (MM/DD/YY) and Birth State	*Male/ Female (M/F)	Does This Person Want Benefits	*Married, Single, Divorced, Separated	Optional For People Not Applying.		
						Social Security Number (SSN)	**Race	US Citizen
Yourself		/ / *State:		❑Yes ❑No		My SSN is above		❑Yes ❑No
		/ / *State:		❑Yes ❑No				❑Yes ❑No
		/ / *State:		❑Yes ❑No				❑Yes ❑No
		/ / *State:		❑Yes ❑No				❑Yes ❑No
		/ / *State:		❑Yes ❑No				❑Yes❑ No

** This is voluntary for food assistance. **Race information is optional, will not affect eligibility, and is to assure that benefits are provided regardless of race/color/national origin. Race options include: Asian – A; Hispanic/Latino – H; American Indian/Alaskan Native - AI; White – W; Native Hawaiian/Pacific Islander- NH; Black/African American. – B; Other – O.*

Are You a Non-Citizen?	❑Yes No❑	*If yes, please include a copy of the front and back of your U.S. Citizenship and Immigration Services card and complete below.*

Name of Non-Citizen				Sponsor(s)' SSN, Name, Address, Phone Number	
Alien Number		Date of Entry Into the U.S.			
Name of Non-Citizen				Sponsor(s)' SSN, Name, Address, Phone Number	
Alien Number		Date of Entry Into the U.S.			

Do You Speak and Read English?	❑Yes No❑	*If no, what language(s) do you speak?*	

You may receive food assistance within 7 days if you have little or no income and less than $100 in the bank and on hand; OR if your monthly shelter costs are more than your monthly income plus any cash on hand and in the bank.

Including yourself, how many people in your home do you buy and prepare food for?		If you are supposed to pay utilities, write the amount:			
Total money expected in the home this month (before deductions).	$	Electricity	$	Gas	$
If you are supposed to pay rent or mortgage, write the amount.	$	Trash	$	Water	$
Total cash on hand and money in your checking/savings accounts.	$	Sewage	$	Phone	$

Is anyone in the home a migrant or seasonal farm worker?	❑Yes No❑	Home Insurance/Property Taxes/HOA Fees	$
Did anyone in the home get benefits in another state in the last 30 days?	❑Yes No❑	Are any costs for heating or cooling?	❑Yes No ❑

Is Anyone in the House Pregnant?		**❑Yes ❑ No**	***If yes, please complete below.***		
Who is Pregnant?		***What is the Due Date?***		***How Many Babies Are Expected?***	
List the name of the father.					

Does Anyone in Your Home Have a Disability?	**❑Yes No❑**	***If yes, who is disabled?***	

Have You or Anyone in the Home Applied for Supplemental Security Income (SSI)?					**❑Yes No❑** ***Complete.***
Who Applied		**Date of Application**		**Application Status**	**❑Pending ❑Approved ❑Denied**
Who Applied		**Date of Application**		**Application Status**	**❑Pending ❑Approved ❑Denied**

Our non-discrimination policy. In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food and Nutrition Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs. To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D. C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers. You may also file a complaint of discrimination with the county department or the state department.

INCOME Use another sheet of paper if there is not enough room for your answers on this application.

Is Anyone Working?	❑Yes No❑	*If yes, please include one full month of income (before taxes and deduction). Please include one month of pay stubs or verification of employment. (Not required by Medical Assistance Programs*).*

Also, tell us if anyone quit or left a job or if anyone is supposed to start working at a new job.

If anyone in your home works for an employer, complete this box.	**If anyone in your home works for an employer, complete this box.**	**If you have a:** **- Home Business;** **- Are Self-Employed; or** **- Earn Money** *such as babysitting or selling goods such as make-up or kitchenware, complete this box.*
Name of Person	Name of Person	

Employer Name and Phone		Employer Name and Phone	
Hourly Wage	$	Hourly Wage	$
Month and Hours Worked		Month and Hours Worked	
How Often Are You Paid?		How Often Are You Paid?	
What Did You Get Paid? Gross	$	What Did You Get Paid? Gross	$

If anyone in your home works for an employer, complete this box.		**If anyone in your home works for an employer, complete this box.**	
Name of Person		Name of Person	
Employer Name and Phone		Employer Name and Phone	
Hourly Wage	$	Hourly Wage	$
Month and Hours Worked		Month and Hours Worked	
How Often Are You Paid?		How Often Are You Paid?	
What Did You Get Paid? Gross	$	What Did You Get Paid? Gross	$

Who is Self-Employed?	
One Month's Gross Income	$
Utilities Paid for Business	$
Business Taxes Paid	$
Interest Paid for Business	$
Gross Business Labor Costs	$
Business Equipment Costs	$
Cost of Merchandise for Business	$
	$
	$
Other Business Costs. List:	$
	$
	$
	$

Complete if anyone in the home is going to receive income *(starting a new job).*		**If anyone in the home quit or lost a job in the past 60 days complete.**			
Name of Person		Name of Person			$
Employer Name and Phone		Employer Name and Phone			$
					$
				Total Income (Net Income)	$
Hourly Wage	$	Hourly Wage	$	Signature of Person Who Has This Income.	
Month and Hours Worked		Month and Hours Worked			
How Often Will You Be Paid?		How Often Were You Paid?		***For any other income, attach the information to blank piece of paper.***	
What Did You Get Paid? Gross	$	What Did You Get Paid? Gross	$		
Date You Will Start New Job		When Did You Lose Your Job?			

**All household income may need to be verified when applying for Medical Assistance. It is not required, but if you provide your Social Security Number (SSN), we may be able to verify your income electronically through the Department of Labor's system. You may be asked for further information if needed.*

List the OTHER income you or anyone in your household received this or last month. Fill out a line for each item. *Examples: • Unemployment Benefits • Child Support • Retirement/Pension • Social Security Benefits • SSI • SSDI • Veterans Benefits • Veteran Widow • Dividends/Interest • Alimony • Worker's Compensation • Disability Benefits • Financial Aid • Railroad Retirement • Rental Income • Survivor Benefits • Other Cash Received Monthly • Loans/Gifts • Something Of Value You Receive In Exchange For Your Work*

Does Anyone Have OTHER Income?	❑Yes No❑	*Include one full month of income (before taxes and deductions)*

Person Getting Money	Money From	Amount	Person Getting Money	Money From	Amount
		$			$
		$			$
		$			$

Has Anyone Who is Applying Received a Lump Sum Payment? (*Lawsuit or Insurance Settlement, Social Security, SSI, SSDI, Veterans, Inheritance, Surrender of Annuity or Life Insurance, Other*)			❑Yes ❑ No	*If yes, complete.*
Who	When Received	Type of Lump Sum	Amount	
			$	
Who	When Received	Type of Lump Sum	Amount	
			$	

Do You Pay Child or Adult Daycare, Child Support, Alimony*, or Medical Expenses?			❑Yes No❑	*List below.*
Expense	Who Pays Expense	Who it is For	Month	Amount Paid
				$
				$

** Alimony does not apply to food assistance eligibility.*

Does Anyone in the Home Who is Applying Have a Medical or Developmental Condition that Lasted, or is Expected to Last, More than 12 Months?	❑Yes ❑No	*If yes, who?*	

Is Anyone in the Home that is Applying in a Medical Facility *(such as a nursing home, hospital, a mental health institution, or a group home)* **or Has Been Within the Last 90 Days?**			❑Yes ❑No	*If yes, complete.*
Name of Person	Date Entered	Name of Facility	Phone	

Is Anyone in the Home in High School, Vocational, Trade School, or College?		❑Yes No❑	*If yes, complete.*
Who is in School	Name of School	Last Grade Completed	Expected Date of Graduation

Does Every Adult in the Home Share Home Bills?	❑Yes No❑	*If no, who is NOT sharing the home bills?*
Name		Name

Are You Applying for Food Assistance or Colorado Works?	❑Yes No❑	*If yes, please complete.*

1. Have you or any member of your home been convicted of fraudulently receiving duplicate Food Assistance benefits in any state after 9/22/1996? ❑Yes No❑
2. Are you or any member of your home 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❑
3. Have you or any member of your home been convicted of a felony under federal or state law for possession, use, or distribution of a controlled drug substance (felony drug conviction) or for a crime while under the influence of a controlled drug substance after 8/22/1996? ❑Yes No❑
4. Have you or any member of your home been convicted of buying or selling Food Assistance benefits for more than $500 after 9/22/1996? ❑Yes No❑
5. Have you or any member of your home been convicted of trading Food Assistance benefits for guns, ammunitions, explosives, or drugs after 9/22/1996? ❑Yes No❑
6. Have you or any member of your home been convicted of a felony? *(only required for Colorado Works)* ❑Yes No❑
7. Have you or any member of your home applying for assistance been convicted of welfare fraud? ❑Yes No❑

If you are only applying for Food Assistance, go to page 7.

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

Do Any of the Children Living in the Home Have an Absent Parent?	❑Yes ❑No	*If yes, have you tried to obtain medical support from the child's absent parent?* ❑Yes No❑

Name of Parent	Address	Phone	For Which Child	Other Information You Can Provide

Did Anyone Have Medical Expenses in the Past Three Months?	❑Yes No❑	*You may qualify for help with some of these expenses.*

Name of Person with Medical Expenses in the Past Three Months	List the Months of Medical Expense

Does Anyone in Your Home Receive Medicare?	❑Yes ❑No	*Please include a copy of the front and back of the Medicare card(s).*

Who Receives Medicare?		❑Part A Hospital Coverage ❑Part B Medical Insurance ❑ Part D Prescription Plan
Who Receives Medicare?		❑Part A Hospital Coverage ❑Part B Medical Insurance ❑ Part D Prescription Plan

Does Anyone Regularly Need Help with Some or All of Their Self-Care Activities? *(such as bathing, dressing, eating, using the bathroom)*	❑Yes ❑No	*If yes, complete.*

Name		Name	

Are You Applying for OAP, AND, Adult Medical Assistance, or Long Term Care Medical Assistance?	❑Yes ❑No	*If yes, complete this box.*

List what you own: *Cash • Checking and Saving Accounts • Certificates of Deposits (CD)• Annuities • Mutual Funds • Inheritance • PASS Accounts • Individual Development Accounts • Retirement Accounts • Stocks • Bonds • Trusts • Promissory Notes • College Funds • Education Accounts • Property (Land, Homes) • 401 K • Proceeds from Sale of Home(s)*:

Do You Own Anything?	❑Yes No ❑	*List everything you own below.*

Person Who Owns It	What Do They Own	Amount	Person Who Owns It	What Do They Own	Amount
		$			$
		$			$

Do You Own a Car, Truck, Van, Boat, Motorcycle, RV, or Trailer?	❑Yes No ❑	*List them below.*

Person Who Owns It	Make/Model and Year	Value	Person Who Owns It	Make/Model and Year	Value
		$			$
		$			$
		$			$

Have You Given Away Anything of Value in the Last Five Years?	❑Yes No ❑	*List what was given away below.*

Person Who Gave It	What was Given Away and When	Value	Person Who Gave It	What was Given Away and When	Value
		$			$

Are You Buying or Own Land, Property, House, Rental Property, Timeshare, Cabin, or Lot?	❑Yes No ❑

Person Who is Buying/Own	Address or Property Description	Value	Person Who is Buying/Own	Address or Property Description	Value
		$			$

Do You Have Life Insurance or Burial Insurance Policies?	❑Yes No ❑	*List the policies below.*

Who	Company and Policy Number	Revocable or Irrevocable	Value	Who	Company and Policy Number	Revocable or Irrevocable	Value
			$				$

Have You Had Group Health Insurance Through an Employer Within the Last Three Months?		❑Yes No ❑
Person Who Has or Had Insurance	If the insurance stopped: ❑ The policyholder is no longer employed by the company. ❑ The company no longer offers insurance. ❑ The employee voluntarily withdrew.	Name(s) of Person(s) Covered
Policy Number/ Group Number		Amount Employer Pays/Paid Each Month
Insurance Company and Phone		$
		Amount You Pay/Paid Each Month
		$

If You Need Help to Pay Your Burial/Funeral Costs, Would You Prefer:		Cremation		Burial		No Preference

Do You Need Help Paying Your Medicare Costs?	❑Yes No❑	*There may be help to pay the premium and additional costs.*

Does Anyone Who is Applying Have Any Other Type of Medical Health Insurance?	❑Yes ❑No	*If yes, is this insurance COBRA?*	❑Yes No❑	*If no, complete.*
		Who is Covered?	Policy Holder Name	
Policy/Group Number		Name and Phone Number of Insurance Company		

To receive health care insurance through CHP+, you **MUST** choose a Health Maintenance Organization (HMO) for the child(ren) applying. You must select the same HMO for all children in the household requesting Medical Assistance. You can find information about HMOs in your county at ChpPlus.org

Do You Have Children 18 and Under?	❑Yes No❑	*If yes, complete below. If your children qualify for Medicaid, **Health**Colorado will contact you to enroll in an HMO.*
Name of HMO Selected:		

Are You Applying for Colorado Works, Aid to the Needy Disabled, Old Age Pension, Home Care Allowance, or Colorado Supplement?	❑Yes ❑No	*If yes, anyone in your house over 18 needs to complete and sign here.*

	I am a United States citizen; or		I am a United States citizen; or
	I am a Legal Permanent Resident of the United States; AND		I am a Legal Permanent Resident of the United States; AND
	I am lawfully present in the United States pursuant to federal law.		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 admit 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	Signature	Date

Do You Have Identification *(such as a school ID with picture)* **for Your Child Who is 15 Years or Younger?**	❑Yes ❑No ❑N/A	*If YES, include a copy of the ID for each child.* *If NO, complete below for each child.*

I swear I am	❑ mother ❑father ❑grandparent ❑other:	of (list child's FULL name)	
This child was born on	/ /	in (City, State, Country of Birth Place)	
Signature		Date	

Do You Have Identification *(such as a school ID with picture)* **for Your Child Who is 15 Years or Younger?**	❑Yes ❑No ❑N/A	*If YES, include a copy of the ID for each child.* *If NO, complete below for each child.*

I swear I am	❑ mother ❑father ❑grandparent ❑other:	of (list child's FULL name)	
This child was born on	/ /	in (City, State, Country of Birth Place)	
Signature		Date	

Do You Have Identification *(such as a school ID with picture)* **for Your Child Who is 15 Years or Younger?**	❑Yes ❑No ❑N/A	*If YES, include a copy of the ID for each child.* *If NO, complete for each child.*

I swear I am	❑ mother ❑father ❑grandparent ❑other:	of (list child's FULL name)	
This child was born on	/ /	in (City, State, Country of Birth Place)	
Signature		Date	

What I Should Know PLEASE KEEP THIS FOR YOUR INFORMATION

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

- **I must tell the truth; it is a crime to lie on this application.**
- **I may have to give papers that show what I've told you is true.**
- **I must tell you of any changes in money I get.**
- **I must tell you of any changes to the information I gave you on my application.**
- **If I think you made a mistake, I can ask for an appeal or fair hearing.**

- **The department will not discriminate.**
- **The department will verify citizenship and immigration status for everyone applying for benefits.**
- **The department will tell you if your benefits change.**
- **The department will take back any benefits you should not have received.**

- The Department of Health Care Policy and Financing (HCPF) is the state agency responsible for Medical Assistance Programs in Colorado. The Department of Human Services is the state agency responsible for the other public assistance programs. The County Departments of Human/Social Services and Medical Assistance Sites are the agencies that receive and process applications for all public assistance programs. In this statement, the term "department" is used to refer to all agencies.
- I must give the department all needed proof and documents before qualifying for benefits.
- If there is an absent parent(s) from my home and I am applying for Medicaid, I must seek medical support from the absent parent(s). I may contact Child Support Enforcement for assistance.
- I am responsible for paying fees and copayments for myself and my family if they are required for Medical Assistance benefits.
- If enrolled in Medicaid and other insurance is paying for medical care, Medicaid will pay last.
- The information I give on the application and in the application interview is confidential. But, the department can use or share the information with other program(s) that any of my family members are getting or are applying. The information can only be used for purposes of treatment, payment, determining eligibility, and other program and administrative operations, or other purposes permitted by law for my family members or me.
- It is a crime to lie on the application or to take benefits that I know that my family and I are not eligible to receive and I may be subject to criminal prosecution for knowingly providing false information. **Giving false information may be punished by a fine of up to $250,000 or a jail term of up to 20 years, or both.**
- **A person found to have intentionally given false information cannot get food assistance and/or Colorado Works/TANF for 12 months for the first offense, 24 months for the second offense, and permanently for the third offense**. A court can also stop a person from getting food assistance for another eighteen months. This crime is subject to prosecution under other federal laws. **Receiving duplicate benefits of food assistance by lying about identity or residence will be a 10-year disqualification.**
- **The department will notify me in writing of how and when to tell the department of any changes.**

- If I do not tell the truth on my application or if information is left off of the application, or if I do not report changes to the department, as required, I may lose my assistance, and I may have to pay the department for the assistance received when I was not eligible, including Medical Assistance received and medical premium payments. Income tax refunds the persons on my application and I might get, may be taken to pay back money to the department.
- The law says the department must check the immigration status and citizenship for anyone who is applying. They will not check immigration status of family members who are not applying for benefits. I may be requested to verify proof of non-citizen registration documentation received from the United States Citizen and Immigration Service (USCIS) for every non-citizen member in my house who is applying for benefits. The department will verify information with USCIS and any information received from USCIS may affect my eligibility and benefits. Federal law (Public Law 97-98) requires me to give the department the Social Security number and/or alien registration number of all persons who are applying for public assistance. I must also provide the Social Security number and/or alien registration number for all sponsors. **For medical assistance and adult financial programs, sponsor information will be verified with USCIS and the information received from USCIS may affect sponsor repayment for my eligibility and benefits. My sponsor is responsible for reimbursing the state for benefits I receive.**
- I do not have to be a U.S. citizen to apply for assistance. Both U.S. citizens and qualified non-citizens may be eligible for Medical Assistance. Please do not let the fear about immigration status stop you from seeking benefits for your family. Receiving Medical Assistance will not stop you from gaining lawful permanent residence or U.S. citizenship.
- If I am a resident of an institution and jointly applying for SSI and food assistance prior to leaving the institution, the filing date of the application is my date of release from the institution. Processing time will begin from the date the application is received in the food assistance office.
- Privacy Act Information: The department is authorized to collect information on the application, including Social Security numbers and will confirm information that may affect initial or ongoing eligibility and payments for all persons listed on my application. **I am allowing**

the department to use Social Security numbers and other information from my application to request and receive information or records to confirm the information in my application. Food assistance will be denied to individuals that do not provide a Social Security number, and Social Security numbers will be used and disclosed in the same manner for both eligible and ineligible members. **I release the department from all liability for sharing this information with other agencies for this purpose.** For example, the department may get and share information with any of the following agencies: Social Security Administration; Internal Revenue Service; United States Customs and Immigration Services; Colorado Department of Labor and Employment; Financial institutions (banks, savings and loans, credit unions, insurance companies, etc.); child support enforcement agencies; employers; courts; and other federal or state agencies; and for food assistance, law enforcement officials for the purposes of apprehending persons fleeing to avoid the law.

- If a food assistance over payment occurs against my household, the information on this application, including all Social Security numbers, may be referred to Federal and State agencies, as well as private claims collection agencies for claims collection action.

- The EBT (or Quest) card is used to pay me most of my public assistance benefits. I cannot trade or sell EBT cards or use, or have in my possession, EBT cards that are not mine and I cannot let someone else use my EBT card.
- If I think the department made a mistake, I can ask for a Fair Hearing. The department will tell me in writing how to make an appeal. I may request an appeal for any action on any program except for the CHP+ program.
- If I think the CHP+ program made a mistake, I can ask for an appeal. CHP+ tells me about how to make an appeal in writing.
- Colorado Works is Colorado's TANF (Temporary Assistance for Needy Families) program. It is not an entitlement program and benefits are not guaranteed. Each county has the authority to determine eligibility requirements and benefit levels. To remain eligible, I may be required to complete an assessment and develop a plan. Unless exempted, I will be required to participate in work readiness activities.
- As an applicant for Colorado Works, I am required to assign all rights to child support that may be received on my behalf or for those in my

household that I am applying for. This assignment starts when I am determined eligible and will continue until my Colorado Works benefits end. If I do not do this or refuse to cooperate with Child Support Enforcement at the time I apply or while receiving cash assistance through Colorado Works, without good cause, I will not receive assistance or a basic cash assistance grant for my family.

- To receive food assistance all members of the house that are required to register for work must follow all requirements (comply with) Employment First. Anyone who does not follow the work requirements may be disqualified from receiving food assistance.
- If I am an adult between the ages of 18 and 49, with no children under the age of 18 in my food assistance house, I will only be able to get food assistance benefits for three months during the next three years unless: I work in a job 80 hours each month and report that information to Employment First; or I work my assigned hours at my Employment First office, including *Workfare* or the Employment First work program; or I am determined to be physically or mentally unable to work; or the food assistance office tells me that I am exempt. As long as I do one of these activities each month, I will be able to receive food assistance benefits if I am otherwise eligible.
- I must cooperate fully with state and federal staff if my case is reviewed. My information on this application may be reviewed and verified by the department, or its representatives. My house will not be eligible for food assistance if I refuse to cooperate with any review of my case, including a quality control review.
- I cannot use food assistance benefits to buy nonfood items, such as alcohol or cigarettes, or to pay on credit accounts. **A person found guilty of using food assistance to illegally purchase controlled substances shall be disqualified for two years for a first offense and permanently for a second offense. Individuals found by a Federal, State, or local court to have used or received benefits in a transaction involving the sale of firearms, ammunition, or explosives shall be permanently ineligible to receive food assistance upon the first occasion of such violation. 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 receive food assistance upon the first occasion of such violation.**

- I will immediately notify the State of any medical claim or lawsuit I have. I will cooperate with the State in collecting the medical bills the State has paid. The State may collect from any insurance company or court settlement for medical bills that the State has paid. If I am on Medical Assistance and receive money for the same medical bills that the State has paid, I will give the money to the State. I assign to the State all rights to payment for medical expenses and treatment. I also assign my right to appeal a denial of benefits by another party responsible for payment for the benefits to the State.
- The Medical Assistance Estate Recovery Program authorizes the department 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 governing estate recovery also provide for certain exemptions to the medical assistance Estate Recovery Program. For further information or questions please contact the department and request "The Medical Assistance Estate Recovery Program" brochure.
- If I do not report and provide proof of rent, mortgage, housing fees, property insurance, property taxes, court ordered child support payments, child or adult care, and medical expenses paid by elderly or disabled members, I am stating that I do not want that specific deduction used to determine my food assistance benefit amount.
- **Domestic violence** information and services are available to me. If I ever feel I am in immediate danger I will call 911. If I would like to receive information regarding safety and services in Colorado, I will call the Colorado Coalition Against Domestic Violence at 303-831-9632 or toll free at 1-888-778-7091. I may also find the location of services near me by going to colorado.gov/cdhs/dvp. The National Domestic Violence Hotline at 1−800−799−SAFE (7233) or TTY 1−800−787−3224 or ndvh.org can also provide information. If I am a survivor of domestic violence, sexual assault, or stalking the Address Confidentiality Program (ACP) can provide me with a legal substitute address to use instead of my real address for use with state and local government agencies. I can find out more about ACP at acp.colorado.gov. If I need or receive either of these services I will tell my department worker.