COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

PRESUMPTIVE ELIGIBILITY FORM
COLORADO MEDICAID BREAST AND CERVICAL CANCER PROGRAM

Name _____ _____ _____ Social Security #_____
Last First Middle

Mailing Address _____ _____ Home Phone_____
Box or Route, number and Street Apt

_____ Work Phone_____
City/Town State Zip (If you can receive calls at work)

Date of Birth _____ Cell/Other_____

Do you have medical insurance? Yes No If yes, what type? Medical Hospital Cancer Other_____

Policy Number _____ Company Name _____ Phone_____

*Do you have children under the age of 19? Yes No

*What is your monthly gross income? _____

*Do you have a diagnosed disability? Yes No

*These questions are being asked to determine your eligibility for other Medicaid programs.

1. I certify that all statements on this form have been read by me or read to me and I understand the questions. I certify that all the information I have given is true and correct.
2. I give my permission for any financial institution, government agency or department, doctor, hospital, business concern, or person to give any information to an employee of the Department which would have to do with my receiving benefits.
3. I know that no person may be denied Medicaid benefits on the grounds of race, color, sex, age, disability, religion, national origin, or political belief.
4. I understand that if I give incorrect or false information or if I fail to report changes, then I may be required to repay any benefits I receive. I understand that any information given is subject to verification by an authorized representative of the Department.
5. I understand that by accepting medical assistance under BCCP, I agree to give back to the State any and all money that is received from an insurance company for repayment of medical and/or hospital bills for which the Medicaid Program has made or will make payment.
6. I understand that the Medicaid application must be completed and submitted within 30 days of the date on this form to receive benefits under this program.

_____ _____
Signature of Applicant Date

_____ _____
Witness, if signed by mark Signature of person helping to complete the form

Medicaid State ID Issued_____

Date Help Desk Was Called_____

WWC Site Number_____

WWC Site Phone_____

Diane Stayton
Phone 303-866-2385
Fax 303-866-2573

"The mission of the Department of Health Care Policy & Financing is to improve access to cost-effective, quality health care services for Coloradans."

http://www.chcpf.state.co.us