



Department of Health Care Policy and Financing  
External Eligibility Training Request Form

\*Requestor Name: \_\_\_\_\_

\*Requesting Site: \_\_\_\_\_

\*Date Requested: \_\_\_\_\_ \*Target Training Date: \_\_\_\_\_

\*Training Topics Requested:

(Please specify which program(s) you are requesting training for)

\*Select your training location preference from the drop down list:

\*Reason for requesting training

(If you are requesting cross training please specify)

\*Select your training audience from the drop down list:

\*How many will be attending: \_\_\_\_

Once the training has been confirmed, we will request a list of attendees.

\*Contact Information:

Primary Contact: \_\_\_\_\_ Email: \_\_\_\_\_ Phone number: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(\*) Fields must be completed with your supervisor's signature to process your request.

Health Care Policy and Financing Use Only	
Date Received	
Who Received Request	
Supervisor Signature	
Date Responded Back	

The Department will make every effort to accommodate the training preference and target date of your training request. Please allow up to **three days** to process your training request. All request forms and questions should be emailed to [HCPF.EligibilityTrainingRequest@hcpf.state.co.us](mailto:HCPF.EligibilityTrainingRequest@hcpf.state.co.us)