

COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS (Senior Dental Program) ELIGIBILITY AND OTHER HEALTH PROGRAMS

Senior Adult Programs	Description of Programs	Federal Poverty Level	Eligible for the Senior Dental Program
*Medicaid for Adults	Adults through the age of 64 without a dependent child in the home.	133%	No
*Old Age Pension (OAP) – Medicaid	Disabled or over 65.	76.9%	No
*Old Age Pension-OAP Health and Medical Care Program	Disabled or over 65. Not eligible for Medicaid.	76.9%	No
Colorado Indigent Care Program (CICP)	Adults of any age. Senior should have a **CICP Card for proof.	250%	Yes

Medicare Savings Programs (MSP)	Description of Programs	Federal Poverty Level	Eligible for the Senior Dental Program
Specified Low-Income Medicare Beneficiary Program (SLMB)	Age 65 or older or disabled, limited financial resources and income, State pays percentage of premium of Part B.	120%	Yes
Qualified Individual Program (QI1)	Individuals must apply every year; does not qualify for any Medicaid program: state pays Part B premium.	120%-135%	Yes
Qualified Medicare Beneficiary Program (QMB)	State pays 20% Medicare Part B co-insurance.	100%	Yes
*Medicare/Medicaid – QMB (Dual Eligibles)	65 years or older, or disabled, status under Social Security or Railroad Retirement assistance with Medicare premiums and out of pocket Medicaid expenses.	100%	No
*Long-Term Care	65 years or older, blind, or disabled on SSI.	100%	No
*HCBS & Nursing Home Patients	Disabled Seniors needing long-term care.	300% of supplemental Security Income Level.	No

*If the applicant appears to meet the eligibility criteria for any of the Medicaid eligibility categories, a denial letter from the local county Department of Human Services, Medical Assistance Site or Social Services must be received. Note: A letter indicating voluntary withdrawal or denial due to refusal to submit complete documentation is not sufficient proof that the Senior has applied for Medicaid and been denied.

**Copy of CICP Card below

COLORADO INDIGENT CARE PROGRAM (CICP) THIS IS NOT HEALTH INSURANCE	
Name	_____
Rate Assigned	_____ Copay Cap \$ _____
County Code	_____
App Date	_____ Expires _____
Health Care Facility	_____
Technician's Signature	Phone _____

The following family members are covered under the rating assigned on the front of this card (family members eligible for Medicaid or CHP+ are not listed)	
Name: _____	DOB: _____
Please present this card each time you receive services at a CICP Provider.	
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