



## **Colorado Indigent Care Program**

Fiscal Year 2015-16 Provider Application

July 1, 2015 through June 30, 2016

### **Completing This Application:**

**This application serves as the Provider Agreement between the Department of Health Care Policy and Financing and the CICP Provider. All requested information needs to be completed in its entirety and returned to the Department no later than April 15, 2015.**

- ◇ **Please type or complete the updates on a computer.**
- ◇ **Please complete all required contact information and provide the Administrator's signature in the designated section on page 7 of the application.**
- ◇ **Persons designated by you will be contacted by the Department, as needed, to respond to questions and requests.**
- ◇ **The designated contacts MUST be updated as changes occur.**
- ◇ **Please update incorrect information or changes in staff.**

Providers must meet the following criteria to become or remain a Colorado Indigent Care Program (CICP) Provider:

1. Licensed or Certified by the Department of Public Health and Environment as a General Hospital **or** Community Health Clinic. **or** Is a Federally Qualified Health Center (FQHC).
2. Provider must be physically located outside the City and County of Denver. **or** Provider must offer either unique services or service a unique population. These providers must provide 50% of their indigent care to residents outside the City and County of Denver. A proposal must be submitted with this application identifying the unique feature(s) of the provider. **or** Provider is required by statute to participate; i.e. Denver Health Medical Center and University of Colorado Hospital.
3. If the provider is a hospital, the hospital must have at least two (2) obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services as Medicaid clients. In the case where a hospital is located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This obstetrics requirement does not apply to a hospital in which the patients are predominantly under 18 years of age; or which does not offer non-emergency obstetric services as of December 21, 1987.
4. Acknowledge and agree to the following: Payments made to providers in error for any reason, including, but not limited to, overpayments or improper payments, may be recovered from the provider by deduction from subsequent payments, grants or agreements between the Department of Health Care Policy and Financing (the Department) and provider, or by other appropriate methods, and collected as a debt due to the Department.
5. Agree to follow all applicable federal and state laws and rules, including the provisions of §25.5-3-101, C.R.S. et seq., and the rules of the CICP as detailed in Code of Colorado Regulations (CCR) at 10 CCR 2505-10, Section 8.900, et seq., as they now exist or may hereafter be amended. This information can be found on the Department's website at: [www.colorado.gov/hcpf](http://www.colorado.gov/hcpf). under For Our Stakeholders select Regulatory Resource Center, and then Code of Colorado Regulation for Medicaid.

## Provider Information for Fiscal Year 2015-16

Please remember that the provider names and addresses listed on pages 4 through 7 should reflect your business situation effective July 1, 2015. Information on satellite facilities should be listed only on the *Satellite Facility Information Worksheet* starting on page 8. The information already provided reflects our most recent data and must be reviewed/updated for accuracy. **Any missing or updated information should be completed directly on these pages.**

### Legal and Administrative Information:

Legal Name of Business and Legal Address (*the business name and address that appears in contracts*).

**Note: If you have a change in your legal name, there must be a new W-9 completed**

Provider Legal Name: \_\_\_\_\_

Legal Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

### Updated Information

Provider Legal Name: \_\_\_\_\_

Legal Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

### Facility Specific Information:

Any information on satellite facilities should be listed on the *Satellite Facility Information Worksheet*.

Facility DBA name (the *“doing business as”* name of facility) and **physical location** address:

**Required. The name and physical location address that clients will recognize to access services. This information will be published in the CICP Directory.**

Provider DBA: \_\_\_\_\_

Physical Location Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### Updated Information

Provider DBA: \_\_\_\_\_

Physical Location Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### CICP Client Access:

**Required. Phone number clients should call for more information or make appointments to complete the CICP Application.**

**Phone Number:**

*(This number will be published in the CICP Phone Directory, available to clients.)*

**Updated Phone Number**

\_\_\_\_\_

**Colorado Indigent Care Program  
Service Information for Fiscal Year 2015-16**

• Health Care Services:

Health care services available to CICP clients at \_\_\_\_\_

<b>Clinics:</b>	<b>Primary Care</b>	<input type="checkbox"/>	<b>Hospitals:</b>	<b>Emergency</b>	<input type="checkbox"/>
	<b>Urgent Care</b>	<input type="checkbox"/>		<b>Inpatient</b>	<input type="checkbox"/>
	<b>After Hour Care</b>	<input type="checkbox"/>		<b>General Outpatient</b>	<input type="checkbox"/>
	<b>Radiology</b>	<input type="checkbox"/>		<b>Physician</b>	<input type="checkbox"/>
	<b>Laboratory</b>	<input type="checkbox"/>		<b>Specialty Care</b>	<input type="checkbox"/>
	<b>Pharmacy</b>	<input type="checkbox"/>		<b>Children Services</b>	<input type="checkbox"/>
	<b>Other (Explain)</b>	<input type="checkbox"/>		<b>Pharmacy</b>	<input type="checkbox"/>
				<b>Emergency Transportation</b>	<input type="checkbox"/>
				<b>Other (Explain)</b>	<input type="checkbox"/>

Please list service limitations. *(Example: facility only provides emergency care, non-emergency care; facility provides children services, laboratory service, after hours care, or any specialty care of which CICP clients should be aware.)*

*If your facility has a limited service area for non-emergency care, your facility is required to submit a written waiver to the Department. No verbal waiver requests will be accepted.*

Does your facility offer an Outpatient Pharmacy Service at a discount to CICP?  Yes  No

Please provide any relevant details on your Outpatient Pharmacy Service:

*Please note if your facility offers a discounted Outpatient Pharmacy Service, but not under the CICP guidelines. If your facility responds in the affirmative that an Outpatient Pharmacy Service is offered at a discount under the CICP, then your facility is required to submit the appropriate summary spreadsheet associated with those charges.*

Does your facility offer discounted physician charges for services rendered by Physicians to CICP clients?

Yes  No

Please provide any relevant details or limitations on your Discounted Physician Service:

*Please note if your facility offers discounted Physician Services but not under the CICP guidelines. If your facility responds in the affirmative that Physician Services are offered at a discount under the CICP, then your facility is required to submit the appropriate summary spreadsheet associated with those charges.*

Please explain below how your facility will prioritize the following services within the available funding:

Emergency Care:

Urgent Care:

Medical care for conditions determined to be the most serious threat to the health of medically indigent persons:

Any Additional Care:

**Colorado Indigent Care Program  
Contact Information for Fiscal Year 2015-16**

**This is the most current information from the CICP database. If the information below is NOT correct, please update it in the space provided. Please TYPE the information.**

•Chief Financial Officer: **Required**

**Updated Contact Information**

Name: \_\_\_\_\_

\_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

\_\_\_\_\_

E-Mail Address: \_\_\_\_\_

\_\_\_\_\_

Direct Phone Number: \_\_\_\_\_

\_\_\_\_\_

•Contract Contact: **Required.** *Individual responsible for overseeing the CICP contract and provider application*

**Updated Contact Information**

Name: \_\_\_\_\_

\_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

\_\_\_\_\_

E-Mail Address: \_\_\_\_\_

\_\_\_\_\_

Direct Phone Number: \_\_\_\_\_

\_\_\_\_\_

•Billing Contact: **Required.** *Individual responsible for overseeing the CICP billing process.*

**Updated Contact Information**

Name: \_\_\_\_\_

\_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

\_\_\_\_\_

E-Mail Address: \_\_\_\_\_

\_\_\_\_\_

Direct Phone Number: \_\_\_\_\_

\_\_\_\_\_

•Eligibility Contact: **Required.** *Individual responsible for overseeing the CICP client application and eligibility process.*

**Updated Contact Information**

Name: \_\_\_\_\_

\_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

\_\_\_\_\_

E-Mail Address: \_\_\_\_\_

\_\_\_\_\_

Direct Phone Number: \_\_\_\_\_

\_\_\_\_\_

•Complaint Representative: **Required.** *Individual responsible for receiving CICP complaints/concerns and for communicating and/or preparing response.*

**Updated Contact Information**

Name: \_\_\_\_\_

\_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

\_\_\_\_\_

E-Mail Address: \_\_\_\_\_

\_\_\_\_\_

Direct Phone Number: \_\_\_\_\_

\_\_\_\_\_

•Cost Report Accounting Contact: **Required.** *Individual responsible for submitting provider’s cost report worksheets and other supporting financial documents.*

**Updated Contact Information**

Name: _____	_____
Mailing Address: _____	_____
City, State, Zip Code: _____	_____
E-Mail Address: _____	_____
Direct Phone Number: _____	_____

•Annual Audit Contact: **Required.** *Individual responsible for submitting facility’s annual audit report to the Department.*

**Updated Contact Information**

Name: _____	_____
Mailing Address: _____	_____
City, State, Zip Code: _____	_____
E-Mail Address: _____	_____
Direct Phone Number: _____	_____

•Data Contact: **Required.** *Individual responsible for submitting data to the Department.*

**Updated Contact Information**

Name: _____	_____
Mailing Address: _____	_____
City, State, Zip Code: _____	_____
E-Mail Address: _____	_____
Direct Phone Number: _____	_____

•Electronic Mailing Contact: **Required.** *In our efforts to reduce paper waste and print costs the Department is now sending documents such as newsletters, surveys, and various other correspondence to providers electronically. Please verify that we have the most current information*

**Updated Contact Information**

Name: _____	_____
E-Mail Address: _____	_____
Direct Phone Number: _____	_____

**Changes to the email address you indicate above must be reported to the Department immediately to ensure timely communications.**

• **Satellite Facilities:**

Our records show that your facility has \_\_\_\_\_ **satellite facility/facilities**. Any information on satellite facilities should be listed on the *Satellite Facility Information Worksheet* starting on page 8. A Satellite Facility cannot have a separate Employer Identification Number (EIN) from your main facility. The Satellite Facility is considered part of the main facility or a separate contract is required. Do not list nursing homes or mental health facilities. The facility must be licensed as a Community Health Clinic or Hospital by the Colorado Department of Public Health and Environment.

**Colorado Indigent Care Program**  
**Projection of Emergency and Non-Emergency Utilization**  
 Fiscal Year 2015-16  
 July 1, 2015 through June 30, 2016

The CICP enabling legislation requires providers to furnish emergency services to all CICP eligible clients throughout the year. Non-emergency services furnished to CICP eligible clients must be prioritized within available funding, but provided throughout the entire year. This worksheet is used to monitor compliance with the legislation. Please complete the following projections of CICP activity for the 2015-16 contract year.

**Please Note: New Providers need to prorate their expected visits and provide an explanation of how they calculated their numbers.**

**Projected Admissions of Medically Indigent Patients:**

	<u>Number</u>	<u>Percent of Total Admissions</u>
Emergency Admissions	_____	_____
Non-Emergency Admissions	_____	_____
Total	_____	<u>100%</u>

**Projected Visits of Medically Indigent Patients:**

	<u>Number</u>	<u>Percent of Total Visits</u>
Emergency Visits	_____	_____
Non-Emergency Visits	_____	_____
Total	_____	<u>100%</u>

# Colorado Indigent Care Program

## Participation Verification

Fiscal Year 2015-16

July 1, 2015 through June 30, 2016

\_\_\_\_\_ requests to participate in the Colorado Indigent Care Program for FY 2015-16.

I certify that \_\_\_\_\_ meets the following conditions for FY 2015-16:

1. \_\_\_\_\_ is licensed by the Colorado Department of Public Health and Environment (DPHE) as a: General Hospital \_\_\_\_\_ Community Health Clinic \_\_\_\_\_ **OR** is a Federal Qualified Health Center (FQHC). \_\_\_\_\_
2. \_\_\_\_\_ will assure that medically necessary care as offered under the CICP regulations at 10 CCR 2505-10, Section 8.900, *et seq.*, will be available to all CICP clients throughout FY 2015-16.
3. If \_\_\_\_\_ is a hospital, I have indicated which of the below criterion apply to assure that the applicable criterion is met. (This condition does not apply to community health clinics.)  
\_\_\_\_\_ is located in an urban county (counties with a population of more than 100,000) and has at least two obstetricians with staff privileges that provide obstetric services to Medicaid clients.  
\_\_\_\_\_ is located in a rural area (counties with a population of less than 100,000) and has at least two physicians with staff privileges to perform non-emergency obstetric procedures to Medicaid clients.  
\_\_\_\_\_ is a hospital in which the patients are predominantly under 18 years of age; or which does not offer non-emergency obstetric services as of December 21, 1987. (Applies to Children's Hospital Colorado and National Jewish Health ONLY)
4. By signing below you acknowledge and agree to the following: Payments made in error for any reason, including, but not limited to, overpayments or improper payments, may be recovered from the provider by deduction from subsequent payments, grants or agreements between the Department of Health Care Policy and Financing (the Department) and provider or by other appropriate methods and collected as a debt due to the Department.

\_\_\_\_\_  
Signature of Administrator

\_\_\_\_\_  
Date

• Administrator: **Required**

### Updated Contact Information

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Direct Phone Number: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Colorado Indigent Care Program Satellite Facility Information Worksheet

Satellite facilities provide services at locations other than the address listed on Page 2 of your CICP Application. Please provide/verify the information below for each facility participating under your provider contract. A Satellite Facility cannot have a separate EIN from that of your main facility. The Satellite Facility is considered part of the main facility. Do not list nursing homes or mental health facilities. The facility must be licensed as a Community Health Clinic or Hospital by the CDPHE.

**Facility Location Address:** The name and physical location that clients will recognize to access services

### Updated Information

Facility Name: _____	_____
Facility Physical Address: _____	_____
City, State, Zip Code: _____	_____
County: _____	_____
Phone Number: _____	_____
CICP Phone Number: _____	_____

**Eligibility Contact:** Individual responsible for overseeing the CICP client application and eligibility process

### Updated Contact Information

Name: _____	_____
Mailing Address: _____	_____
City, State, Zip Code: _____	_____
E-Mail Address: _____	_____
Direct Phone Number: _____	_____

**Service Available:**

The health care services available for CICP clients. Please list service limitations. Example: facility only provides urgent care, emergent care; facility provides children services, laboratory service, after hours care, or any specialty care of which clients should be aware

<b>Clinics:</b>	<b>Primary Care</b> <input type="checkbox"/> <b>Urgent Care</b> <input type="checkbox"/> <b>After Hour Care</b> <input type="checkbox"/> <b>Radiology</b> <input type="checkbox"/> <b>Laboratory</b> <input type="checkbox"/> <b>Pharmacy</b> <input type="checkbox"/> <b>Other (Explain)</b> <input type="checkbox"/>	<b>Hospitals:</b>	<b>Emergency</b> <input type="checkbox"/> <b>Inpatient</b> <input type="checkbox"/> <b>General Outpatient</b> <input type="checkbox"/> <b>Physician</b> <input type="checkbox"/> <b>Specialty Care</b> <input type="checkbox"/> <b>Children Services</b> <input type="checkbox"/> <b>Pharmacy</b> <input type="checkbox"/> <b>Emergency Transportation</b> <input type="checkbox"/> <b>Other (Explain)</b> <input type="checkbox"/>
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Does this facility offer an Outpatient Pharmacy Service at a discount to CICP?  Yes  No

Does this facility offer Physician Services at a discount to CICP?  Yes  No

**Colorado Indigent Care Program  
Waiver Request Form**

Please use this form to verify current waivers or request new waivers with the Colorado Indigent Care Program related to procedures in the CICP Provider Manual. **If you do not have a waiver currently and you do not wish to request a waiver, you do not need to complete this form.**

Complete the form for new waiver requests, if requesting more than one waiver please number each waiver requested.

Any currently approved waivers are indicated below. Note any changes requested for existing waivers. If no changes are necessary, simply sign the form and return it with your CICP application.

Waivers are granted indefinitely unless an end date is stipulated. For new waivers, the Department will notify you of its decision to approve or disapprove your waiver request. Please note: the Department cannot approve a request to waive requirements that would contradict State statutes or regulations.

**Facility's Name:** \_\_\_\_\_

**Indicate waiver request or change below:**

\_\_\_\_\_  
**Signature of Administrator or CEO**

\_\_\_\_\_  
**Date**

**For Department of Health Care Policy and Financing Use Only:**

Waiver Approved \_\_\_\_\_

Waiver Denied \_\_\_\_\_

Waiver Approved under the following conditions:

  
  

Signature \_\_\_\_\_

Date \_\_\_\_\_