



**COLORADO**

Department of Health Care  
Policy & Financing

**Colorado Indigent Care Program**  
Fiscal Year 2016-17 Provider Application  
July 1, 2016 through June 30, 2017

**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, 2016.**

- ◇ **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 **by new providers** 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.

## APPEALS PROCESS

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After the Department receives an application from a provider, the application will be reviewed to ensure all pertinent information was provided. If the Department determines that there is information missing from the application, the provider will be contacted and given ten (10) business days to provide the requested information to the Department. Applicant providers who do not return the requested information within ten (10) business days may have their application denied.

If a provider's application is denied and the provider disagrees with the denial, the provider can file a dispute in writing to:

Cindy Arcuri  
Financing Section Manager  
1570 Grant Street  
Denver, CO 80203

within five (5) business days upon receiving their denial letter. A copy of the dispute should also be emailed to [CICPCorrespondence@state.co.us](mailto:CICPCorrespondence@state.co.us). No new information or documentation may be submitted as part of the dispute process. A determination of the dispute will be made by Cindy Arcuri within ten (10) business days of receipt of the dispute.

If the provider disagrees with the dispute determination made by Cindy Arcuri, they may then file an appeal of that determination in writing to:

Sue Birch  
Executive Director  
Department of Health Care Policy and Financing  
1570 Grant Street  
Denver, CO 80203

within five (5) business days upon receiving the final dispute determination from Cindy Arcuri. A copy of the appeal shall be sent to:

Nancy Dolson  
Special Financing Division Director  
1570 Grant Street  
Denver, CO 80203

A copy of the appeal shall also be emailed to [CICPCorrespondence@state.co.us](mailto:CICPCorrespondence@state.co.us).

Following receipt of the appeal, the Special Financing Division Director will perform a review. No new information or documentation may be submitted by the provider during the appeals process. A final determination will be made by the Executive Director, Sue Birch, within ten (10) business days of receipt of the appeal. **The decision of the Executive Director is final.**

**Provider Information for Fiscal Year 2016-17**

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Please remember that the provider names and addresses listed on pages 4 through 7 should reflect your business situation effective July 1, 2016. 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 or address, 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 (*“Doing Business As”*) name of facility and **physical location** address:

***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:

County:

Phone Number:

**Updated Information**

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

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

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

County: \_\_\_\_\_

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:** \_\_\_\_\_

**Service Information for Fiscal Year 2016-17**

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**Health Care Services:**

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

**Clinics**

- After Hours Care
- Laboratory
- Primary Care
- Radiology

**Hospitals**

- Emergency Transportation
- General Outpatient
- Inpatient
- Physician

**Both**

- Emergency
- Children Services
- Pharmacy
- Specialty Care
- Urgent Care

Other (Explain)

**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 CICIP 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 CICIP?       Yes       No

Please provide any relevant details on your Outpatient Pharmacy Service. Please specify if your facility offers a discounted Outpatient Pharmacy Service, but not under the CICIP guidelines. ***If your facility responds in the affirmative that an Outpatient Pharmacy Service is offered at a discount under the CICIP, 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 CICIP clients?  
 Yes       No

Please provide any relevant details or limitations on your Discounted Physician Service. Please specify if your facility offers discounted Physician Services but not under the CICIP guidelines. ***If your facility responds in the affirmative that Physician Services are offered at a discount under the CICIP, 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:

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

Any Additional Care:

**Contact Information for Fiscal Year 2016-17**

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

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

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

Billing Contact: *Individual responsible for overseeing the CICIP billing process.*

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

Chief Financial Officer:

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

Complaint Contact: *Individual responsible for receiving CICIP complaints/concerns and for communicating and/or preparing response.*

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

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

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

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

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

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

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

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

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

**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.

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**Projection of Emergency and Non-Emergency Utilization for Fiscal Year 2016-17**

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The CICIP enabling legislation requires providers to furnish emergency services to all CICIP eligible clients throughout the year. Non-emergency services furnished to CICIP 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 CICIP activity for the 2016-17 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	_____	_____

**Projected Visits of Medically Indigent Patients:**

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

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**Non-Federally Qualified Health Centers Information**

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**To Be Completed by NON-FQHC: Clinic Cost Information**

CICIP reimburses clinics based on write-off costs. All non-FQHC providers must submit a brief narrative and auditable documentation with this application to demonstrate either how to (Select One)

- Convert FY 2014-15 write-off charges submitted to the CICIP to write-off costs, OR
- Convert FY 2014-15 charges per visit submitted to the CICIP to CICIP cost per visit

Supporting documentation must clearly indicate:

1. Name of the facility
2. Cost period covered
3. Anticipated date of audit (if data submitted is unaudited)
4. Methodology for converting either CICIP write-off charges to write-off costs, OR methodology for converting average CICIP charges per visit to average CICIP cost per visit

**Participation Verification for Fiscal Year 2016-17**

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\_\_\_\_\_ requests to participate in the Colorado Indigent Care Program for FY 2016-17.

I certify that \_\_\_\_\_ meets the following conditions for FY 2016-17:

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.

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Signature

Date

Administrator:

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

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

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

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

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