

# Colorado Indigent Care Program Manual

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*Fiscal Year 2016-17*

## **Section V: Miscellaneous Documents**

**Effective July 1, 2016**



**COLORADO**

Department of Health Care  
Policy & Financing

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## **ARTICLE I.            REGULATIONS**

### **Section 1.01    Regulation Summary and link**

The Colorado Department of Health Care Policy and Financing (Department) administers the CICP by distributing funding to qualified health care providers who serve eligible persons who are indigent. The Department issues procedures to ensure the funding is used to serve the indigent population in a uniform method. The legislative authority for this program was originally enacted in 1983 and can currently be found under 25.5-3-101, et seq., C.R.S., the "Reform Act for the Provision of Health Care for the Medically Indigent." Rules implementing this legislation, 10 CCR 2505-10 8.900 – 8.908, are found at the [Colorado Secretary of State's website](#).

## **ARTICLE II.            LEGISLATION**

### **Section 2.01    Legislation Summary and link**

(1) The general assembly hereby determines, finds, and declares that:

- (a) The state has insufficient resources to pay for all medical services for persons who are indigent and must therefore allocate available resources in a manner that will provide treatment of those conditions constituting the most serious threats to the health of such medically indigent persons, as well as increase access to primary medical care to prevent deterioration of the health conditions among medically indigent people; and
- (b) Such allocation of resources will require the prioritization of medical services by providers and the coordination of administration and delivery of medical services.

(2) The general assembly further determines, finds, and declares that the eligibility of medically indigent persons to receive medical services rendered under the conditions specified in subsection (1) of this section exists only to the extent of available appropriations, as well as to the extent of the individual provider facility's physical, staff, and financial capabilities.

Medically indigent persons accepting medical services from such program shall be subject to the limitations and requirements imposed in this part 1. Implementing legislation, 10 CCR 2505-10 8.900 – 8.908, are found at the [Colorado Secretary of State's website](#).

## **ARTICLE III.      STATEMENT OF RESPONSIBILITIES**

### **Section 3.01    Provider Statement of Responsibility**

Providers participating in the CICP shall:

1. Treat all clients with respect and with consideration for the client's dignity and privacy;
2. Inform clients of how to express opinions, compliments or concerns, and how to make a complaint without fear of reprisal;
3. Strive to provide timely resolutions to the client's complaints or concerns;
4. Protect the privacy and confidentiality of the client's health and financial records;
5. Offer clients information on all treatment options, and allow clients to participate in decisions regarding his or her health care;
6. Notify the client of the availability of sign language and interpreter services in accordance with applicable laws and regulations, when such services are necessary;
7. Ensure the availability of program information – applications, informational materials, forms and brochures;
8. Prohibit discrimination based on race, color, national origin, sex, age or disability;
9. Upon request, provide applicants with copies of all signed worksheets and documents; and
10. Explain to the client or guardian that discounted services may vary and that a rating based on financial resources will determine their portion of the bill.

### **Section 3.02 Client's Statement of Responsibilities**

Clients applying for or receiving discounted CICIP services shall:

1. Acknowledge that the CICIP is not health insurance, does not offer a specific benefit package, is not an entitlement to medical benefits and that there are limitations to services discounted;
2. Acknowledge that discounted CICIP health care services vary by provider location;
3. Give the CICIP provider all the necessary financial information and documentation needed to complete the application;
4. Shall not give false information with the intent to commit fraud;
5. Tell the CICIP provider if a CICIP financial rating was issued by another provider and notify the CICIP provider within 15 days if the CICIP rating is disputed;
6. Be responsible for paying any money owed on time, and as required, or work with the CICIP provider to make payment arrangements;
7. Notify the CICIP provider promptly of changes in resources, income and all other household changes that may affect the CICIP rating;
8. Communicate any information, concerns and/or questions related to the financial screening to the appropriate representative;
9. Respect the property of the CICIP provider, fellow clients and others; and
10. Follow all other rules and regulations of the CICIP provider's location relating to respectful treatment and rights of other clients and provider staff.



## **Welcome to the Colorado Indigent Care Program (CICP)**

The Colorado Indigent Care Program (CICP) is a discounted health care program for residents of Colorado. Health care providers who participate in the CICP offer discounted health care services to people who qualify for the program.

The CICP health care provider has assigned you a “rating” based on your financial resources. Your rating determined what your CICP “copayment” is. The copayment is the portion of your medical bills under the CICP that you will be responsible for. Payment of the copayment is expected at the time of service, unless you have made other payment arrangements with the CICP Provider.

The CICP is not health insurance and the CICP cannot guarantee benefits. Services must be received by a qualified CICP provider. Available discounted services may be different from provider to provider. If your CICP provider refers you to a non-CICP health care provider for care, you may be responsible for the bill without a discount. Please check with your health care provider before receiving care so that you understand what CICP will cover and what it will not cover.

Please discuss questions about your medical bills and medical care directly with your CICP provider at the following phone number:

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If you need more information about CICP, or have concerns that have not been resolved with your CICP provider, call:

Colorado Department of Health Care Policy and Financing  
Customer Contact Center  
1-800-221-3943

Information about CICP is also available on the Department of Health Care Policy and Financing’s Website, including a Provider Directory: Go to [www.colorado.gov/hcpf](http://www.colorado.gov/hcpf) and click the link “Explore Programs and Benefits”, “Adults”, Colorado Indigent Care Program (CICP), then select “Program Information Page”, “View the CICP Provider Directory”.

Your CICIP provider can enter your copayment amount for health care services in the table, below. Copayments are different for different types of medical care, and your CICIP provider may not offer all types of services. You should ask your CICIP provider about what health care services are available at a discount and which copayment applies.

CICIP Copayment Information for Clients based on rating:

<b><u>Service/Setting</u></b>	<b><u>Copayment per Visit (depends on rating)</u></b>
Outpatient Clinic	\$ _____
Specialty Outpatient Clinic	\$ _____
Emergency Room Facility Charge (physician charges may be applied separately)	\$ _____
Inpatient Hospital (physician charges may be applied separately)	\$ _____
Ambulatory Surgery	\$ _____
Physician Services (while in the hospital or emergency room)	\$ _____
Laboratory	\$ _____
Prescription Drugs	\$ _____
MRI/CT Scans/PET Scans	\$ _____



**COLORADO**

Department of Health Care  
Policy & Financing

## **Bienvenidos al Programa de Atención de Indigentes de Colorado (CICP)**

Programa de atención de indigentes de Colorado (CICP) es un programa de salud con descuento para residentes de Colorado. Proveedores médicos quienes participan en CICP ofrecen servicios médicos a bajo costo a gente que califica para el programa.

El CICP centro médico ha asignado una "calificación" basada en sus recursos financieros. Su clasificación determinada lo que es su centro "copago". El copago es la porción de sus gastos médicos en el centro que usted será responsable. Pago de los copagos se espera que en el momento del servicio, a menos que hayan hecho otros arreglos de pago con el proveedor de CICP.

El CICP no es seguro de salud y el centro no puede garantizar beneficios. Servicios deben ser recibidas por un proveedor calificado del CICP. Servicios con descuento disponibles pueden variar de proveedor a proveedor. Si su proveedor de CICP refiere un centro no médico para el cuidado, usted puede ser responsable de la cuenta sin un descuento. Por favor compruebe con su médico antes de recibir atención para que entienda lo que cubrirá centro y lo que no cubrirá.

Por favor discutir preguntas acerca de sus gastos médicos y atención médica directamente con su proveedor CICP en el siguiente número de teléfono:

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Si usted necesita más información sobre el programa, o tiene preocupaciones que no han sido resueltas con su proveedor de CICP, llame al:

Departamento de Colorado de Salud Política y Financiamiento  
Centro de contacto al cliente  
1-800-221-3943

Información sobre CICP también esta disponible en el sitio web del Departamento de Colorado de Salud Política y Financiamiento, incluyendo un directorio de proveedores visite [www.colorado.gov/hcpf](http://www.colorado.gov/hcpf) y haga clic en el enlace "Explore Programs and Benefits", "Adults", Programa de Atención para Indigentes de Colorado (CICP), luego seleccione "Programa de Información de la página", "Busque un Proveedor de CICP".

Su proveedor de CICIP puede ingresar el monto de su copago para servicios de salud en la tabla, debajo de. Los copagos son diferentes para diferentes tipos de atención médica y médico del centro no puede ofrecer todo tipo de servicios. Usted debe pedir a su proveedor de CICIP acerca de qué servicios de atención médica están disponibles con un descuento y que el copago se aplica

CICIP Copago Información de Clientes Basada en la Clasificación:

<b><u>Servicio</u></b>	<b><u>Co-pago por Visitar (depende del clasificación)</u></b>
Clínica de Consulta Externa	\$ _____
Clínica de Consulta Externa de Especialidad	\$ _____
Carga de Servicio Urgencias (Cargos de Médico pueden Ser Aplicados Por Separado)	\$ _____
Hospitalizados (Cargos de médico pueden ser aplicados por separado)	\$ _____
Cirugía Ambulatoria	\$ _____
Servicios Médicos (Mientras que en el hospital o sala de emergencia)	\$ _____
Prueba de Laboratorio	\$ _____
Medicamentos Con Receta	\$ _____
Las Exploraciones de Mri/Ct/Pet	\$ _____

**Colorado Indigent Care Program  
Client Authorization  
For the Use and Disclosure of Protected Health Information**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 states that we cannot share your protected health information without your permission, except in certain situations. For example, your protected health information can be shared without your permission if it is used to facilitate your health care treatment, payment, to determine enrollment or eligibility for benefits, or for health plan operations. If you sign this form, you are giving us permission to share the protected health information you indicate below. This does not protect the information from being shared with more people once it leaves our office.

This authorization will only last until the date you specify, and must expire on a specific date or upon the occurrence of a specific event.

If you decide later that you do not want us to share your protected health information any more, you may cancel your authorization at any time by signing the REVOCATION SECTION at the end of this form and returning it to Colorado Department of Health Care Policy and Financing, Special Financing Division. Any revocation can only apply to future disclosures or actions regarding your protected health information and cannot cancel actions taken or disclosures made while the authorization was in effect. See the Department's Privacy Policies and Procedures on Use and Disclosure of Protected Health Information – Authorization Required, pursuant to 45 C.F.R. 164.508.

Date: \_\_\_\_\_

**I, \_\_\_\_\_ (print your name)  
authorize the following person or group to disclose my protected health  
information with the Colorado Department of Health Care Policy and  
Financing:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**The following information may be disclosed:**

Information related to eligibility for benefits for the following time period (specify dates):

From: \_\_\_\_\_ To: \_\_\_\_\_

Information including claims, reports and other documents related to claims for benefits from a certain time period (specify dates):

From: \_\_\_\_\_ To: \_\_\_\_\_

Information relating to payment or lack of payment of benefits for services rendered on a specific date:

Date: \_\_\_\_\_

Name of health care provider: \_\_\_\_\_

Other (specify): \_\_\_\_\_

**Purpose of request for information:** (If you prefer not to state a purpose, please state "At the request of the individual") \_\_\_\_\_

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

**Expiration of authorization:** (You must specify a date or event, i.e., at the end of litigation)

Date / event of expiration: \_\_\_\_\_

**Covered entities under HIPAA may not condition treatment, payment, enrollment or eligibility for health plan benefits on receipt of an authorization.**

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

Signature: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

Name of Designated Personal Representative: \_\_\_\_\_

**Legal documentation must be included to show authority to receive information**

Signature of Designated Personal Representative: \_\_\_\_\_

Relationship of Designated Personal Representative: \_\_\_\_\_

**This form must be received by the Department's Colorado Indigent Care Program prior to any discussion with a third party (i.e. hospital, clinic or billing agent) a client's eligibility for benefits; information including claims, reports, and other documents related to claims for benefits; or information relating to payment or lack of payment of benefits for services rendered. Without this form, the Colorado Indigent Care Program will not discuss any client specific issues with any provider or outside agent.**

Return completed form to [cicpcorrespondence@state.co.us](mailto:cicpcorrespondence@state.co.us)

**Programa de Atención de Indigentes de Colorado**  
**Autorización de Cliente**  
**Para el uso y Divulgación de Información Protegida de Salud**

La Health Insurance Portability y Accountability Act (HIPAA) de 1996 afirma que no podemos compartir su información médica protegida sin su permiso, excepto en ciertas situaciones. Por ejemplo, su información de salud protegida puede compartirse sin su permiso si se utiliza para facilitar su tratamiento médico, pago, para determinar la elegibilidad para beneficios o para las operaciones de plan de salud o inscripción. Si usted firma este formulario, usted nos está dando permiso para compartir la información protegida de salud que indican a continuación. Esto no protege la información se comparte con más gente una vez que sale de nuestra oficina.

Esta autorización durará sólo hasta la fecha específica y deben expirar en una fecha específica o a la ocurrencia de un Suceso específico.

Si más adelante decide que no desea que compartamos su información protegida de salud más, usted puede cancelar su autorización en cualquier momento por firmar la sección de revocación al final de este formulario y devolverlo al Departamento de Colorado de salud política y financiamiento, división especial de financiación. Cualquier revocación sólo se puede aplicar a futuras divulgaciones o acciones con respecto a su información de salud protegida y no puede cancelar acciones o revelaciones hechas mientras que la autorización estaba en efecto. Ver políticas de privacidad y procedimientos sobre el uso y divulgación de información médica protegida – el departamento requiere de la autorización, con arreglo al 45 C.F.R. 164.508.

Fecha: \_\_\_\_\_

**Yo,** \_\_\_\_\_ (escriba su nombre)

**autorizo la siguiente persona o grupo a divulgar mi información de salud protegida con el Departamento de Colorado de salud política y financiamiento:**

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**La siguiente información puede ser revelada:**

Información sobre elegibilidad para beneficios para el período siguiente (indicar fechas):

Desde: \_\_\_\_\_ Hasta: \_\_\_\_\_

Información incluyendo reclamaciones, informes y otros documentos relacionados con reclamaciones de beneficios de un determinado periodo de tiempo (indicar fechas):

Desde: \_\_\_\_\_ Hasta: \_\_\_\_\_

Información relativa al pago o falta de pago de beneficios por los servicios prestados en una fecha específica:

Fecha: \_\_\_\_\_

Nombre del proveedor de atención médica: \_\_\_\_\_

Otro (especifique): \_\_\_\_\_

**Purpose of request for information:** (Si prefiere no estado a propósito, por favor, indique "a petición de los interesados") \_\_\_\_\_

**Expiración de autorización:** (Debe especificar una fecha o evento, es decir, al final del litigio)

**Fecha / evento de expiración:** \_\_\_\_\_

**Las entidades cubiertas bajo HIPAA no pueden condicionar tratamiento, pago, inscripción o elegibilidad para beneficios de plan salud en recibo de una autorización.**

Nombre: \_\_\_\_\_

Firma: \_\_\_\_\_

Fecha de Nacimiento: \_\_\_\_\_

Número de Seguro Social: \_\_\_\_\_

Nombre de Representante Personal designado: \_\_\_\_\_

**Documentación legal debe ser incluida para mostrar autoridad para recibir información**

Firma de Representante Personal designado: \_\_\_\_\_

Relación de Representante Personal designado: \_\_\_\_\_

**Este formulario debe ser recibido por Colorado indigente Care programa del departamento antes de cualquier discusión con un tercero (es decir, hospital, clínica o agente de facturación) la elegibilidad de un cliente para beneficios; información incluyendo reclamaciones, informes y otros documentos relacionados con solicitudes de beneficios; o información relativa al pago o falta de pago de beneficios por los servicios prestados. Sin esta forma, el programa de atención de indigentes de Colorado no conversará sobre cualquier problema específico de cliente con cualquier proveedor o agente.**

Devuelva la forma completada a [cicpcorrespondence@state.co.us](mailto:cicpcorrespondence@state.co.us)



**Colorado Indigent Care Program  
Personal Vehicle Use Verification Form**

Date: \_\_\_\_\_

\_\_\_\_\_  
*Name of Employer (Please Print)*

\_\_\_\_\_  
*Employer's Street Address*

\_\_\_\_\_  
*City, State, Zip Code*

To Whom It May Concern:

\_\_\_\_\_  
*Printed Name of Employee (CICP APPLICANT)*

currently uses his/her personal vehicle in the course of performing his/her job responsibilities.

The vehicle is used to:

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

*Please Check to Affirm the Following:*

- The employee (applicant) receives no reimbursement for vehicle expenses incurred.

Sincerely,

\_\_\_\_\_  
Employer Representative's Signature

\_\_\_\_\_  
Printed Name of Employer Representative

\_\_\_\_\_  
Employer's Telephone Number



**PROGRAMA PARA LA ATENCIÓN DE INDIGENTES DE COLORADO**  
**Forma de verificación de uso del vehículo personal**

Fecha: \_\_\_\_\_

\_\_\_\_\_  
*Nombre del Empleador (Por Favor Imprima)*

\_\_\_\_\_  
*Dirección del Empleador*

\_\_\_\_\_  
*Ciudad, Estado, Código postal*

A Quien Corresponda:

\_\_\_\_\_  
*Nombre Impreso de Empleado (Solicitante)*

actualmente utiliza su vehículo personal en el curso de realización de sus responsabilidades de trabajo.

El vehículo se utiliza para:

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

*Por favor comprueba para afirmar lo siguiente:*

- El empleado (solicitante) no recibe ningún reembolso por gastos de vehículo.

Sinceramente,

\_\_\_\_\_  
Firma del Representante del Empleador

\_\_\_\_\_  
Nombre Impreso del Representante del Empleador

\_\_\_\_\_  
Número de Teléfono del Empleador

**ARTICLE VII. CICP ID CARD TEMPLATE**

**Section 7.01 Optional CICP ID Card Template**

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\_\_\_\_\_

Name\_\_\_\_\_ DOB\_\_\_\_\_

Name\_\_\_\_\_ DOB\_\_\_\_\_

Name\_\_\_\_\_ DOB\_\_\_\_\_

Name\_\_\_\_\_ DOB\_\_\_\_\_

Name\_\_\_\_\_ DOB\_\_\_\_\_

Present this card each time you receive services at a CICP Provider



**COLORADO**

Department of Health Care  
Policy & Financing

**PARTICIPATING PHYSICIAN/Nurse Practitioner CONTRACT  
MEDICAL SERVICES AGREEMENT BETWEEN COLORADO INDIGENT CARE  
PROGRAM PROVIDER FACILITY AND PHYSICIAN/Nurse Practitioner**

**1. Effective Dates:**

\_\_\_\_\_ through \_\_\_\_\_

**2. Parties:**

\_\_\_\_\_, a provider facility under contract with  
the Colorado Indigent Care Program (CICP), and \_\_\_\_\_ M. D.  
or N.P., "Contractor", who's mailing address is: \_\_\_\_\_

**3. Purpose:** The purpose of this Contract is to establish the terms for provision of care and the associated reimbursement for physician services rendered to medically indigent patients treated on-site at a Colorado Indigent Care Program provider facility.

Indigent patients are those patients determined by a provider facility to be eligible for the Colorado Indigent Care Program according to the Client Eligibility Section. The provider facility is responsible for rating patients in accordance with this Manual and reporting both the patient and the financial information to the CICP.

**4. Covered Services:** All medical services that a provider customarily furnishes to patients and can lawfully offer to patients. These covered services include, without limitation, medical services furnished by participating physicians. Covered services must be deemed medically necessary by the responsible physician. Covered services do not include:

- a. Non-emergent dental services.
- b. Nursing home care.
- c. Chiropractic services.
- d. Sex change surgical procedures.
- e. Cosmetic surgery.
- f. Experimental and non-FDA approved treatments.
- g. Elective surgeries, not deemed medically necessary.
- h. Court ordered procedures such as drug testing.
- i. Abortions, except as specified in Sec. 25-15-104.5, C.R.S.
- j. Mental health services as a primary diagnosis in an outpatient or clinic setting. The CICP can reimburse for the services if they are a secondary diagnosis.
- k. Prescription drugs included in the definition of Medicare Part-D are excluded from CICP eligible clients who are also eligible for Medicare.

The CICIP reimburses providers for inpatient psychiatric care and inpatient drug and alcohol services. However, only 30 days per patient per contract year are reimbursable under the CICIP. The CICIP reimburses providers for outpatient mental health benefits if these services are provided on-site and are normally offered by the provider.

5. **Priority of Care:** Payment to Contractor by the provider facility shall be for care rendered to qualifying indigent patients in accord with the following priorities:
  - a. Emergency care for the contact period.
  - b. Any additional medical care for those conditions determined to be the most serious threat to the health of medically indigent persons.
  - c. Any other additional medical care.
6. **Emergency Care:** Treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus, Section 26-15-103, C.R.S.
7. **Urgent Care:** To treat an injury or illness of a less serious nature than those requiring Emergency Care but required in order to prevent serious deterioration in the client's health.
8. **Non-Emergency Care:** Treatment for any conditions not included in the emergency care definition and any additional medical care for those conditions the Department determines to be the most serious threat to the health of medically indigent persons, Section 26-15-106 (9) (6) (11), C.R.S.
9. **License Requirement:** The Contractor must remain properly licensed or certified by the State of Colorado during the contract period, and this Contract shall immediately terminate at the provider facility's sole discretion if the Contractor loses such license or certification.
10. **Reimbursement:** The Colorado Indigent Care Program reimburses provider facilities for participating physician services by distributing the fixed State appropriation across all participating providers. The percentage of costs or charges reimbursed to the provider facility cannot be determined in advance.  
**(Specific terms of reimbursement as negotiated between provider facility and participating physicians should be inserted here.)**
11. **Records Retention and Availability:** That all records, documents, communications and other materials (except medical records of Program Patients) related to Contractor's participation in the Program shall be the property of the State and maintained in a central location by Contractor as custodian thereof on behalf of the State, and shall be accessible to the State for a period of six State fiscal years after the expiration of each State fiscal year, or for such further period as may be necessary to resolve any matters which may be pending at the expiration of each six State fiscal year period, or until an audit performed under the provisions of this Contract has been completed with the following qualification: If an audit by or on behalf of the federal and/or State government has begun, but is not completed at

the end of the six State fiscal year period, or if audit findings have not been resolved after the six State fiscal year period, such materials shall be retained for six months after the filing of the final audit report and response thereto.

12. **Patient Copayments:** Qualifying indigent patients cannot be billed for physician services rendered in excess of patient copayment amounts.
13. **Management Fee:** (If applicable)
14. **Year-end Reconciliation for Changes in the Colorado Indigent Care Program Reimbursement:** (If applicable)
15. **Misrepresentation Penalty:** Persons who represent that a medical service is reimbursable or subject to payment under the CICP when they know that it is not, commit a Class 2 misdemeanor that is punishable by a minimum of three months' imprisonment or a \$250 fine (or both), or a maximum of twelve months' imprisonment or a \$1,000 fine (or both).
16. **Independent Contractor Status:** The Parties of the Contract intend that the relationship between them contemplated by this Contract is that of independent contractors. No agent, employee, or servant of Contractor shall be or shall be deemed to be an employee, agent or servant of the provider facility. The Contractor shall be solely and entirely responsible for its acts and omissions during the performance of this Contract.
17. **Indemnification:** The Contractor shall indemnify the provider facility against all liability, loss, cost or expense the provider facility incurs in connection with the default in any term of this Contract by the Contractor or any negligent or intentional act or omission of the Contractor.
18. **Governing Law:** This Contract and all matters relating to it shall be governed by the laws, rules, and regulations of the State of Colorado as are now in effect or as may be later amended or modified. In the event that any provision of this Contract conflicts with, or is inconsistent with the provisions of those laws, rules or regulations, the provisions of the laws, rules or regulations shall govern or supersede.
19. **Entire Contract:** This Contract is intended as the complete integration of all understandings between Parties. No prior or contemporaneous additions, deletions or other amendments hereto shall have force or effect whatsoever, unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written contract executed by both Parties.
20. **Term of Contract:**  
From \_\_\_\_\_ to \_\_\_\_\_, subject to termination during the term as provided in sections 9 and 21.
21. **Termination:** The Contractor may terminate this Contract without cause with days' notice to this provider facility. The provider facility may terminate this Contract without cause with days' notice to the Contractor. Such termination shall in no way prejudice the obligations of either Party accruing prior to the end of the period of notice.

22. **Provider Contact Person:** Bills for physician services rendered should be sent to:  
(If applicable).
23. **Renewal:** This Contract shall be automatically renewed for successive one year terms on the same terms and conditions as contained in this Contract unless either Party shall, prior to expiration of the term of the Contract, give 90 days' written notice of intent not to renew this Contract. If, however, terms or conditions are changed, a new Contract containing these changes will be required.

This Contract was executed and delivered on the day first written above.

Contractor Signature: \_\_\_\_\_

Type or Print Name: \_\_\_\_\_

Provider Facility Signature: \_\_\_\_\_

Type or Print Name and Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_