



Certified Application Assistance Site (CAAS) Enrollment Application

In completing this application, you are applying to become a site where potential clients may receive assistance in applying for public benefits. *(Please type or neatly write your response to each question of the application. If your agency has multiple locations, you must complete a separate form for each location.*

Agency & Contact Information:

Agency Name: _____

Address: _____

City, State Zip _____

Agency County: _____

Agency Telephone: _____

Agency Website: _____

Agency E-mail: _____

Contact Name * : _____

Mailing Address: _____

City, State Zip _____

Contact E-mail: _____

Contact Telephone: _____ Contact Fax: _____

Additional Agency Information:

- Do you want the Department to purchase one (1) free CAAS stamp for your site? Yes No
- Does your agency offer services in Spanish? Yes No
- Any other languages? Yes No (If yes, please list) _____
- In addition to the Application for Medical Assistance, will your agency be offering application assistance with the online Colorado PEAK application to allow applicants to apply for all public medical, food and financial assistance programs?. Yes No
- Does your site have restricted access? Yes No
- If yes, please explain _____

***To ensure your site receives all messages, updates and training opportunities pertaining to CAAS please provide at least one (1), or more back up contacts for your site:**

Name _____	Email _____
Name _____	Email _____
Name _____	Email _____

Please read and check all of the following that apply:

- Our agency agrees to adhere to all communications, rules, regulations and agency letters as set forth by the Department of Health Care Policy and Financing (Department).
- Our agency agrees to include our site name and number as listed in the Mapping Tool on all processed applications and documents; complete and submit a CAAS Employee information sheet; submit a CAAS quarterly excel spreadsheet report (even if no CAAS assistance was provided during the reporting quarter) and; submit a CAAS Renewal/Update form every two years, approximately 2 weeks prior to the current certification end date, or when changes occur.
- Our agency understands that we are only liable if false documents are **knowingly** verified. In this case, our certification will be revoked.
- Our agency agrees to ensure that all staff members assisting clients are adequately trained on the application process and proper procedures for verifying citizenship and identity documents by reading, understanding and successfully passing the interactive CAAS training presentation and quiz.
- Our agency agrees to assist with applications and verify documents for all medical assistance programs.
- Our agency agrees to submit all applications (complete or incomplete) and documentation to the County department of human/social services or the Medical Assistance Site within **five (5) business days** from the date of assistance.
- Our agency is community-based group and/or a non-profit organization and we understand that we are supporting the community and not an individual's interest.
- Our agency agrees to have our location posted on the Department website. This means we will assist ALL clients who come to our organization for application assistance. * Sites with restricted access may list a phone number for additional information in place of their address.
- Our agency agrees to abide by all applicable HIPAA Privacy and Security requirements regarding health information as defined in 42 U.S.C. 1320d – 1320d-8, and implementing regulations at 45 C.F.R. Parts 160, 162 and 164. This includes notifying the Department of any breach or suspected breach of protected health information (PHI) per the requirements of the business associate agreement.
- Our agency agrees to inform the Department within 30 days when our agency withdraws from the CAAS Program.
- Our agency understands that the Department may choose to revoke our certification at any time.

Completed By: _____

Signature: _____ **Date:** _____

Please submit this form to: Department of Health Care Policy and Financing
E-mail: hcpf_assistancesites@state.co.us or Fax: 303-866-2082.

DEPARTMENT USE ONLY: Approval By: _____ Approval Date: _____ Certification # Assigned: _____



Certified Application Assistance Site Personalized Stamp Request Form

Thank you for becoming a Certified Application Assistance Site (CAAS). We would like to assist you by providing a personalized date stamp for your agency. Please fill out this form completely. It may take up to one month to receive your stamp.

If your agency has multiple locations, please complete a separate form for each location that is a Certified Application Assistance Site.

Agency Information:

Agency name as it will appear on the stamp (35-character maximum):

Agency Address: _____

City, State Zip _____

Agency Telephone: _____

Certification #: _____

Shipping Information:

Contact Name: _____

Shipping Address: _____

City, State Zip _____

Contact E-mail: _____

Contact Telephone: _____

Completed By: _____

Signature: _____

Date: _____

Please submit this form to: Department of Health Care Policy and Financing
E-mail: hcpf_assistancesites@state.co.us OR Fax: 303-866-2082

DEPARTMENT USE ONLY

Approval By: _____ Approval Date: _____ Certification # Assigned: _____