Certified Application Assistance Site (CAAS)
Renewal / Update Form

Please submit this CAAS Renewal / Update Form to renew your agency's CAAS status **or** update information for **each** of your existing active CAAS.

In order to remain an active Certified Application Assistance Site, please complete this entire application and return it to the Department at least 14 days PRIOR to the certification expiration date provided on your CAAS Approval or Renewal Letter,

CAAS Site Number (if unknown please leave blank) _____

Is this site still assisting with medical applications? ☐ **Yes** ☐ **No**

If not, would you like to suspend or terminate your certification? ☐ **Yes** ☐ **No**

Agency Information:

Agency Name: _____

Address: _____

City, State Zip _____

Agency County: _____

Agency Telephone: _____ Ext: _____ **Agency Fax:** _____

Agency Website: _____

Agency E-mail: _____

Contact Information: Name and Title of person the Department can contact regarding the CAAS

Contact Name: _____

Contact E-mail: _____

Contact Telephone: _____ Ext: _____ Contact Fax: _____

Additional Agency Information:

- Does your agency provide assistance with the *Colorado PEAK* application? ☐ Yes ☐ No
- Does your agency offer services in Spanish? ☐ Yes ☐ No
- Does your agency offer services in other languages? ☐ Yes ☐ No
  - If so, which language(s)? _____

Does your facility have legally restricted access or serve a specific population based upon your funding?

☐ **No**

☐ **Yes** (Please explain)

_____

_____

_____

This renewal is contingent upon your agencyôs adherence to all communications, rules, regulations, agency letters and training as set forth by the Department. As an approved site, your agency acknowledges that the Departmentôs CAAS guidelines.

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 ensure that all staff members assisting clients are adequately trained on the process for completing an application and the proper procedures for verifying original citizenship and identity documents.

☐ 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 that our employees will read and understand the CAAS training on the Colorado.gov/hcpf Web site or request CAAS training prior to verifying citizenship/identity documents.

☐ Our agency agrees to assist with applications and verify documents for all medical assistance programs.

☐ Our agency agrees to submit all complete or incomplete applications and all documentation to the County department of human/social services, or the Medical Assistance Site within five 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 community and not an individualôs 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.

***Excluding organizations with legally restricted access (schools, mental facilities, etc.)**

☐ Our agency agrees to abide by all applicable HIPAA Privacy and Security requirements regarding health information as defined in 42 U.S.C. 1320d ï 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 addendum.

☐ Our agency agrees to inform the Department within 45 days when our agency withdraws from the CAAS Program.

☐ Our agency understands that the Department may choose to revoke our certification at any time.

Name & Title (print): _____

Signature or e-signature _____ **Date**: _____

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

DEPARTMENT USE ONLY: Approval By: _____ Approval Date: _____