



Colorado Department  
of Public Health  
and Environment

# 2014 Bridging the Gap Colorado Application

## APPLICANT INFORMATION

INCOMPLETE SUBMISSIONS WILL NOT BE ACCEPTED

In order to renew your eligibility for Bridging the Gap Colorado, this form must be filled out completely. Fill out all information you know and mail or fax it to the Colorado ADAP using the information at the end of this packet. Please indicate what parts of Medicare you know you receive.

<b>MEDICARE</b>			<b>HEALTH INSURANCE</b>	
NAME OF BENEFICIARY (your name):			DATE OF BIRTH (MM/DD/YYYY):  ____/____/____	
MEDICARE CLAIM NUMBER:		SEX:		
IS ENTITLED TO: (PLEASE CHECK ALL THAT APPLY): <b>HOSPITAL (PART A)</b> <input type="checkbox"/> <b>MEDICAL (PART B)</b> <input type="checkbox"/>		EFFECTIVE DATES: _____ _____		
			CURRENT ZIP CODE:  _____	
			If this is your first time applying for Bridging the Gap Colorado, please check here: <input type="checkbox"/>	

<b>LOW-INCOME SUBSIDY INFORMATION:</b> <b>(If you make more than \$1,396 a month, please skip to PREMIUM PAYMENT INFORMATION)</b> Are you currently receiving "Extra Help" from Medicare for your Part D costs? (Check One): Yes <input type="checkbox"/> / No <input type="checkbox"/> / I Don't Know <input type="checkbox"/> If No or Don't Know, please complete the following information. This information will not be used to determine eligibility for ADAP's programs but instead will be used as a guide to determine if you may qualify for any financial assistance programs provided by Social Security or Medicaid. ADAP reserves the right to complete an application for Low-Income Subsidy on your behalf. You may receive information about Medicare Savings Programs in the mail.	
SOCIAL SECURITY INCOME:	Do you own any property <i>in addition</i> to the home that you live in and/or any vehicles you may own? (do not count your house you live in, vehicles or burial plots):
OTHER INCOME:	

By signing below, I attest that the above information is, to the best of my knowledge, true and accurate. In addition to the consent granted to ADAP by the release of information included in the ADAP recertification, I grant Bridging the Gap Colorado my permission to correspond with the Centers for Medicare and Medicaid Services (CMS) and my Part D Plan in order to obtain information that they may need in order to coordinate pharmaceutical benefits through Medicare. I grant Bridging the Gap Colorado permission to enroll me in "Extra Help" for Part D if it is determined that I qualify.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PREMIUM PAYMENT INFORMATION

**If you do not have a plan premium or are paying the premium yourself, DO NOT complete this section**

If you have a premium payment you would like BTGC to pay, **but don't have a copy of your 2014 invoice or payment coupon book available yet**, please put this portion in a place you will remember it (for example, on your refrigerator) for when you receive your 2014 Part D coupon book or premium invoice. If you have already received your invoice or coupon book, please read the agreement below, sign and return this form with the applicable invoice/coupon to the Colorado ADAP using the information below. BTGC will pay up to \$80.00/month for your Part D plan premium.

If you received a coupon book, please affix **ONE COUPON** in the space provided below using tape and keep the remaining coupon book for your records. If you have an invoice, please make sure your name is visible on the invoice and staple it to this page.

**AFFIX COUPON  
HERE**

Any portion of the premium that applies to dental, vision or hearing coverage, or exceeds the \$80.00 limit will be your responsibility to pay. BTGC will not be held liable for any loss of coverage that results from non-payment on your behalf or for any plan for which a premium invoice was not submitted to the Colorado ADAP for payment. It is your responsibility to notify the Colorado ADAP of any correspondence you may receive from your Part D plan regarding changes to coverage, late payments or possible discontinuation. You are also required to surrender any refund checks given to you by your Part D plan for any services paid by the Colorado ADAP for premiums or co-pays as that money is the sole property of the Colorado ADAP. Failure to surrender checks in a timely manner will result in discontinuation of coverage until the funds have been returned to the Colorado ADAP. By signing below, you agree to these terms and conditions. Please provide your phone number in case we need to reach you for questions.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Phone Number \_\_\_\_\_

No premium shall be paid on your behalf until this signed document is received with a premium invoice or Part D coupon. Mail or fax this completed form with a copy of your premium invoice or coupon book to the information below.



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