Application for Health Insurance & Help Paying Costs

CONNECT for HEALTH COLORADO

COLORADO Department of Health Care Policy & Financing

Apply faster online at:

Colorado.gov/PEAK

ConnectforHealthCO.com

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Having health insurance can help give you peace of mind and stay healthy. With insurance, you will know you and your family can get health care when you need it. **Fill out this application to see if you qualify for:**

- Free or low-cost public health insurance from Health First Colorado (Colorado's Medicaid Program) or the Child Health Plan *Plus* (CHP+) program administered by the Colorado Department of Health Care Policy and Financing ℹ,
- Affordable private health insurance plans that offer comprehensive coverage available through Connect for Health Colorado ℹ (the Marketplace), or
- A tax credit that can help lower your premiums for health coverage.

You may qualify for free or low-cost health insurance if you earn as much as $46,500 a year for an individual, or $95,000 a year for a family of 4. Filling out this application does not mean you have to buy health insurance.

Who can use this application?

Anyone can use this application. Applying will not affect your immigration status or chances of becoming a permanent resident or citizen.

Call us to get connected to free help in other languages

If someone is helping you fill out this application, you may need to complete **Worksheet A** ✎ (pages 18 - 19).

For a list of languages we can assist in, see **Things to Know.** If you need help in a language other than English, call and tell the customer service representative the language you need.

Llame a nuestro centro de servicio gratis para ayuda o para obtener una copia de esta formulario en Español.

Department of Health Care Policy & Financing's Member Contact Center

- Toll Free: 1-800-221-3943 | State Relay: 711

Connect for Health Colorado Customer Service Center

- Toll Free: 1-855-752-6749 | TTY: 1-855-346-3432

Symbols used in this application

Worksheets are marked with the symbol ✎ in this application (starting on page 18). Terms marked with an ℹ in the application can be found in the **Glossary** (starting on page 41).

Things to Know

Call us to get connected to free help in other languages

Español - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-221-3943 (State Relay: 711).

Tiếng Việt - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-221-3943 (State Relay: 711).

繁體中文 **-** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-221-3943（State Relay: 711）.

한국어 **-** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-221-3943 (State Relay: 711) 번으로 전화해 주십시오.

Русский - Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Звоните 1-800-221-3943 (State relay: 711).

አማርኛ - ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-221-3943 (መስማት ለተሳናቸው: 711).

العربية - ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-221-3943 (رقم هاتف الصم والبكم:711

Deutsch - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-221-3943 (State Relay: 711).

Français - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-221-3943 (ATS : 711).

नेपाली - ध्यान दिनुहोस्: तपाइंले नेपाली बोल्नुहुन्छ भने तपाइंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-221-3943 (टिटिवाइ: 711).

Tagalog - PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-221-3943 (State Relay: 711).

日本語 - 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます. 1-800-221-3943（State Relay: 711）まで、お電話にてご連絡ください.

Oroomiffa - XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-221-3943 (State Relay: 711).

فارسی - توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید
1-800-221-3943 (state relay: 711)

Polski - UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-221-3943 (State Relay: 711).

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants) for everyone in your household who needs insurance
- Employer and income information for everyone in your household
- Current health insurance information, including policy number for each member of your household
- Information about any job-related health insurance available to your household

Things to Know *continued on next page*

Things to Know (continued)

Why do we ask for this information?

We may ask about income and other information to find what health coverage you may qualify for and if you can get help paying for it. We keep all the information you provide us private and secure, as required by law.

What happens next?

- Send or drop off your completed, signed application to one of the addresses in **Addendum A**.
- If you do not have all the information we ask for, sign and submit your application anyway. We will contact you and tell you what you need to do next.
- If you do not hear from us, please contact the agency you sent your application to (a list of agencies can be found in **Addendum A**).
- Please note:
  - It may take up to 45 days — or up to 90 days if the application requires a disability determination — from the date your application was received for a case number to be assigned to you.
  - You can check your status and benefits online through Colorado PEAK. Get more information about your case number and where to find it at: https://www.healthfirstcolorado.com/health-first-colorado/glossary/case-number-find/

Where can you find additional information or help with this application?

	Health First Colorado and CHP+	Connect for Health Colorado
Online:	Colorado.gov/PEAK	ConnectforHealthCO.com
Phone:	1-800-221-3942	1-855-PLANS-4-YOU (1-855-752-6749)
TTY/TDD:	State Relay: 711	1-855-346-3432
In Person:	Find an Application Assistance Site in your area who can help at Colorado.gov/hcpfmap	Visit ConnectforHealthCO.com for a list of Certified Health Coverage Guides, Application Counselors, and Agents/Brokers in your area.

For additional information, please see the separate **Frequently Asked Questions: Applying For Coverage** available at Colorado.gov/HCPF/Apply and ConnectforHealthCO.com/resources/the-basics/customer-resources/.

***Application** starts on next page*

Start application here

Step 1: Tell us about your household

Write each member of your household in the Household Relationship Table on the next page. Use the Household Relationship Table Example below as a guide. Your income and household size help us decide what programs you qualify for.

DO include the following people on your application:

- Yourself
- Your spouse*
- Your children under 19 who live with you
- Anyone on your federal income tax return
  - This could include children over 19, even if they do not live with you
- Your unmarried partner* who needs health coverage
- Anyone else under 19 who you take care of and lives with you

If you are claimed as a dependent* on someone else's federal tax return, also include:

- The person(s) who claims you
- All members of that federal tax filing household claimed as dependents
- Any family member living with you

★ Note: If someone in your household has passed away this year, you should still include them on your application. This will help us better determine what benefits you may qualify for.

★ **You DO NOT have to include other unrelated roommates.**

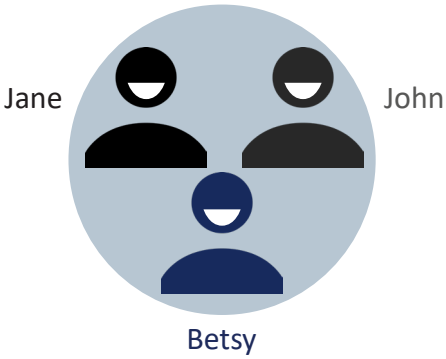
*Find the definitions of these words in the **Glossary** (starting on page 41).

Household Relationship Table Example

In **Step 1**, we are asking how each person in your household is related to each other.
Use the example table on the next page to figure out who should be included in your household.
When you're ready, list each person in your household on the next page.

- **Person 1 is the main contact person for this application.**
- Start with **Person 1**, and fill in the relationship that **Person 1** has to each member of the household.
- Repeat this step for **each person** listed in the household.
- **Only use the terms husband, wife, or spouse when describing people who are legally married** ("legally married" includes common law and common law registered, but does not include civil unions).

1. This household is made up of Jane, John, and Betsy.
2. Jane is the person filling out this application and is known as **Person 1.**
3. Jane and John are married to each other.
4. Betsy is Jane's daughter from a previous relationship.



Person 1:
Jane

Person 2:
John

Person 3:
Betsy

***Step 1** continued on next page*

Step 1: Tell us about your household

Sample Household Relationship Table:

Person 1	is the	Wife	Mother			
Jane		**of Person 2**	**of Person 3**	**of Person 4**	**of Person 5**	**of Person 6**
Person 2	is the	Husband	Stepfather			
John		**of Person 1**	**of Person 3**	**of Person 4**	**of Person 5**	**of Person 6**
Person 3	is the	Daughter	Stepdaughter			
Betsy		**of Person 1**	**of Person 2**	**of Person 4**	**of Person 5**	**of Person 6**

Household Relationship Table

Use the table below to list each person in your household. If you need more space, you can draw more columns and rows, or make a copy of the table.

- **Person 1 is the main contact person for this application.**
- Start with **Person 1**, and fill in the relationship that **Person 1** has to each member of the household.
- Repeat this step for **each person** listed in the household.
- **Only use the terms husband, wife, or spouse when describing people who are legally married** ("legally married" includes common law and common law registered, but does not include civil unions).

Person 1:_____ **Person 2:**_____ **Person 3:**_____

Person 4:_____ **Person 5:**_____ **Person 6:**_____

Person 1	is the					
(You)		**of Person 2**	**of Person 3**	**of Person 4**	**of Person 5**	**of Person 6**
Person 2	is the					
		of Person 1	**of Person 3**	**of Person 4**	**of Person 5**	**of Person 6**
Person 3	is the					
		of Person 1	**of Person 2**	**of Person 4**	**of Person 5**	**of Person 6**
of Person 4	is the					
		of Person 1	**of Person 2**	**of Person 3**	**of Person 5**	**of Person 6**
of Person 5	is the					
		of Person 1	**of Person 2**	**of Person 3**	**of Person 4**	**of Person 6**
of Person 6	is the					
		of Person 1	**of Person 2**	**of Person 3**	**of Person 4**	**of Person 5**

Is someone helping you fill out the application? If yes, remember to complete **Worksheet A** (pages 18 - 19).

Step 2: Person 1 (Start with yourself)

Complete Step 2 for each person in your household. Start with yourself, then add other adults and children in your household. If you have more than 2 people in your household, you can fill out **Worksheet I** (pages 31 - 34) and make copies of the pages if needed. **You do not need to provide immigration status or Social Security Number (SSN) for household members who are not applying for health coverage**. We will use your personal information only to check if you qualify for health coverage.

1. Legal Name (First) (Middle) (Last) Suffix

2. Date of Birth (mm/dd/yyyy) 3. Sex: ☐ Male ☐ Female

4. Home Address (leave blank if you do not have one) Apartment/Suite #

City	State	Zip Code	County

5. Mailing Address (if different from Home Address) Apartment/Suite #

6. In Care Of (If applicable):

City	State	Zip Code	County

7. Email Address

Tip: If you would like to receive notices electronically, please visit Colorado.gov/PEAK to create an account.

8. Primary Phone	Ext	Phone Type: ☐ Cell ☐ Home ☐ Work
9. Secondary Phone	Ext	Phone Type: ☐ Cell ☐ Home ☐ Work

10. Preferred Spoken Language: ☐ English ☐ Spanish	Other (Please Specify):
11. Preferred Written Language: ☐ English ☐ Spanish	Other (Please Specify):

Note: Information we send you in writing, including letters and emails, can only be sent in English and Spanish.

12. Are you temporarily living outside of Colorado? ☐ Yes ☐ No

13. If you are temporarily living outside of Colorado, where will you be living in Colorado when you return?

City	Zip Code	County

***Step 2, Person 1** continues on next page*

Step 2: Person 1 (continue with yourself)

14. Social Security Number (or Taxpayer ID):

If you are applying for Health First Colorado or Child Health Plan *Plus* (CHP+), and have a SSN, we need this information. If you are applying for help paying for health insurance costs through the Marketplace, providing your SSN will help us to quickly process your application. We use SSNs to check income and other information to see what type of health coverage you may qualify for. If you do not have a SSN, and you are applying for health coverage, tell us why you do not have a SSN. If you are not eligible to receive a SSN, do you have a Taxpayer Identification Number (TIN), such as an Individual Taxpayer Identification Number (ITIN) or an Adoption Taxpayer Identification Number (ATIN)? If so, enter it above. **If you do not have a Social Security Number**, please visit http://www.ssa.gov/ssnumber/ for information on how to apply for a Social Security Number, or call the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778) for assistance.

Please answer the following:

- ☐ Have applied for a SSN*
- ☐ Only eligible to receive a SSN for valid non-work reason
- ☐ Not eligible to receive a SSN
- ☐ Refuses to obtain due to well established religious objection

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15. **Do you plan to file a federal income tax return next year?** ☐ Yes ☐ No

You can still apply for Health First Colorado, CHP+, or other health insurance even if you do not file a federal income tax return. However, you must plan to file federal taxes every year you receive Advance Premium Tax Credits (APTC) or Cost Sharing Reductions (CSR) through the Marketplace.

If you selected **Yes**, answer questions a - f. If you selected **No**, skip to question e.

a. What is your current federal income tax filing status? ☐ Single ☐ Married Filing Jointly ☐ Head of Household ☐ Married Filing Separately ☐ Qualifying Widow(er) with Dependent Child

b. If you selected "Head of Household" or "Married Filing Separately", do exceptional circumstances apply to your case?
☐ Yes ☐ No

c. If you are "Married Filing Jointly", please name your spouse:

d. Will you claim dependents on your tax return? ☐ Yes ☐ No

If **Yes**, list the legal name(s) of your dependents:

e. If you are a tax dependent, list who claims you as a dependent:

Is this person listed on the application? ☐ Yes ☐ No

Is this person a non-custodial parent? ☐ Yes ☐ No

f. Are you living with both parents, but your parents do not expect to file a joint federal income tax return?

☐ Yes ☐ No

Attention: On the **following pages** the answers to questions marked with an asterisk (*) cannot be used to determine the availability or cost of premiums for any health insurance purchased through the Marketplace. This information is necessary to ensure you and your family receive a correct determination for the program you may qualify for.

***Step 2, Person 1** continues on next page*

Step 2: Person 1 (continue with yourself)

16. *Are you pregnant? ☐ Yes ☐ No

If **Yes**, how many babies are expected? _____

Due Date (mm/dd/yyyy)? _____

17. **Do you need health coverage?**
☐ Yes (If **Yes**, answer all of the following questions.) ☐ No (If **No**, skip to question 31.)

18. Do you live with at least one child under the age of 19, and are you the main person taking care of this child?
☐ Yes ☐ No

19. Are you a full-time student? ☐ Yes ☐ No

20. *Do you have a medical, physical, mental, or developmental condition that has lasted, or is expected to last, more than 12 months, including blindness? ☐ Yes ☐ No

21. *Do you have a medical, physical, mental, or developmental condition that causes you to regularly need help with some or all of your self-care activities (such as bathing, dressing, eating, using the bathroom)?
☐ Yes ☐ No

22. *Do you need to move to a nursing home, acute care, hospital, group home, mental health institution or long-term care facility within the next 30 days, or do you need in-home health care to stay in your home?
☐ Yes ☐ No

If you have answered "Yes" to either question 20, 21, 22, or if you qualify for Medicare, you have the option to complete Worksheet B (pages 20 - 24) to find out if you qualify for health coverage for individuals who have a disability, are 65 and older, and/or who are blind.

23. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

24. If you are not a U.S. citizen or U.S. national, do you have an eligible immigration status?
☐ Yes If **Yes**, fill out the following table:

Non-Citizen Status:		**Immigration Document Type:**	
Alien or I-94 Number:		**Card/Passport Number:**	
Document Expiration Date:		**Country of Issuance:**	
Have you lived in the U.S. since 1996?		☐ **Yes** ☐ **No**	
Are you, your spouse, or parent an honorable discharged veteran or an active-duty member of the U.S. military?		☐ **Yes** ☐ **No**	

For more information on non-citizenship status and immigration documents, please see **Frequently Asked Questions: Applying for Coverage** at Colorado.gov/HCPF/Apply and ConnectforHealthCO.com/resources/the-basics/customer-resources/.

Other Health Coverage

25. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

If **Yes**, list the months that you want help (mm/yyyy) _____

26. Are you being treated for an injury for which you have brought or may bring a legal claim? ☐ Yes ☐ No

27. Do you qualify for or are you enrolled in any of the following types of health care coverage? If **Yes**, fill out **Worksheet C** (pg 25).

☐ TRICARE ☐ Peace Corps ☐ Other State or Federal Health Benefit Program

☐ COBRA ☐ VA Health Care Benefits ☐ Retiree Health Plan ☐ Other: _____

***Step 2, Person 1** continues on next page*

Step 2: Person 1 (continue with yourself)

28. Do you qualify for or are you enrolled in Medicare? ☐ Yes ☐ No

If **Yes,** you have the option to complete **Worksheet B** **(pages 20 - 24) to find out if you qualify for health coverage for individuals who have a disability, are 65 and older, and/or who are blind**.

29. Do you qualify for health insurance through a current employer? ☐ Yes ☐ No

If **Yes,** fill out **Worksheet D** (page 26).

30. Are you currently incarcerated? ☐ Yes ☐ No

If **Yes,** are you currently waiting for a decision on charges? ☐ Yes ☐ No

31. Race (optional - check all that apply)

☐ American Indian or Alaska Native (fill out **Worksheet E**) ☐ Asian Indian ☐ Black or African American

☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Hispanic/ Latino

☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese

☐ White or Caucasian ☐ Other: _____

If you are an American Indian or Alaska Native, you may not have to pay certain co-pays or premiums. **Fill out Worksheet E (page 27) to see if you qualify.**

32. Current Job & Income Information (check all that apply)

☐ **I do not have a job.** Skip to question 61.

☐ **I have a job.** If you are currently employed, tell us about your income. Start with question 33.

☐ **I am self-employed.** Fill out **Worksheet F** (page 28) and return to question 61.

☐ **I have another income (including rental income).** Fill out **Worksheet G** (page 29) and return to question 61.

Current Job 1:

33. Employer Name

34. Employer Address

35. Apartment/Suite #

36. Employer Phone

37. City

38. State

39. Zip Code

40. Wages/tips (before taxes)
$

Pay Period: ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Twice a Month ☐ Yearly

41. Average Hours Worked Each Week:

42. Tell us the total gross pay that you got or will get this month as a one-time payment from this employer (this could be a bonus or other extra pay you got).

43. Does your income from this job change month to month? ☐ Yes ☐ No

If **Yes**, fill out the Current Wages/Tips **AND** Expected Annual Income for this job. If **No**, only fill out the Current Wages/Tips in number 40 above. You do not need to fill out the Expected Annual Income.

44. Expected Annual income from this job:

45 a. Is this income from seasonal employment? If **yes**, answer 46. ☐ Yes ☐ No

45 b. Is this income from commission-based employment (including tip based employment)? If **yes**, answer 46. ☐ Yes ☐ No

46. Will the expected annual income from this job be the same or lower in the next calendar year? ☐ Yes ☐ No

Current Job 2: (If you only have one job skip to question 61.)

47. Employer Name

48. Employer Address

49. Apartment/Suite #

***Step 2, Person 1** continues on next page*

Step 2: Person 1 (continue with yourself)

50. Employer Phone	51. City	52. State	53. Zip Code

54. Wages/tips (before taxes) $	Pay Period:	☐ Daily ☐ Monthly	☐ Weekly ☐ Twice a Month	☐ Every 2 Weeks ☐ Yearly

55. Average Hours Worked Each Week:

56. Tell us the total gross pay that you got or will get this month as a one-time payment from this employer (this could be a bonus or other extra pay you got).

57. Does your income from this job change month to month? ☐ Yes ☐ No

If **Yes**, fill out the Current Wages/Tips **AND** Expected Annual Income for this job. If **No**, only fill out the Current Wages/Tips in number 54 above. You do not need to fill out the Expected Annual Income.

58. Expected Annual income from this job:

59 a. Is this income from seasonal employment? ☐ Yes ☐ No

59 b. Is this income from commission-based employment (including tip based employment)? ☐ Yes ☐ No

60. Will the expected annual income from this job be the same or lower in the next calendar year? ☐ Yes ☐ No

61. **DEDUCTIONS:** Check all that apply, and give the amount and how often you pay it. Telling us about these deductions could make the cost of your health insurance lower. You should not include a cost that you already considered in your answer to job income and net self-employment.

62. Do your deductions change month to month? ☐ Yes ☐ No

If **Yes**, for each deduction that changes, fill out the Current Amount **AND** the Expected Annual Amount columns.

If you are not paying the deduction at this time, but expect to claim it on your tax return, fill out $0 for the Current Amount, and write the amount you will include on your tax return for the Expected Annual Amount.

If **No**, only fill out the Current Amount column. You do not need to fill out the Expected Annual Amount column.

Deduction Types:

- Alimony Paid
- Student Loan Interest
- Capital Losses
- Certain Business Expenses of Reservists, Performing Artists, or Fee-Based Government Officials
- Penalty of Early Withdrawal of Savings
- Domestic Production Activities
- Health Savings Account (HSA) Deduction
- Contribution made to your Traditional IRA
- Moving Expenses

Type of Deduction	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only ☐ Weekly ☐ Every 2 Weeks	☐ Twice Monthly ☐ Monthly ☐ Yearly
Type of Deduction	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only ☐ Weekly ☐ Every 2 Weeks	☐ Twice Monthly ☐ Monthly ☐ Yearly
Type of Deduction	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only ☐ Weekly ☐ Every 2 Weeks	☐ Twice Monthly ☐ Monthly ☐ Yearly

63. Tell us the total amount of income you plan to report on your tax return that you have NOT yet included in this application and its Worksheets. Include incomes such as past employment, or benefits that you received in past months.

64. After you submit this application, we will verify your income. Please tell us if any of the following have happened to you in the past two years to help us with this verification process. Check the box and enter the date this change occurred for all reasons that apply showing why your income has changed.

- ☐ Stopped working at a job
- ☐ Hours changed at a job
- ☐ Change in Employment
- ☐ Married, Legal Separation, or Divorce
- ☐ Other:

Date the change occurred? (mm/dd/yyyy)

*End of **Step 2, Person 1***

Step 2: Person 2

Make copies of these pages if necessary.

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your federal income tax return. See Step 1 for more information about who to include.

1. Legal Name (First) (Middle) (Last) Suffix

2. Date of Birth (mm/dd/yyyy) 3. Sex: ☐ Male ☐ Female

4. Home Address (Leave blank if you do not have one) Apartment/Suite #

City	State	Zip Code	County

5. If Person 2 is 18 years or older, would they like to receive their own mail about their health coverage? ☐ Yes ☐ No
If yes, please fill out the mailing address below.

6. Mailing Address (If different from Home Address) Apartment/Suite #

7. In Care Of (If applicable):

City	State	Zip Code	County

8. Email Address

Tip: If Person 2 would like to receive notices electronically please visit Colorado.gov/PEAK to create an account.

9. Primary Phone	Ext	Phone Type: ☐ Cell ☐ Home ☐ Work
10. Secondary Phone	Ext	Phone Type: ☐ Cell ☐ Home ☐ Work

11. Preferred Spoken Language: ☐ English ☐ Spanish	Other (Please Specify):
12. Preferred Written Language: ☐ English ☐ Spanish	Other (Please Specify):

Information we send in writing, including letters and emails, can only be sent in English and Spanish.

13. Is Person 2 temporarily living outside of Colorado? ☐ Yes ☐ No

14. If Person 2 is temporarily living outside of Colorado, where will they be living in Colorado when they return?

City	Zip Code	County

***Step 2, Person 2** continues on next page*

Step 2: Person 2 (continue with Person 2)

Make copies of these pages if necessary.

15. Social Security Number (or Taxpayer ID):

If Person 2 is applying for Health First Colorado or Child Health Plan *Plus* (CHP+), and has a SSN, we need this information. If they are applying for help paying for health insurance costs through the Marketplace, providing their SSN will help us to quickly process their application. We use SSNs to check income and other information to see what type of health coverage they may qualify for. If Person 2 does not have a SSN, and they are applying for health coverage, tell us why they do not have a SSN. If they are not eligible to receive a SSN, do they have a Taxpayer Identification Number (TIN), such as an Individual Taxpayer Identification Number (ITIN) or an Adoption Taxpayer Identification Number (ATIN)? If so, enter it above. *If they do not have a Social Security Number, please visit http://www.ssa.gov/ssnumber/ for information on how to apply for a Social Security Number, or call the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778) for assistance.

Please answer the following:

- ☐ Have applied for a SSN*
- ☐ Only eligible to receive a SSN for valid non-work reason
- ☐ Not eligible to receive a SSN
- ☐ Refuses to obtain due to well established religious objection

16. **Does Person 2 plan to file a federal income tax return next year?** ☐ Yes ☐ No

They can still apply for Health First Colorado, CHP+, or other health insurance even if they do not file a federal income tax return. However, they must plan to file federal taxes every year you receive Advance Premium Tax Credits (APTC) or Cost Sharing Reductions (CSR) through the Marketplace.

If they selected **Yes**, answer questions a - f. If you selected **No**, skip to question e.

a. What is Person 2's current federal income tax filing status? ☐ Single ☐ Married Filing Jointly ☐ Head of Household ☐ Married Filing Separately ☐ Qualifying Widow(er) with Dependent Child

b. If Person 2 selected "Head of Household" or "Married Filing Separately", do exceptional circumstances apply to their case? ☐ Yes ☐ No

c. If Person 2 is "Married Filing Jointly", please name his or her spouse:

d. Will Person 2 claim dependents on their tax return? ☐ Yes ☐ No

If **Yes**, list the legal name(s) of their dependents:

e. If Person 2 is a tax dependent, list who claims them as a dependent:

Is this person listed on the application? ☐ Yes ☐ No

Is this person a non-custodial parent? ☐ Yes ☐ No

f. Is Person 2 living with both parents, but their parents do not expect to file a joint federal income tax return?

☐ Yes ☐ No

Attention: On the **following pages** the answers to questions marked with an asterisk (*) cannot be used to determine the availability or cost of premiums for any health insurance purchased through the Marketplace. This information is necessary to ensure you and your family receive a correct determination for the program you may qualify for.

***Step 2, Person 2** continues on next page*

Step 2: Person 2 (continue with Person 2)

Make copies of these pages if necessary.

17. *Is Person 2 pregnant? ☐ Yes ☐ No

If **Yes**, how many babies are expected? _____

Due Date (mm/dd/yyyy)? _____

18. **Does Person 2 need health coverage?**
☐ Yes (If **Yes**, answer all of the following questions.) ☐ No (If **No**, skip to question 32.)

19. Does Person 2 live with at least one child under the age of 19, and is Person 2 the main person taking care of this child? ☐ Yes ☐ No

20. Is Person 2 a full-time student? ☐ Yes ☐ No

21. *Does Person 2 have a medical, physical, mental, or developmental condition that has lasted, or is expected to last, more than 12 months, including blindness? ☐ Yes ☐ No

22. *Does Person 2 have a medical, physical, mental, or developmental condition that causes them to regularly need help with some or all of their self-care activities (such as bathing, dressing, eating, using the bathroom)?
☐ Yes ☐ No

23. *Does Person 2 need to move to a nursing home, acute care, hospital, group home, mental health institution or long-term care facility within the next 30 days, or do they need in-home health care to stay in your home?
☐ Yes ☐ No

If Person 2 answered "Yes" to either question 21, 22, 23, or qualifies for Medicare, Person 2 has the option to complete Worksheet B (pages 20 - 24) to find out if they qualify for health coverage for individuals who have a disability, are 65 and older, and/or who are blind.

24. Is Person 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

25. If Person 2 is not a U.S. citizen or U.S. national, do they have an eligible immigration status?
☐ Yes If **Yes**, fill out the following table:

Non-Citizen Status:		**Immigration Document Type:**	
Alien or I-94 Number:		**Card/Passport Number:**	
Document Expiration Date:		**Country of Issuance:**	
Has Person 2 lived in the U.S. since 1996?		☐ **Yes** ☐ **No**	
Is Person 2, their spouse, or parent an honorable discharged veteran or an active-duty member of the U.S. military?		☐ **Yes** ☐ **No**	

For more information on non-citizenship status and immigration documents, please see **Frequently Asked Questions: Applying for Coverage** at Colorado.gov/HCPF/Apply and ConnectforHealthCO.com/resources/the-basics/customer-resources/.

Other Health Coverage

26. Does Person 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No
If **Yes**, list the months that they want help (mm/yyyy) _____

27. Is Person 2 being treated for an injury for which they have brought or will bring a legal claim? ☐ Yes ☐ No

28. Does Person 2 qualify for or are they enrolled in any of the following types of health care coverage?
If **Yes**, fill out **Worksheet C** (page 25).
☐ TRICARE ☐ Peace Corps ☐ Other State or Federal Health Benefit Program
☐ COBRA ☐ VA Health Care Benefits ☐ Retiree Health Plan ☐ Other: _____

***Step 2, Person 2** continues on next page*

Step 2: Person 2 (continue with Person 2)

Make copies of these pages if necessary.

29. Does Person 2 qualify for or are you enrolled in Medicare? ☐ Yes ☐ No

If **Yes,** Person 2 has the option to complete **Worksheet B** **(pages 20 - 24) to find out if they qualify for health coverage for individuals who have a disability, are 65 and older, and/or who are blind**.

30. Does Person 2 qualify for health insurance through a current employer? ☐ Yes ☐ No

If **Yes,** fill out **Worksheet D** (page 26).

31. Is Person 2 currently incarcerated? ☐ Yes ☐ No

If **Yes,** are they currently waiting for a decision on charges? ☐ Yes ☐ No

32. Race (optional - check all that apply)

☐ American Indian or Alaska Native (fill out **Worksheet E**) ☐ Asian Indian ☐ Black or African American

☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Hispanic/ Latino

☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese

☐ White or Caucasian ☐ Other: _____

If Person 2 is an American Indian or Alaska Native, they may not have to pay certain co-pays or premiums. **Fill out Worksheet E (page 27) to see if they qualify.**

33. Current Job & Income Information (check all that apply)

☐ **Does not have a job.** Skip to question 62.

☐ **Has a job.** If they are currently employed, tell us about their income. Start with question 34.

☐ **Is self-employed.** Fill out **Worksheet F** (page 28) and return to question 62.

☐ **Has other income (including rental income).** Fill out **Worksheet G** (page 29) and return to question 62.

Current Job 1:

34. Employer Name

35. Employer Address

36. Apartment/Suite #

37. Employer Phone

38. City

39. State

40. Zip Code

41. Wages/tips (before taxes)
$

Pay Period: ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Twice a Month ☐ Yearly

42. Average Hours Worked Each Week:

43. Tell us the total gross pay that Person2 got or will get this month as a one-time payment from this employer (this could be a bonus or other extra pay they got).

44. Does Person 2's income from this job change month to month? ☐ Yes ☐ No

If **Yes**, fill out the Current Wages/Tips **AND** Expected Annnual Income for this job. If **No**, only fill out the Current Wages/Tips in number 41 above. They do not need to fill out the Expected Annual Income.

45. Expected Annual income from this job:

46 a. Is this income from seasonal employment? If **yes**, answer 46. ☐ Yes ☐ No

46 b. Is this income from commission-based employment (including tip based employment)? If **yes**, answer 46. ☐ Yes ☐ No

47. Will the expected annual income from this job be the same or lower in the next calendar year? ☐ Yes ☐ No

Current Job 2: (If you only have one job skip to question 62.)

48. Employer Name

49. Employer Address

50. Apartment/Suite #

***Step 2, Person 2** continues on next page*

Step 2: Person 2 (continue with Person 2)

Make copies of these pages if necessary.

51. Employer Phone	52. City	53. State	54. Zip Code

55. Wages/tips (before taxes) $	Pay Period:	☐ Daily ☐ Monthly	☐ Weekly ☐ Twice a Month	☐ Every 2 Weeks ☐ Yearly

56. Average House Worked Each Week:

57. Tell us the total gross pay that Person 2 got or will get this month as a one-time payment from this employer (this could be a bonus or other extra pay they got).

58. Does Person 2's income from this job change month to month? ☐ Yes ☐ No

If **Yes**, fill out the Current Wages/Tips **AND** Expected Annnual Income for this job. If **No**, only fill out the Current Wages/Tips in number 55 above. They do not need to fill out the Expected Annual Income.

59. Expected Annual income from this job:

60 a. Is this income from seasonal employment? ☐ Yes ☐ No

60 b. Is this income from commission-based employment (including tip based employment)? ☐ Yes ☐ No

61. Will the expected annual income from this job be the same or lower in the next calendar year? ☐ Yes ☐ No

62. **DEDUCTIONS:** Check all that apply, and give the amount and how often Person 2 pays it. Telling us about these deductions could make the cost of their health insurance lower. Person 2 should not include a cost that they already considered in their answer to job income and net self-employment.

63. Do their deductions change month to month? ☐ Yes ☐ No

If **Yes**, for each deduction that changes, fill out the Current Amount **AND** the Expected Annual Amount columns.

If Person 2 is not paying the deduction at this time, but expects to claim it on their tax return, fill out $0 for the Current Amount, and write the amount Person 2 will include on their tax return for the Expected Annual Amount.

If **No**, only fill out the Current Amount column. Person 2 does not need to fill out the Expected Annual Amount column.

Deduction Types:

- Alimony Paid
- Student Loan Interest
- Capital Losses
- Certain Business Expenses of Reservists, Performing Artists, or Fee-Based Government Officials
- Penalty of Early Withdrawal of Savings
- Domestic Production Activities
- Health Savings Account (HSA) Deduction
- Contribution made to your Traditional IRA
- Moving Expenses

Type of Deduction	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only ☐ Weekly ☐ Every 2 Weeks	☐ Twice Monthly ☐ Monthly ☐ Yearly
Type of Deduction	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only ☐ Weekly ☐ Every 2 Weeks	☐ Twice Monthly ☐ Monthly ☐ Yearly
Type of Deduction	Current Amount	Expected Annual Amount	Frequency	☐ One Time Only ☐ Weekly ☐ Every 2 Weeks	☐ Twice Monthly ☐ Monthly ☐ Yearly

63. Tell us the total amount of income Person 2 plans to report on your tax return that you have NOT yet included in this application and its Worksheets. Include incomes such as past employment, or benefits that you received in past months.

64. After this application is submitted, we will verify Person 2's income. Please tell us if any of the following have happened to Person 2 in the past two years to help us with this verification process. Check the box and enter the date this change occurred for all reasons that apply showing why their income has changed.

- ☐ Stopped working at a job
- ☐ Hours changed at a job
- ☐ Change in Employment
- ☐ Married, Legal Separation, or Divorce
- ☐ Other:

Date the change occurred? (mm/dd/yyyy)

*End of **Step 2 Person 2***

Step 3: What I Should Know

Step 2 Note (page 12): If you have **more than two people** in your household to include, go to **Worksheet I** (pages 31 - 34) **make additional copies as needed**, and complete.

1. I know I or another applicant may be automatically provided enrollment into Health First Colorado (Colorado's Medicaid Program) or Child Health Plan *Plus* (CHP+) if we are eligible. I can visit the Health First Colorado website at Colorado.gov/PEAK for more information. I will immediately notify the State of any medical claim or lawsuit I have. I will cooperate with the State in collecting the medical bills the State has paid. The State may collect from any insurance company or court settlement for medical bills that the State has paid. If I am on Health First Colorado and receive money for the same medical bills that the State has paid, I will give the money to the State. I assign to the State all rights to payment for medical expenses and treatments. I also assign my right to appeal a denial of benefits by another party responsible for payment for benefits to the State. If there is an absent parent(s) from my home, and I am applying for Health First Colorado, I must seek medical support from the absent parent(s). I may contact Child Support Enforcement for assistance.

2. Federal and Colorado state law require the Department of Health Care Policy and Financing to recover all medical assistance benefits, including capitation payments, paid on behalf of Health First Colorado clients from the estates of deceased Health First Colorado clients who were permanently institutionalized. For Health First Colorado clients who were over the age of 55 when benefits were provided, the Department recovers payments for nursing facility services, home and community-based services, and related hospital and prescription drug services. There are certain exemptions to estate recovery. For further information, please contact your county and request the "Medical Assistance Estate Recovery Program" brochure.

3. If I am eligible for Advance Premium Tax Credit ("APTC"), these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC may impact my annual tax liability. I will be given the option to apply all, some or none of the APTC amount I may be eligible for to my monthly premium.

4. If I am receiving financial assistance, I know that I must tell the organization providing the assistance if information I listed on this application changes. I am aware I have 10 calendar days to report any changes if I am enrolled in Health First Colorado or Child Health Plan *Plus* (CHP+). Changes are to be reported to my local county office for Health First Colorado or to CHP+. I am responsible for paying fees, premiums and co-payments for myself and my family if they are required for Medical Assistance benefits. I know I have 30 calendar days to report any change to Connect for Health Colorado if I am receiving Advance Premium Tax Credits, Reduced Co-Pays or Deductibles, or I am enrolled in a Qualified Health Plan. If my family is enrolled in multiple insurance affordability programs, I must report changes to each organization in the appropriate time frame. I understand that a change in information could affect my eligibility and eligibility for member(s) of my household.

5. I understand that my answers, together with any supplements or additional pages, are the basis for the health insurance policy that is issued. I agree that no insurance of financial assistance program will be effective until the date specified by the insurance company or organization providing the certificate, policy, or notice. I understand that I may request a copy of the Application. I agree that a photographic copy of this application shall be as valid as the original. A legible copy signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

6. To make it easier to determine my eligibility for help paying for health coverage in future years, if I am enrolled in a Qualified Health Plan, I agree to allow Connect for Health Colorado to use income data, including information from tax returns for the next coverage year. Connect for Health Colorado will send me a notice, let me make changes, and I can opt out at any time. I can visit the Connect for Health Colorado website at ConnectforHealthCO.com for more information.

7. I understand that if I am eligible for the Advance Premium Tax Credit (APTC) and/or Reduced Co-pays and Deductibles these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or Reduced Co-pays and Deductibles may impact my coverage year(s) tax liability. I will be given the option to apply all, some, or none of any APTC amount I may be eligible for to my monthly premium.

***Step 3** continues on next page*

8. The Department of Health Care Policy and Financing and Connect for Health Colorado do not discriminate on the basis of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, disability, or marital status in any of its programs, services and activities. For further information about the Department's policy, to request free disability and/or language aids and services, or to file a discrimination complaint, contact: 504/ADA Coordinator, 1570 Grant St, Denver, CO 80203, Phone: 303-866-6010, Fax: 303-866-2828, State Relay: 711, Email: hcpf504ada@state.co.us. For information about Connect for Health Colorado's policy, aids and services or to file a discrimination complaint, contact: General Counsel, 3773 Cherry Creek N. Dr., Suite 1005, Phone: 303-590-9640, Fax: 303-322-4217. Complaints can also be filed with the U.S. Department of Health and Human Services Office for Civil Rights at http://www.hhs.gov/ocr/filing-with-ocr/index.html.

9. I know that it is unlawful to receive APTC and CSR from two state Marketplaces at the same time. I have agreed to submit this application for myself and/or my family. By signing this application, I certify that I have reviewed this application; that I understand and agree to the Rights, Responsibilities, and Penalties; and that under the penalty of perjury, I certify the information I have given is true including the information concerning citizenship and alien status. This means I have provided true answers to all the questions on this form to the best of my knowledge. This certification extends to Producers or other persons filling out an application on behalf of an applicant. I know that if I am not truthful, there may be a penalty. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purposes of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance with the Department of Regulatory Agencies. I have received information on how to apply, what information is available, and what I may need to give the application site to help me with getting benefits.

My right to appeal:

10. If I think Health First Colorado/Child Health Plan *Plus* (CHP+) or Connect for Health Colorado has made a mistake, I can appeal the decision. To appeal means to tell someone at Health First Colorado/CHP+ or Connect for Health Colorado that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting Health First Colorado at 1-800-221-3943, or I can contact the Marketplace at 1-855-PLANS-4-YOU or by visiting their website at ConnectforHealthCO.com. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Additional Information

Domestic violence information and services are available to me. If I ever feel I am in immediate danger I will call 911. If I would like to receive information regarding safety and services in Colorado, I will call the Colorado Coalition Against Domestic Violence at 303-831-9632 or toll free at 1-888-778-7091. I may also find the location of services near me by going to http://www.colorado.gov/cdhs/dvp. The National Domestic Violence Hotline at 1-800-799-SAFE (7233) or TTY 1-800-787-3224 or http://www.thehotline.org/ can also provide information. If I am a survivor of domestic violence, sexual assault, or stalking, the Address Confidentiality Program (ACP) can provide me with a legal substitute address to use instead of my real address for use with state and local government agencies. I can find out more about ACP at acp.colorado.gov. If I need or receive either of these services I will tell my department worker.

Acknowledge (check box below)

☐ **By checking this box**, I agree to allow my information to be used and collected from the data sources for this application, including information from federal tax returns. I have consent from all people I list on the application allowing collection of information about them from data sources for this application. (See full **Privacy Statement** on page 17.)

***Step 3** continues on next page*

Step 3: What I Should Know (continued)

As part of the eligibility process, we are required to verify information you have provided us for this application. By checking the box below, you indicate that Connect for Health Colorado does not have permission to verify income information from tax returns. By not allowing the use of this data, you understand that Connect for Health Colorado will send you a letter requesting that you provide proof of information for your household, including your annual income.
If you do not provide the requested proof of your household's income tax return information within 90 days of the request, you will be determined ineligible for Advance Premium Tax Credits/Cost Sharing Reductions (APTC/CSR).

☐ I do not give Connect for Health Colorado permission to validate my income data against federal sources.

Sign Here

Sign this application. The person who filled out **STEP 1** should sign this application. If you are an authorized representative, you may sign here as long as you have provided the information required in **Worksheet A** (pages 18 - 19).

Person 1 signature or Authorized Representative	**Date** (mm/dd/yyyy)

If you are signing this application outside of Open Enrollment make sure you review **Worksheet H** (page 30). Open Enrollment begins November 1 and ends January 31.

The next two (2) questions are used to figure out if you qualify for services from the Healthy Communities Program through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions of Health First Colorado (Colorado's Medicaid Program). These questions are optional.

1. Special services may be available to children and pregnant women. Please check the health services that any pregnant women or children in your household get or use:

☐ Medical Services ☐ Prescriptions
☐ Mental or Behavioral Health Services ☐ School or Health Services
☐ Other (Describe): _____

2. Has any child in your household been to the emergency room for treatment since his or her last visit to the doctor? ☐ Yes ☐ No

Attention: You may not be done

- Did you get help with this application? Fill out **Worksheet A** (pages 18 - 19).
- Does one of the following apply to anyone on the application? If yes, fill out **Worksheet B** **to find out if you qualify for additional services** (pages 20 - 24).
  - A person on the application has a medical or developmental condition that has lasted, or is expected to last, more than 12 months, including blindness.
  - A person on the application needs help with some or all of his/her self-care activities (bathing, dressing, eating, or using the bathroom).
  - A person on the application is in, or has been in a medical facility (such as a nursing home, hospital, mental health institution, or a group home) within the last 90 days.
  - Qualify for or enrolled in Medicare.
- Qualifies for or is enrolled in: Medicare, TRICARE, Peace Corp, Other State or Federal Health Benefit Program, VA Health Care Benefits, or Other Coverage fill out **Worksheet C** (page 25).
- Qualifies for or is enrolled in insurance from an employer: fill out **Worksheet D** (page 26).
- American Indian/Alaska Native? Fill out **Worksheet E** (page 27).
- Self-employed? Fill out **Worksheet F** (page 28).
- Other income that is not from a job or self-employment? Fill out **Worksheet G** (page 29).
- Applying outside of Open Enrollment and had a life change event in the past 60 days? Fill out **Worksheet H** (page 30).
- More than two people in the household? Fill out **Worksheet I** (pages 31 - 34) for each additional person.

*End of **Step 3***

Step 4: Submit Your Completed Application and Worksheets

Your application can be processed at either your local County Department of Human and Social Services Office or by Connect for Health Colorado.

If you think you may qualify for Health First Colorado or CHP+, or you filled out Worksheet B (pages 20 - 24), you may want to submit your signed application to your local County Department of Human and Social Services Office.

Mail: The mailing addresses and fax numbers of your local office can be found in **Addendum A**.

Online: To find your local office go to Colorado.gov/HCPF/Counties

Call: To find your local office call: 1-800-221-3943

TDD: 1-800-659-2656

Note: If you need help in a language other than English, call and tell the customer service representative the language you need.

En Espanol: Llame a nuestro centro de sevicio gratis para ayuda o para obtener una copia de este formulario en Espanol, al 1-800-221-3943.

If you think you may qualify for tax credits or cost sharing reductions, you may want to submit your signed application to Connect for Health Colorado.

Mail: The mailing address and fax number for Connect for Health Colorado can be found in **Addendum A**.

Online: Go to ConnectforHealthCO.com to create your User Account and upload the application.

Call: Connect for Health Colorado call: 1-855-PLANS-4-YOU (1-855-752-6749)

TTY: 1-855-346-3432

Note: If you need help in a language other than English, call and tell the customer service representative the language you need.

En Espanol: Llame a nuestro centro de sevicio gratis para ayuda o para obtener una copia de este formulario en Espanol, al 1-855-PLANS-4-YOU (1-855-752-6749).

*End of **Step 4***

Privacy Statement

Connect for Health Colorado ("the Marketplace") and the Department of Health Care Policy and Financing will keep the information you provide private, as required by law. However, if you chose to apply for assistance, the Marketplace and Department of Health Care Policy and Financing can use or share your household information with other program(s). The information can only be used for purposes of insurance coverage, treatment, payment, determining eligibility, and other program and administrative operations or other purposes permitted by law. Assistance programs will check your answers using information in our electronic databases and the databases of partner agencies. If the information does not match, we may ask you to send us proof.

You will be asked to provide only the minimum information necessary to determine eligibility for assistance and relevant health plan options, as applicable. As part of the process, we will communicate with you or your authorized representative, and then provide the information to the health plan you select so that they can enroll those who are eligible in a qualified health plan or an insurance affordability program.

Demographic information on race and ethnicity will be shared with health insurance carriers by the Marketplace only for the purpose of determining your eligibility for benefits that are applicable to certain ethnic groups.

Health insurance carriers can no longer deny coverage based on your health status. If you are seeking assistance, we may ask you screening questions about your medical history to help us determine which assistance programs you are eligible for. This information is not used to determine your insurance rates. Household members who do not want insurance will not be asked questions about citizenship or immigration status.

Important: The Marketplace and the Department of Health Care Policy and Financing are authorized to collect information on the application, including Social Security numbers, and will confirm information that may affect initial or ongoing eligibility for all persons listed on your application. You are allowing the Marketplace and the Department of Health Care Policy and Financing to use Social Security numbers and other information from your application to request and receive information or records to confirm the information in your application; if you apply for other public assistance programs, the Department of Human Services may use this information as well. You release the Marketplace and the Department of Health Care Policy and Financing from all liability for sharing this information with other agencies for this purpose. For example, the Marketplace and the Department of Health Care Policy and Financing may receive from and/or share your information with any of the following agencies: Social Security Administration; Internal Revenue Service; United States Customs and Immigration Services; Department of Homeland Security; Centers for Medicare and Medicaid Services; Colorado Department of Labor and Employment; financial institutions (banks, savings and loans, credit unions, insurance companies, etc.); child support enforcement agencies; employers; courts; and other federal or state agencies. We need this information to check your eligibility for health insurance or help paying for health insurance and to give you the best service possible if you choose to apply.

The Marketplace and the Department of Health Care Policy and Financing will also use the information you provide as part of the ongoing operation of both agencies, including activities such as reporting on and managing the insurance affordability programs for eligible individuals, performing oversight and quality control activities, combating fraud, and responding to any concerns about the security or confidentiality of the information. We will use the information you provide for our internal business purposes only, and we will not sell or trade it.

You have the right to see certain information we have about you. You may also have the right to have this information corrected if we have any incorrect information on file.

Protection of your data: Connect for Health Colorado and the Department of Health Care Policy and Financing have significant protections in place to ensure the privacy of your personal information.

To review the full privacy policy for Connect for Health Colorado please visit: http://connectforhealthco.com/site-information/privacy-policy/

To review the full privacy policy for the Department of Health Care Policy and Financing please visit: https://www.colorado.gov/pacific/hcpf/health-insurance-portability-and-accountability-act-hipaa-0

***Application** continues on next page*

Person 1 Name:	Date of Birth:

Worksheet A Tell Us About Who Is Helping You With Your Application

For **Worksheet A**, tell us about who is helping you with your application.

- **Fill out Section A for Authorized Representative**
- **Fill out Section B for Certified Application Counselor, Health Coverage Guide, Agent/Broker, Agency Representative or Outreach Specialist**

Section A: Authorized Representative or Organization

You can choose an Authorized Representative. An Authorized Representative is a trusted person or organization who you choose to help you with your application. We need your permission so that your Authorized Representative can talk with us about this application, see your information, and act for you on all issues related to your health coverage. If you ever want to change your Authorized Representative, or no longer want an Authorized Representative, contact Health First Colorado & CHP+ or Connect for Health Colorado.

1. Is your authorized representative an: ☐ Individual ☐ Organization

2. Authorized Representative First Name:	Middle Name:	Last Name:

3. Organization/Company Name (if applicable)	4. Organization/Company ID (if applicable)

5. How is the Authorized Representative related to you? (if applicable)

6. Authorized Representative's address (leave blank if you don't have one)	Apartment/Suite #

7. In Care Of (If applicable):

8. City	9. State	10. Zip Code	11. County

12. Email Address

13. Phone	Ext.

14. Do you want your Authorized Representative to receive copies of your notices/communications? ☐ Yes ☐ No

By signing, you allow the Authorized Representative to sign your application, get information about this application, and act for you on all future matters with this agency and/or Connect for Health Colorado.

Applicant's Signature	Date (mm/dd/yyyy)

***Worksheet A** continues on next page*

Person 1 Name:	Date of Birth:

Worksheet A Tell Us About Who Is Helping You With Your Application (ctd.)

By signing, I agree to fulfill all responsibilities within the scope of the authorized representation that the individual who I represent is required to fulfill. I agree to maintain the confidentiality of any information regarding the applicant or client provided by the agency or Connect for Health Colorado in compliance with state, federal, and all other applicable laws.

If an Authorized Representative is an organization, the signature of an organizational contact who is either a provider, staff member or volunteer of the organization is required.

As a provider, staff member or volunteer of an organization which is an Authorized Representative, I affirm that I will adhere to the regulations in 42 CFR §431, Subpart F and to 45 CFR §155.260(f), and 42 CFR §447.10, as well as all other relevant state and federal laws concerning conflicts of interests and confidentiality of information.

Authorized Representative/Organizational Contact Signature	Date (mm/dd/yyyy)

If you have been given the legal authority to act as an Authorized Representative on the applicant or client's behalf through some means other than assignment through this Worksheet, you will need to affirm that you have that authority and provide the appropriate documents verifying that you have that authority.

____ I affirm that I have legal authority to act on behalf of the applicant or client. (Please provide a copy of the following documents with this application when it is submitted: a power of attorney, court order establishing legal guardianship, or other legal document explicitly stating that you may legally act on behalf of the applicant or client.)

Section B: For Certified Application Counselors, Health Coverage Guides, Agents, Brokers, Agency Representative, or Outreach Specialist only.

Only complete this section if you are a Certified Application Counselor, Health Coverage Guide, Agent, Broker, Agency Representative, or Outreach Specialist filling out this application for somebody else. NOTE: The types of assisters listed here are not considered authorized representatives, but can help you complete your application. If you do not have someone assisting you with this application, you can leave this blank.

15. Date (mm/dd/yyyy)	16. Select One: ☐ Certified Application Counselor ☐ Health Coverage Guide ☐ Agent/Broker ☐ Agency Representative ☐ Outreach Specialist	
17. Legal First Name:	Middle Name:	Last Name:
18. Organization/Site Name	19. ID Number (Guide ID or state license number, as applicable)	

End of Worksheet A

Person 1 Name: | Date of Birth:

Worksheet B Aged, Blind, Disabled, & Long Term Care

The information in **Worksheet B** is needed to find out if individuals that are 65 years or older or have disabilities qualify for medical assistance or Medicare premium assistance. This is also needed for individuals that are in, or have been in, a medical facility or need help with self-care activities in the home (Long-Term Care Services and Supports). You have the option to complete **Worksheet B** to find out if you qualify for health coverage for individuals who have a disability, are 65 and older, and/or who are blind. If you fill out this Worksheet, send this application to your Local County Department of Human and Social Services (see a list in **Addendum A**). Please fill out completely. If you need to add more information please make a copy of this worksheet.

Additional Income

1. Your Name (First, Middle, Last): | Date of Birth:

2. Tell us about **Additional Income** you or your spouse received this month or last month. **Do not repeat** income that may have already been listed on earlier income pages.

☐ No Additional Income.

Examples of **Additional Income** include:

- Public Cash Assistance
- Railroad Retirement
- Rental Income
- Survivor Benefit
- Retirement/Pension
- Social Security Benefit
- Supplemental Security Income
- Social Security Disability Insurance
- Veterans Benefit
- Veteran Widow Benefit
- Child Support
- Dividends/Interest
- Alimony
- Unemployment
- Worker's Compensation
- Disability Benefit
- Financial Aid
- Other Cash Received Monthly
- Employment Income

Type of income	Month received	Who it is for?	Monthly amount before taxes and deductions

3. Tell us about **Expenses** you or your spouse have this month or last month. **Do not repeat** expenses that may have already been listed on earlier pages.

☐ No Expenses.

Examples of **Expenses** include:

- Child Care
- Dependent Elder Care
- Medical Expenses
- Health Insurance Premiums
- Mortgages(1st, 2nd, 3rd)
- Heating
- Cooking
- Child Support
- Alimony
- Facility
- Medical
- HOA Fees
- Phone/Cell
- Prescriptions
- Rent
- Water
- Sewer
- Trash
- Electricity
- Care Provider

Type of expense	Who pays this expense?	Who is it for?	Month	Amount

Worksheet B continues on next page

Person 1 Name: | Date of Birth:

Worksheet B Aged, Blind, Disabled, & Long Term Care (ctd.)

4. Tell us about **Resources** you or your spouse received this month or last month, even if you or your spouse are not requesting assistance.

☐ No Resources.

Examples of **Resources** include:

- Cash
- Checking & Savings Accounts
- Certificates of Deposits
- Annuities
- Mutual Funds
- Inheritance
- PASS Accounts
- Individual Development Accounts
- Retirement Accounts
- Stocks
- Bonds
- Trusts
- Promissory Notes
- College Funds
- Education Accounts
- Property (land, homes)
- Proceeds from Sale of Home(s)
- ABLE Accounts

Type of Resource	Owners Name(s)?	Account Number	Amount	Name of Financial Institution	Jointly Owned?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

5. Tell us about **Property** you or your spouse own or are buying, even if you or your spouse are not requesting assistance.

☐ No Property.

Examples of **Property** include:

- House
- Warehouse
- Rental Property
- Empty Lot
- Timeshare
- Land

Owners Name(s)?	Jointly Owned?	Full Address of Property	Type of Property	Value	Amount Owed?
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				

6. Tell us about **Vehicles** you or your spouse own or are buying, even if you or your spouse are not requesting assistance.

☐ No Vehicles.

Examples of **Vehicles** include:

- Car
- Van
- Trailer
- Truck
- ATV
- RV
- SUV
- Boat

Owners Name(s)?	Jointly Owned	Type of Vehicle	Year	Make/Model	Value	Amount Owed?
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					

***Worksheet B** continues on next page*

Person 1 Name: | Date of Birth:

Worksheet B Aged, Blind, Disabled, & Long Term Care (ctd.)

Make copies of these pages if necessary.

7. Tell us about **Life Insurance Policies** you or your spouse own, even if you or your spouse are not requesting assistance.

☐ No Life Insurance Policies.

Owner Name(s)	Policy Number	Individuals Covered	Insurance Company	Face Value	Cash Value

8. Tell us about **Burial Policies** you or your spouse own, even if you or your spouse are not requesting assistance.

☐ No Burial Policies.

Name of Applicant or Spouse	Amount	Is it Irrevocable?	Name of Institution or Person Holding the Money
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

9. Tell us if you, your spouse, or anyone acting on you or your spouse's behalf has given away anything of **value** within the last 5 years, even if you or your spouse are not requesting assistance.

☐ Nothing of value has been given away within the last 5 years.

Examples include:
- Home
- Land
- Cash
- Vehicles

Person Who Gave Item Away	Item Given Away	Date Given Away	Value of Item	Amount Owed

***Worksheet B** continues on next page*

Person 1 Name: | Date of Birth:

Worksheet B Aged, Blind, Disabled, & Long Term Care (ctd.)

Make copies of these pages if necessary.

Disability Questions

10. Has anyone who is disabled in the household applied for Supplemental Security Income (SSI)?
☐ Yes ☐ No

If yes, Name of person (First, Last): | SSI application date (mm/dd/yyyy): | What is the status of the application? ☐ Pending ☐ Approved ☐ Denied

11. Does this person receive Supplemental Security Income or Social Security Disability Insurance?
☐ Yes ☐ No

If no, has this person ever received Supplemental Security Income/Social Security Disability Insurance?
☐ Yes ☐ No

If yes, when did Supplemental Security Income/Social Security Disability Insurance end? | End date (mm/dd/yyyy):

Reason Supplemental Security Income/Social Security Disability Insurance Ended:

Fill out this section if you qualify for or are enrolled in Medicare. If you only get one type of Medicare, leave the other questions blank.

12. What is your Medicare Number? You can find this number on the front of your Medicare card:

MEDICARE PART A	MEDICARE PART B	MEDICARE PART C	MEDICARE PART D
13. Are you entitled to or receiving Medicare Part A? ☐ Yes ☐ No	18. Are you entitled to or receiving Medicare Part B? ☐ Yes ☐ No	22. Are you entitled to or receiving Medicare Part C (Medicare Advantage)or will you be entitled or enrolled in the month in which you would like to purchase private health insurance? ☐ Yes ☐ No	24. Are you entitled to or receiving Medicare Part D? ☐ Yes ☐ No
14. Is your Medicare Part A premium free? ☐ Yes ☐ No	19. When did your Medicare Part B begin (mm/yyyy)? ☐ I don't know.	23. When did your Medicare Part C begin (mm/yyyy)? ☐ I don't know.	25. When did your Medicare Part D begin (mm/yyyy)? ☐ I don't know.
15. Are you currently enrolled? ☐ Yes ☐ No	20. How much is your Medicare Part B premium? ☐ I don't know.		26. How much is your Medicare Part D premium? ☐ I don't know.
16. When did your Medicare Part A begin (mm/yyyy)? ☐ I don't know.	21. Who pays for your Medicare Part B premium?		27. Who pays for your Medicare Part D premium?
17. Who pays for your Medicare Part A premium?			

Worksheet B continues on next page

Person 1 Name:	Date of Birth:

Worksheet B Aged, Blind, Disabled, & Long Term Care (ctd.)

Signature and Certification

By signing this form I am giving my permission to the State of Colorado and its designees to make contacts to verify the information given within this form. Under penalty of perjury I also certify all information I have given is true and correct. **I must also sign page 15 of this application.**

(Print Name) First	Middle	Last	Suffix

Applicant's Signature	Date (mm/dd/yyyy)

Authorized Representative, Conservator, Guardian, or other Contact:

(Print Name) First	Middle	Last	Suffix

Applicant's Signature	Date (mm/dd/yyyy)

End of Worksheet B

Person 1 Name: | Date of Birth:

Worksheet C Tell Us About Household Member(s) With Other Health Coverage

Part 1

If you or anyone in your household are currently entitled to receive or are enrolled in any of the following types of coverage, please fill out the table below. If there are more than four individuals in your household that are enrolled in this coverage, please make a copy of this Worksheet.

- TRICARE
- Peace Corps
- Other State or Federal Health Benefit Program

Name of Person Enrolled	Type of Coverage From List Above	Insurance Company Name	Policy Number

Part 2

If you or anyone in your household are currently enrolled in any of the following types of coverage, please fill out the table below. If there are more than four individuals in your household that are enrolled in this coverage, please make a copy of this Worksheet.

- VA Health Care Benefits
- COBRA
- Retired Health Plan

Name of Person Enrolled	Type of Coverage From List Above	Insurance Company Name	Policy Number

End of Worksheet C

Person 1 Name: | Date of Birth:

Worksheet D

Tell us About Household Member(s) Who Can Get Health Insurance from an Employer

Information provided should be based on coverage year you are applying for. If you have COBRA or a Retiree Health Plan, fill out **Worksheet C**.

First and Last Name of Employee Offered Coverage | Date of Birth (mm/dd/yyyy)

Who else in your household has access to this coverage? If there are more than four individuals in your household that have access to coverage, please make a copy of this Worksheet.

Household Member's Name	Is this person eligible but not enrolled, or is this person enrolled? Check the box that applies.	Date your insurance could have started (mm/yyyy)
	☐ Eligible but not enrolled ☐ Enrolled	
	☐ Eligible but not enrolled ☐ Enrolled	
	☐ Eligible but not enrolled ☐ Enrolled	
	☐ Eligible but not enrolled ☐ Enrolled	

Employer Name

Employer Phone | Employer Identification Number (EID) ☐☐ — ☐☐☐☐☐☐☐

Employer Address | City | State | Zip Code

A health plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. In other words, in most cases a plan that meets minimum value will cover 60% of covered medical costs. You'd pay 40%. Most job-based plans meet the minimum value standards. **Do you have access to an employee-only health plan that meets the minimum value standard health plan?** ☐ Yes ☐ No

If yes, what is the name of the lowest-cost plan offered only to the employee (do not include family plans):

☐ I don't know.

How much would you pay in premiums for this plan?

How often do you pay this premium? ☐ Weekly ☐ Monthly ☐ Other: ☐ Every 2 Weeks ☐ Yearly ☐ Twice a Month ☐ I don't know

Does your employer offer wellness programs to the employee (do not include family plans)? ☐ Yes ☐ No

If yes, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs: $

What change, if any, will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan that meets the minimum value standard and is available to the employee only. (Premium should reflect the discount for the wellness program).

How much will the employee have to pay in premiums for that plan? $

Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly ☐ Twice a Month ☐ I don't know

Date of change (mm/dd/yyyy):

End of Worksheet D

Person 1 Name:	Date of Birth:

Worksheet E

Tell us About Household Member(s) Who Are American Indian or Alaska Native

Complete this Worksheet if you or a household member are an American Indian or Alaska Native (AI/AN). Submit this with your application. If you qualify for a tax credit or other help with costs, the Marketplace will request proof of your status. American Indians and Alaska Natives can get services from the Indian Health Services, Tribal Health Programs, or Urban Indian Health Programs or through a referral from one of these programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

Certain money you receive may not count as income for determining if you qualify for Health First Colorado or CHP+. List any income (type, amount, and how often) reported on your application that includes money from these sources:

- Per capita payments from a Tribe that come from natural resources, usage rights, leases or royalties.
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).
- Money from selling things that have cultural significance.

AI/AN Person A Name and Income from above sources:

(Print Name) First	Middle	Last	Suffix

Income Type:	Amount	How often?

Member of a federally recognized Tribe? ☐ Yes ☐ No	If Yes, Tribe name:	State Tribe is located in?

AI/AN Person B Name and Income from above sources:

(Print Name) First	Middle	Last	Suffix

Income Type:	Amount	How often?

Member of a federally recognized Tribe? ☐ Yes ☐ No	If Yes, Tribe name:	State Tribe is located in?

AI/AN Person C Name and Income from above sources:

(Print Name) First	Middle	Last	Suffix

Income Type:	Amount	How often?

Member of a federally recognized Tribe? ☐ Yes ☐ No	If Yes, Tribe name:	State Tribe is located in?

AI/AN Person D Name and Income from above sources:

(Print Name) First	Middle	Last	Suffix

Income Type:	Amount	How often?

Member of a federally recognized Tribe? ☐ Yes ☐ No	If Yes, Tribe name:	State Tribe is located in?

Indian Health Services	**Check all that apply**
1. Who in the household has received a service from the Indian Health Service, a Tribal Health Program, or Urban Indian Health Program or through a referral from one of these programs?	☐ Person A ☐ Person C ☐ Person B ☐ Person D
2. If none, who in the household is eligible to receive services from the Indian Health Service, a Tribal Health Program, or Urban Indian Health Program or through a referral from one of these programs?	☐ Person A ☐ Person C ☐ Person B ☐ Person D

End of Worksheet E

Person 1 Name: | Date of Birth:

Worksheet F

Tell us About Household Member(s) Who Have Self-Employment

Make copies of these pages if necessary.

1. First and Last Name | 2. Date of Birth (mm/dd/yyyy)

3. What type of self-employment do you have? ☐ Day Care ☐ Self-Employment Farming ☐ Sale of Crops ☐ Sale of Livestock/Poultry ☐ Other:

4. What is the name of your self-employment business?

5. Are you the only owner of the business? ☐ Yes ☐ No

If **no**, please answer the questions at right. If yes, please skip to question 6.

How many owners are there (including yourself)?

What percent of the business do you own?

6. How much money does your self-employment business make? Give us the amount the business earns before any taxes, deductions, or expenses are taken out. If your income changes from month to month, tell us your Current Gross Monthly Amount (6a) **AND** your Expected Annual Amount (6b) **AND** if you expect your Expected Annual Amount will be the same or lower for the next calendar year (6c). If your income is the same each month, then only tell us your Current Gross Monthly Amount (6a).

6a. Current Gross Monthly Amount:

6b. Expected Annual Amount:

6c. Will the Expected Annual Amount from this self employment be the same or lower in the next calendar year? ☐ Yes ☐ No

7. Do you have any monthly self-employment expenses? ☐ Yes ☐ No

If **yes**, list all of your self-employment expenses below.

If you need more space to report all of your expenses make a copy of this page. For a more extensive list please see **Frequently Asked Questions: Applying For Coverage** available at Colorado.gov/HCPF/Apply and ConnectforHealthCO.com/resources/the-basics/customer-resources/. If your self-employment expenses change month to month, fill out both the Current Amount **AND** the Expected Annual Amount. If your self-employment expenses do not change month to month, you only need to fill out the Current Amount.

Types of Expenses can include but are not limited to:

- Business rent
- Labor/employee salaries
- Certain business taxes paid
- Business interest paid
- Cost of goods sold
- Utility costs for your business
- Business equipment costs
- Other business costs

Type of Expense	Current Amount	Expected Annual Amount	Frequency ☐ One Time Only ☐ Twice Monthly ☐ Weekly ☐ Monthly ☐ Every 2 Weeks ☐ Yearly
Type of Expense	Current Amount	Expected Annual Amount	Frequency ☐ One Time Only ☐ Twice Monthly ☐ Weekly ☐ Monthly ☐ Every 2 Weeks ☐ Yearly
Type of Expense	Current Amount	Expected Annual Amount	Frequency ☐ One Time Only ☐ Twice Monthly ☐ Weekly ☐ Monthly ☐ Every 2 Weeks ☐ Yearly
Type of Expense	Current Amount	Expected Annual Amount	Frequency ☐ One Time Only ☐ Twice Monthly ☐ Weekly ☐ Monthly ☐ Every 2 Weeks ☐ Yearly
Type of Expense	Current Amount	Expected Annual Amount	Frequency ☐ One Time Only ☐ Twice Monthly ☐ Weekly ☐ Monthly ☐ Every 2 Weeks ☐ Yearly

End of Worksheet F

Person 1 Name:	Date of Birth:

Worksheet G

Tell us About Your Household Member(s) Who Have Other Income

1. First and Last Name	2. Date of Birth (mm/dd/yyyy)

Section A: Grants, Scholarships, or Work Study

2. Does this person have any income from Grants, Scholarships, or Work Study?

☐ Yes ☐ No If **yes**, answer questions 3 and 4 below.
If **no**, skip to Section B.

3. What is the amount ($) of Grants, Scholarships, and/or Work Study this person used for living expenses this month? ☐

4. What is the taxable amount ($) of Grants, Scholarships, and/or Work Study this person received for the year? ☐

Section B: Other Income

Please list all your other income below.

5. Does your other income type change month-to-month? ☐ Yes ☐ No

If **yes**, fill out the Current Amount AND Expected Annual Amount columns for each type of other income that applies to you. If **no**, you do not need to fill out the Expected Annual Amount column.

You do not need to report any money from the following types because they are not considered income: Supplemental Security Income (SSI), Veterans Benefits, Child Support Payments, Adoption Assistance Program, Workers Compensation, or Gifts.

Types of Other Income can include but are not limited to:

- Unemployment
- Social Security
- Spousal maintenance/alimony
- Net Capital Gains
- Retirement/Pensions
- Dividends/Interest
- Net Farming/Fishing
- Net Rental/Royalty
- Other

Type of Income	Current Amount	Expected Annual Amount	Frequency		
				☐ One Time Only	☐ Twice Monthly
				☐ Weekly	☐ Monthly
				☐ Every 2 Weeks	☐ Yearly
Type of Income	Current Amount	Expected Annual Amount	Frequency		
				☐ One Time Only	☐ Twice Monthly
				☐ Weekly	☐ Monthly
				☐ Every 2 Weeks	☐ Yearly
Type of Income	Current Amount	Expected Annual Amount	Frequency		
				☐ One Time Only	☐ Twice Monthly
				☐ Weekly	☐ Monthly
				☐ Every 2 Weeks	☐ Yearly
Type of Income	Current Amount	Expected Annual Amount	Frequency		
				☐ One Time Only	☐ Twice Monthly
				☐ Weekly	☐ Monthly
				☐ Every 2 Weeks	☐ Yearly
Type of Income	Current Amount	Expected Annual Amount	Frequency		
				☐ One Time Only	☐ Twice Monthly
				☐ Weekly	☐ Monthly
				☐ Every 2 Weeks	☐ Yearly

End of Worksheet G

Person 1 Name:	Date of Birth:

Worksheet H

Tell us About Household Member(s) Who Have a Life Change Event

If you or someone in your household have experienced a Life Change Event, tell us about that here. If your life circumstances have not changed within the past 60 days, you can leave the answers blank. These questions are optional unless you are trying to enroll in a health plan through Connect for Health Colorado outside of the **Open Enrollment Period.**

Certain changes in your household may allow you to purchase a new plan or make changes to your existing plan through Connect for Health Colorado.

If you need more space to fill in the names of the household members who have experienced the Life Change Event you are reporting, make a copy of this Worksheet before filling in this page.

Note: The loss of other health insurance can be reported up to 60 days before you lose the other insurance. Members of federally recognized tribes and Alaska Natives can enroll in coverage through Connect for Health Colorado any time of the year.

1. Someone lost health insurance in the last 60 days, or expects to lose health insurance in the next 60 days.

Name(s)	Date coverage ended or will end (mm/dd/yyyy)

2. Someone got married in the last 60 days.

Name(s)	Date of marriage (mm/dd/yyyy)

3. Someone was released from incarceration, detention, or jail in the last 60 days.

Name(s)	Date of release (mm/dd/yyyy)

4. Someone gained eligible immigration status within the last 60 days.

Name(s)	Date status changed (mm/dd/yyyy)

5. Someone was born, adopted, placed for adoption, or placed for foster care in the last 60 days.

Name(s)	Date (mm/dd/yyyy)

6. Someone moved in the last 60 days.

Name(s)	Date of move (mm/dd/yyyy)	Zip code of previous address

7. Someone became a member of a federally recognized American Indian or Alaska Native Tribe.

Name(s)	Date of membership (mm/dd/yyyy)

End of Worksheet H

Person 1 Name: | Date of Birth:

Worksheet I Tell us About Household Member(s)

Make copies of these pages if necessary.

Person #

Use this Worksheet for additional household members by filling in the number of the person each page applies to (example, PERSON 3, PERSON 4, etc.). Make additional copies and attach if necessary.

1. Legal Name (First) (Middle) (Last) Suffix

2. Date of Birth (mm/dd/yyyy) 3. Sex: ☐ Male ☐ Female

4. Home Address (leave blank if you do not have one) Apartment/Suite #

City	State	Zip Code	County

5. If this person is 18 years or older, would they like to receive their own mail about their health coverage? If yes, please fill out mailing address below. ☐ Yes ☐ No

6. Mailing Address (if different from Home Address) Apartment/Suite #

7. In Care Of (if applicable):

City	State	Zip Code	County

8. Email Address

9. Primary Phone	Ext	Phone Type: ☐ Cell ☐ Home ☐ Work
10. Secondary Phone	Ext	Phone Type: ☐ Cell ☐ Home ☐ Work

11. Preferred Spoken Language: ☐ English ☐ Spanish Other (Please Specify):

12. Preferred Written Language: ☐ English ☐ Spanish Other (Please Specify):

13. Is this person temporarily living outside of Colorado? ☐ Yes ☐ No

14. If this person is temporarily living outside of Colorado, where in Colorado will they be living when they return?

City	Zip Code	County

15. Social Security Number (SSN)

If THIS PERSON is applying for Health First Colorado or Child Health Plan *Plus* (CHP+), ℹ and have a SSN, we need this information. If they are applying for help paying for health insurance costs through the Marketplace, providing their SSN will help us to quickly process **THIS PERSON's** application.

***Worksheet I** continues on next page*

Person 1 Name: | Date of Birth:

Worksheet I Tell us About Household Member(s) (ctd.)

Make copies of these pages if necessary.

If **THIS PERSON** does not have a SSN, and is applying for health coverage, tell us why **THIS PERSON** does not have a SSN.

☐ Has applied for a SSN* ☐ Not eligible to receive a SSN ☐ Only eligible to receive a SSN for valid non-work reason
☐ Refuses to obtain due to well established Religious objection

*If someone does not have a Social Security Number, they can visit http://www.ssa.gov/ssnumber/ for information on how to apply for a Social Security Number. They can also call the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778).

16. Does THIS PERSON plan to file a federal income tax return next year? ☐ Yes ☐ No
You can still apply for Health First Colorado, CHP+, or other health insurance even if you do not file a federal income tax return. However, you must plan to file federal taxes every year you receive Advance Premium Tax Credits (APTC) or Cost Sharing Reductions (CSR) through the Marketplace. If **yes**, answer questions **A-F**. If **no**, skip to question **E**.

A. What is **THIS PERSON's** current federal income tax filing status? ☐ Single ☐ Married Filing Jointly
☐ Head of Household ☐ Married Filing Separately ☐ Qualifying Widow(er) with Dependent Child

B. If this person checked that they are "Head of Household" or "Married Filing Separately", do exceptional circumstances ⓘ apply to their case? ☐ Yes ☐ No

C. If **THIS PERSON** is filing jointly, please name his or her spouse. ☐ Yes ☐ No

D. Will **THIS PERSON** claim any dependents on their tax return? ☐ Yes ☐ No

- If yes, list the legal name(s) of dependents:

E. If **THIS PERSON** is a tax dependent, list who claims them as a dependent:

- Is this person listed on the application?
  ☐ Yes ☐ No
- Is this person a non-custodial parent?
  ☐ Yes ☐ No

F. Is **THIS PERSON** living with both parents, but their parents do not expect to file a joint federal income tax return? ☐ Yes ☐ No

The answers to the questions with an (*) cannot be used to determine the availability or cost of premiums for any health insurance purchased through the Marketplace. This information is necessary to ensure you and your family receive a correct determination for the program you may qualify for.

17. Is **THIS PERSON** pregnant?
☐ Yes ☐ No

If yes, how many babies are expected? | Due Date (mm/dd/yyyy)?

18. Does **THIS PERSON** need health coverage?
☐ Yes. (Answer all the following questions.) ☐ No. (Skip to Question 32.)

19. Does **THIS PERSON** live with at least one child under the age of 19, and is **THIS PERSON** the main person taking care of this child? ☐ Yes ☐ No

20. Is **THIS PERSON** a full-time student? ☐ Yes ☐ No

21. *Does **THIS PERSON** have a medical, physical, mental, or developmental condition that has lasted, or is expected to last, more than 12 months, including blindness? ⓘ ☐ Yes ☐ No

22. *Does **THIS PERSON** have a medical, physical, mental, or developmental condition that causes **THIS PERSON** to regularly need help with some or all of **THIS PERSON**'s self-care activities (such as bathing, dressing, eating, using the bathroom)? ☐ Yes ☐ No

***Worksheet I** continues on next page* ▶▶

Person 1 Name: | Date of Birth:

Worksheet I Tell us About Household Member(s) (ctd.)

Make copies of these pages if necessary.

23. *Does **THIS PERSON** need to move to a nursing home, acute care, hospital, group home, mental health institution or long-term care facility within the next 30 days, or does T**HIS PERSON** need in-home health care to stay in their home?

☐ Yes ☐ No

If **THIS PERSON** answered '**Yes**' to either Question 21, 22, 23, or qualifies for Medicare, **THIS PERSON** has the option to complete **Worksheet B** (pages 20 - 24) to find out if they qualify for health coverage for individuals who have a disability, are 65 and older, and/or who are blind.

24. Is **THIS PERSON** a U.S. citizen or U.S. national?

☐ Yes ☐ No

25. If **THIS PERSON** is not a U.S. citizen or U.S. national, does **THIS PERSON** have an eligible immigration status?

☐ Yes (Fill out the following table.)

Non-citizen Status:	Immigration document type:
Alien or I-94 number:	Card/Passport number:
Document expiration date:	Country of issuance:

Has **THIS PERSON** lived in the U.S. since 1996?

☐ Yes ☐ No

Is **THIS PERSON**, their spouse or parent an honorable discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

For more information on non-citizenship status and immigration documents, please see **Frequently Asked Questions: Applying For Coverage** at Colorado.gov/HCPF/Apply and ConnectforHealthCO.com/resources/the-basics/customer-resources/.

26. Does **THIS PERSON** want help paying for medical bills from the last 3 months?

☐ Yes ☐ No

If yes, list the months that they want help (mm/yyyy)

27. Is **THIS PERSON** being treated for an injury for which they have brought or will bring a legal claim?

☐ Yes ☐ No

28. Does **THIS PERSON** qualify for or are they enrolled in any of the following types of health care coverage? If yes, select which applies and fill out **Worksheet C** (page 25).

☐ TRICARE ☐ Peace Corps ☐ Other State or Federal Health Benefit Program ☐ VA Health Care Benefits

☐ COBRA ☐ Retiree Health Plan ☐ Other: _____

29. Does **THIS PERSON** qualify for or are they enrolled in Medicare? ☐ Yes ☐ No

If yes, Person 2 has the option to complete **Worksheet B** (pages 20 - 24) to find out if they qualify for health coverage for individuals who have disabilities, are age 65 or older, and/or who are blind.

30. Does **THIS PERSON** qualify for health insurance through a current employer? If yes, fill out **Worksheet D** (page 26). ☐ Yes ☐ No

31. Is **THIS PERSON** currently incarcerated?

☐ Yes ☐ No

If yes, is **THIS PERSON** currently waiting for a decision on charges? ☐ Yes ☐ No

32. Race (optional - check all that apply)

☐ American Indian or Alaska Native (fill out **Worksheet E**) ☐ Asian Indian ☐ Black or African American

☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Hispanic/ Latino

☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese

☐ White or Caucasian ☐ Other: _____

***Worksheet I** continues on next page*

Person 1 Name: | Date of Birth:

Worksheet I Tell us About Household Member(s) (ctd.)

Make copies of these pages if necessary.

33. Current Job & Income Information (check all that apply)

- ☐ **Does not have a job** Skip to question 62.
- ☐ **Has a job** If they are currently employed, tell us about their income. Start with questions 34.
- ☐ **Is self-employed** Fill out **Worksheet F** (page 28) and return to question 62.
- ☐ **Has other income** (including rental income). Fill out **Worksheet G** (page 29) and return to question 62.

Current Job 1:

34. Employer Name:

35. Employer Address (leave blank if you do not have one) | 36. Apartment/Suite #

37. Employer Phone | 38. City | 39. State | 40. Zip Code

41. Wages/tips (before taxes) $ | Pay Period: ☐ One Time Only ☐ Twice Monthly ☐ Weekly ☐ Monthly ☐ Every 2 Weeks ☐ Yearly

42. Average Hours Worked Each Week:

43. Tell us the total gross pay that **THIS PERSON** got or will get this month as a one-time payment from this employer. (This could be a bonus or one time payment they got.)

44. Does **THIS PERSON**'s income from this job change month to month? ☐ Yes ☐ No

If **yes**, fill out the Current Wages/Tips **AND** Expected Annual Income for this job. If **no**, only fill out the Current Wages/Tips in number 42 above. They do not need to fill out the Expected Annual Income.

45. Expected Annual income from this job.

46 a. Is this income from seasonal employment? If **yes**, answer 47. ☐ Yes ☐ No

46 b. Is this income from commission-based employment (including tip based employment)? ☐ Yes ☐ No

47. Will the expected annual income from this job be the same or lower in the next calendar year? ☐ Yes ☐ No

Current Job 2: (If you only have one job, skip to question 62.)

48. Employer Name:

49. Employer Address (Leave blank if you do not have one) | 50. Apartment/Suite #

51. Employer Phone | 52. City | 53. State | 54. Zip Code

55. Wages/tips (before taxes) $ | Pay Period: ☐ One Time Only ☐ Twice Monthly ☐ Weekly ☐ Monthly ☐ Every 2 Weeks ☐ Yearly

56. Average Hours Worked Each Week:

57. Tell us the total gross pay that **THIS PERSON** got or will get this month as a one-time payment from this employer. (This could be a bonus or one time payment they got.)

***Worksheet I** continues on next page*

Person 1 Name: | Date of Birth:

Worksheet I — Tell us About Household Member(s) (ctd.)

Make copies of these pages if necessary.

58. Does **THIS PERSON**'s income from this job change month to month? ☐ Yes ☐ No

If **yes**, fill out the Current Wages/Tips **AND** Expected Annual Income for this job. If **no**, only fill out the Current Wages/Tips in number 42 above. They do not need to fill out the Expected Annual Income.

59. Expected Annual income from this job:

60 a. Is this income from seasonal employment? If **yes**, answer 61. ☐ Yes ☐ No

60 b. Is this income from commission-based employment (including tip based employment)? If **yes**, answer 61. ☐ Yes ☐ No

61. Will the expected annual income from this job be the same or lower in the next calendar year? ☐ **Yes** ☐ **No**

62. **DEDUCTIONS:** Check all that apply, and give the amount and how often **THIS PERSON** pays it. Telling us about these deductions could make the cost of health insurance lower. **THIS PERSON** should not include a cost that they already considered in their answer to job income and net self-employment.

63. Does **THIS PERSON's** deductions change month to month? ☐ Yes ☐ No

If **Yes**, for each deduction that changes, fill out the Current Amount **AND** the Expected Annual Amount columns.

If **THIS PERSON** is not paying the deduction at this time, but expects to claim it on their tax return, fill out $0 for the Current Amount, and write the amount they will include on their tax return for the Expected Annual Amount.

If **No**, only fill out the Current Amount column. They do not need to fill out the Expected Annual Amount column.

Deduction Types:

- Alimony Paid
- Student Loan Interest
- Capital Losses
- Certain Business Expenses of Reservists, Performing Artists, or Fee-Based Government Officials
- Penalty of Early Withdrawal of Savings
- Domestic Production Activities
- Health Savings Account (HSA) Deduction
- Contribution made to your Traditional IRA
- Moving Expenses

Type of Deduction	Current Amount	Expected Annual Amount	Frequency		
				☐ One Time Only	☐ Twice Monthly
				☐ Weekly	☐ Monthly
				☐ Every 2 Weeks	☐ Yearly
Type of Deduction	Current Amount	Expected Annual Amount	Frequency		
				☐ One Time Only	☐ Twice Monthly
				☐ Weekly	☐ Monthly
				☐ Every 2 Weeks	☐ Yearly
Type of Deduction	Current Amount	Expected Annual Amount	Frequency		
				☐ One Time Only	☐ Twice Monthly
				☐ Weekly	☐ Monthly
				☐ Every 2 Weeks	☐ Yearly

64. Tell us the total amount of income **THIS PERSON** plans to report on their tax return that they have NOT yet included in this application and its Worksheets. Include incomes such as past employment, or benefits that **THIS PERSON** received in past months.

65. After you submit this application, we will verify your income. Please tell us if any of the following have happened to you in the past two years to help us with this verification process. Check the box and enter the date this change occurred for all reasons that apply showing why your income has changed.

- ☐ Stopped working at a job
- ☐ Hours changed at a job
- ☐ Change in Employment
- ☐ Married, Legal Separation, or Divorce
- ☐ Other:

Date the change occurred? (mm/dd/yyyy)

End of Worksheet I

Person 1 Name: | Date of Birth:

Worksheet J

Household Member(s) Exposed To Coronavirus (COVID-19)

Complete this worksheet if you or someone in your household has been exposed to coronavirus (COVID-19). If more than three people in your household are enrolled or need coverage, please make a copy of this worksheet.

1. Have you or someone in your household been exposed to or potentially infected with coronavirus (COVID-19)?

☐ Yes ☐ No

If yes, who in your household has been exposed:

Full names of household member(s)

2. Do you or anyone in your household have health insurance or coverage for health care?

☐ Yes ☐ No

If yes, who in your household has coverage:

Name of person enrolled	Type of Coverage	Insurance Name	Policy Number

3. Do you or someone in your household need health care coverage for COVID-19 testing?

☐ Yes ☐ No

If yes, who in your household needs health care coverage for testing:

Full names of household member(s)

End of Worksheet J

Addendum A

Connect for Health Colorado and County Mailing Addresses

Connect for Health Colorado - Individual Applications
P.O. Box 35681
Colorado Springs, CO 80935
Phone: 1-855-752-6749; Fax: 1-855-346-5175
Write your Marketplace Account number on each page if you have one.

Adams - Department of Human Services
11860 Pecos Street
Westminster, CO 80234
Phone: 303-227-2800; Fax: 303-227-2380

Alamosa - Department of Human Services
P.O. Box 1310
Alamosa, CO 81101
Phone: 719-589-2581; Fax: 719-589-9794

Arapahoe - Department of Human Services
14980 East Alameda Drive
Aurora, CO 80012
Phone: 303-636-1170; Fax: 303-636-1426

Archuleta - Department of Human Services
P.O. Box 240
Pagosa Springs, CO 81147
Phone: 970-264-2182; Fax: 303-636-1426

Baca - Department of Public Welfare
772 Colorado Street
Springfield, CO 81073
Phone: 719-523-4131; Fax: 719-523-4820

Bent County - Department of Social Services
215 2nd Street
Las Animas, CO 81054
Phone: 719-456-2620; Fax: 719-456-2640

Boulder - Department of Housing and Human Services
P.O. Box 471
Boulder, CO 80306
Phone: 303-441-1000; Fax: 303-441-1523

Broomfield - Department of Health and Human Services
100 Spader Way
Broomfield, CO 80020
Phone: 720-887-2200; Fax: 303-469-2110

Chaffee - Department of Human Services
448 East 1st St. Suite 166
Salida, CO 81201
Phone: 719-530-2500; Fax: 719-539-6430

Cheyenne - Department of Human Services
560 West 6th North
P.O. Box 146
Cheyenne Wells, CO 80810
Phone: 719-767-5629; Fax: 719-767-5101

Clear Creek - Department of Health and Human Services
P.O. Box 3669
Idaho Springs, CO 80453
Phone: 303-670-7541; Fax: 303-567-2274

Conejos - Department of Social Services
P.O. Box 68
Conejos, CO 81129
Phone: 719-367-5455; Fax: 719-376-2389

Costilla - Department of Social Services
233 Main Street, Suite A
San Luis, CO 81152
Phone: 719-672-4136; Fax: 719-672-4141

Crowley - Department of Human Services
631 Main Street, Suite 100
Ordway, CO 81063
Phone: 719-267-3456; Fax: 719-267-5296

Custer - Department of Human Services
P.O. Box 929
Westcliffe, CO 81252
Phone: 719-783-2371; Fax: 719-783--0163

Addendum A

Connect for Health Colorado and County Mailing Addresses (ctd.)

Delta - Department of Health and Human Services
560 Dodge Street
Delta, CO 81416
Phone: 970-874-2030; Fax: 970-874-2068

Denver - Department of Human Services
1200 Federal Boulevard
Denver, CO 80204
Phone: 720-944-3666; Fax: 720-944-3094

Dolores - Department of Social Services
P.O. Box 485
Dove Creek, CO 81324
Phone: 970-677-2250; Fax: 970677-2859

Douglas - Department of Human Services
4400 Castleton Court
Castle Rock, CO 80109
Phone: 303-688-4825 ext. 5341; Fax: 877-285-8988

Eagle - Department of Health and Human Services
P.O. Box 660
Eagle, CO 81631
Phone: 970-328-8888 (Eagle County I-70 Corridor)
Phone: 970-704-2777 (Roaring Fork Valley); Fax: 855-846-0751

Elbert - Department of Human Services
P.O. Box 924
Kiowa, CO 80117
Phone: 303-621-3149; Fax: 303-621-0122

El Paso - Department of Human Services
1675 West Garden of the Gods Road
Colorado Springs, CO 80907
Phone: 719-444-5124 and 719-636-0000
Fax: 719-444-8353

Fremont - Department of Human Services
172 Justice Center Road
Canon City, CO 81212
Phone: 719-275-2318; Fax: 719-275-5206

Garfield - Department of Human Services
195 West 14th Street
Rifle, CO 81650
Phone: 970-625-5282 ext. 3255; Fax: 970-625-2876

Gilpin - Department of Human Services
2960 Dory Hill Road, Suite 100
Black Hawk, CO 80422
Phone: 303-582-5444; Fax: 303-582-5798

Grand - Department of Social Services
P.O. Box 204
Hot Sulphur Springs, CO 80451
Phone: 970-725-3331; Fax: 970-725-3696

Gunnison - Department of Health and Human Services & Hinsdale - Department of Public Health
225 North Pine Street, Suite A
Gunnison, CO 81230
Phone: 970-641-3224; Fax: 970-641-3738

Huerfano - Department of Social Services
121 West 6th Street
Walsenburg, CO 81089
Phone: 719-738-2810 ext. 110; Fax: 719-738-2549

Jackson - Department of Social Services
P.O. Box 338
Walden, CO 80480
Phone: 970-723-4950; Fax: 970-723-4619

Jefferson - Department of Human Services
900 Jefferson County Parkway
Golden, CO 80401
Phone: 303-271-1388; Fax: 303-271-4500

Kiowa - Department of Social Services
P.O. Box 187
Eads, CO 81036-0345
Phone: 719-438-5541; Fax: 719-438-5370

Addendum A

Connect for Health Colorado and County Mailing Addresses (ctd.)

Kit Carson - Department of Health Services
P.O. Box 160
Burlington, CO 80807
Phone: 719-346-8732 ext. 155; Fax: 719-346-8066

Lake - Department of Human Services
P.O. Box 884
Leadville, CO 80461
Phone: 719-486-2088; Fax: 719-486-4164

La Plata - Department of Human Services
1060 East 2nd Avenue
Durango, CO 81301
Phone: 970-382-6120; Fax: 970-382-6151

Larimer - Department of Human Services
1501 Blue Spruce Drive
Fort Collins, CO 80524
Phone: 970-498-6300;Fax: 970-498-6304

Las Animas - Department of Human Services
204 South Chestnut Street
Trinidad, CO 81082
Phone: 719-846-2276; Fax: 719-846-4269

Lincoln - Department of Human Services
P.O. Box 37
103 3rd Avenue
Hugo, CO 80821
Phone: 719-743-2404; Fax: 719-743-2879

Logan - Department of Human Services
P.O. Box 1746
Sterling, CO 80751
Phone: 970-522-2194; Fax: 970-521-0853

Mesa - Department of Human Services
PO Box 20000
Grand Junction, CO 81502
Phone: 970-241-8480; Fax: 970-248-2849

Mineral - Department of Social Services
P.O. Box 40
Del Norte, CO 81132
Phone: 719-657-3381; Fax: 719-657-2997

Moffat - Department of Social Services
595 Breeze Street
Craig, CO 81625
Phone: 970-824-8282; Fax: 970-824-9552

Montezuma - Department of Social Services
109 West Main Street, Room 203
Cortez, CO 81321
Phone: 970-565-3769; Fax: 970-565-8526

Montrose - Department of Health and Human Services
1845 South Townsend Avenue
Montrose, CO 80701
Phone: 970-252-5000; Fax: 970-252-5073

Morgan - Department of Human Services
800 East Beaver Avenue
Fort Morgan, CO 80701
Phone: 970-542-3530; Fax: 970-542-3415

Otero - Department of Human Services
P.O. Box 494
La Junta, CO 81050
Phone: 719-383-3100; Fax: 719-383-3102

Ouray - Department of Social Services
P.O. Box 530
Ridgway, CO 81432
Phone: 970-626-2299; Fax: 970-626-9911

Park - Department of Human Services
P.O. Box 1193
Bailey, CO 80421
Phone: 303-816-5939; Fax: 303-816-5942

Addendum A

Connect for Health Colorado and County Mailing Addresses (ctd.)

Park - Department of Human Services
P.O. Box 968
Fairplay, CO 80440
Phone: 719-836-4139; Fax: 719-836-0508

Phillips - Department of Social Services
127 East Denver Street, Suite A
Holyoke, CO 80734
Phone: 970-854-2280; Fax: 970-854-3637

Pitkin - Department of Health and Human Services
0405 Castle Creek Rd. Suite 102
Aspen, Colorado 81611
Phone: 970-920-5244
Fax: 970-445-3032

Prowers - Department of Human Services
P.O. Box 1157
Lamar, CO 81052
Phone: 719-336-7486; Fax: 719-336-7198

Pueblo - Department of Human Services
201 West 8th Street, Suite 120
Pueblo, CO 81003
Phone: 719-583-6160; Fax: 719-583-6185

Rio Blanco - Department of Human Services
345 Market Street
Meeker, CO 81641
Phone: 970-878-9640; Fax: 970-878-4893

Rio Grande - Department of Social Services
P.O. Box 40
Del Norte, CO 811325
Phone: 719-657-3381; Fax: 719-657-2297

Routt - Department of Human Services
P.O. Box 772790
Steamboat Springs, CO 80477
Phone: 970-870-5533; Fax: 970-870-5260

Saguache - Department of Social Services
P.O. Box 215
Saguache, CO 81149
Phone: 719-655-2537; Fax: 719-655-0206

San Juan - Department of Social Services
P.O. Box 376
Silverton, CO 81433
Phone: 970-384-5631; Fax: 970-387-5326

San Miguel - Department of Social Services
P.O. Box 96
Telluride, CO 81435
Phone: 970-728-4411; Fax: 970-728-4412

Sedgwick - Department of Human Services
P.O. Box 27
Julesburg, CO 80737
Phone: 970-474-3397; Fax: 970-474-9881

Summit - Department of Social Services
P.O. Box 869
Frisco, CO 80443
Phone: 970-668-9161; Fax: 970-668-4114

Teller - Department of Social Services
P.O. Box 7245
Woodland Park, CO 80863
Phone: 719-686-5518; Fax: 719-686-5545

Washington - Department of Human Services
P.O. Box 395
Akron, CO 80720
Phone: 970-345-2238; Fax: 970-345-2237

Weld - Department of Human Services
P.O. Box A
Greeley, CO 80631
Phone: 970-352-1151 ext. 6012; Fax: 970-346-7661

Addendum A

Connect for Health Colorado and County Mailing Addresses (ctd.)

Yuma - Department of Human Services
340 South Birch Street
Wray, CO 80758
Phone: 970-332-4877; Fax: 970-332-4978

Glossary Terms and Definitions

Agent	An agent represents a health insurer and offers their policies to consumers. They are generally either employed directly by an insurer or contracted by them to market their plans. Agents are familiar with the features of the plans their company sells and can provide expert and detailed answers to your questions about those policies.
Alimony (Spousal Maintenance)	An allowance for support made under court order to a divorced person by the former spouse.
Appeal	A request for your health insurer or plan to review a decision or a grievance again.
Application Assistance Site	An agency or organization that assists individuals in completing their Application for Health Coverage & Help Paying Costs.
Authorized Representative	An Authorized Representative is either a person or an organization that you trust and let fill out your application, talk about this application with us, see your information, get information about your application, and sign your application on your behalf. An Authorized Representative also takes legal responsibility for the information provided in this application. If an Authorized Representative is a person, they must be 18 or older. An Authorized Representative is NOT an Agent/Broker, Health Coverage Guide, or a Certified Application Counselor.
Blindness	Blindness is the total lack of vision or vision in the better eye of 20/200 or less with the use of a correcting lens and/or tunnel vision to the extent that the field of vision is no greater than 20 degrees.
Broker	A broker offers policies from several insurers that they are contracted to represent. Brokers can provide assistance in comparing the rates and benefits of health plans from several companies. An experienced broker can provide expert and detailed information on plan specific features and limitations of various policies.
Certified Application Counselor	Certified Application Counselors are certified by Connect for Health Colorado to assist customers with applying for health coverage and financial assistance programs that help reduce health insurance costs. They also help customers to understand coverage options and provide unbiased assistance in shopping for and selecting health plans.
Child Health Plan *Plus* (CHP+)	CHP+ is public health insurance for children and pregnant women who earn too much to qualify for Health First Colorado, but cannot afford private health insurance. For more information on CHP+ go to CHPPlus.org.
COBRA	A Federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or you experience another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.
Connect for Health Colorado	Also referred to as the Marketplace. Connect for Health Colorado™ offers individuals, families and small businesses an online marketplace for health insurance and exclusive access to up-front financial assistance, based on income, to reduce costs. Customers can shop through a website and get expert help in person and over the phone from a network of customer service professionals, including Customer Service Center Representatives, Health Coverage Guides and certified health insurance agents and brokers. The Marketplace is a non-profit entity established by a 2011 state law.
Coverage Year	The coverage year is the calendar year you are applying to get tax credits or help to lower your health care costs. For example, if you are applying in November of 2014 for 2015 health care coverage, the coverage year would be 2015. Or, if you are applying in February of 2015 for 2015 health care coverage, the coverage year would be 2015.
Deductions	A deduction is an amount you can take off of the total amount you earn (gross income). Common deductions include alimony and student loan interest. We do not need you to tell us about things like charitable contributions or home mortgage interest. For additional information, visit the IRS website at http://www.irs.gov/taxtopics/tc450.html.
Department of Health Care Policy and Financing	The Department administers the Health First Colorado and Child Health Plan *Plus* (CHP+) programs as well as a variety of other programs for low-income Coloradans. For more information about the Department, go to Colorado.gov/hcpf.

Glossary Terms and Definitions (ctd.)

Dependent	A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction.
Disability	Having a disability means you cannot do any substantial gainful activity or major activity to receive pay (or, in the case of a child, having marked and severe functional limitations or have an easily recognized and extreme lack of ability to do everyday activities).
Dividend/Interest	The charge for the use of borrowed money. Interest you get from a bank or dividends from a stock you own are examples of investment income, which you should tell us about if you apply for help paying for health coverage.
Division of Insurance	The Department of Regulatory Agencies' Division of Insurance regulates the insurance industry and assists consumers and other stakeholders with insurance issues. For more information go to Colorado.gov/dora/division-insurance.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	The EPSDT benefit provides comprehensive and preventive health diagnostic and treatment care services for children (ages 0-20) who qualify for Health First Colorado.
Eligible Immigration Status	An immigration status that's considered eligible for getting health coverage. The rules for eligible immigration status may be different in each insurance affordability program.
Exceptional Circumstances	If you have been a victim of domestic violence and are still married to the perpetrator but will not be able to file a joint tax return, please enter how you plan to file as either Head of Household or as Married Filing Separately. Also mark the Exceptional Circumstances check box in the application.
Expected Annual Income	Annual income is the total income you expect to make from your job in the coverage year. For example, if you are applying for 2016 coverage in 2016, you will provide job income for 2016. If you are applying for 2017 coverage in 2016, you will give estimated job income for 2017.
Federal Income Tax Return	Income tax return is a document you file with the Internal Revenue Service or the state tax board reporting your income, profits and losses of your business and other deductions as well as details about your tax refund or tax liability. A 1040 form is an example of a federal income tax return.
Federally Recognized Tribe	Any Indian or Alaska Native tribe, band, nation, pueblo, village or community that the Department of the Interior acknowledges to exist as an Indian tribe. Read the current list of federally recognized tribes at the Bureau of Indian Affairs website: bia.gov.
Gross pay/Income	Profits before taxes, deductions, or expenses are paid.
Health Coverage	Legal entitlement to payment or reimbursement for your health care costs, generally under a contract with a health insurance company, a group health plan offered by an employer, or a government program like Medicare, Health First Colorado, TRICARE, or the Child Health Plan *Plus* (CHP+).
Health Coverage Guides	Health Coverage Guides are certified by Connect for Health Colorado to assist customers with applying for health coverage and financial assistance programs that help reduce health insurance costs. They also help customers to understand coverage options and provide unbiased assistance in shopping for and selecting health plans.
Health First Colorado	Health First Colorado (Colorado's Medicaid Program) is public health insurance for low-income Coloradans who qualify
Health Insurance	A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.
Healthy Communities Program	Focuses on the activities necessary for you or your children to obtain coverage and access to coordinated health care services in Medical Homes.

Terms and Definitions (ctd.)

Insurance Affordability Programs	Insurance affordability programs include Health First Colorado, Child Health Plan *Plus* (CHP+), and the tax credits and reduced out of pocket costs available through Connect for Health Colorado. Health First Colorado: Public health insurance for low-income Coloradans who qualify. More information is available at Colorado.gov/hcpf.
Legal Claim	A demand for money to pay for damages you have suffered due to an injury. Damages is the sum of money the law imposes to compensate the injured party for their loss or injury. Insurance claims, court filings and criminal charges against the individual you believe caused the injury are examples of legal claims.
Medicare	A Federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). For more information about Medicare, go to Medicare.gov.
Minimum Value Standard	A health plan meets this standard if it is designed to pay at least 60% of the total cost of medical services for a standard population. Starting in 2014, individuals offered employer-sponsored coverage that provides minimum value and that is affordable will not be eligible for a premium tax credit.
Outreach Specialist	An Outreach Specialist is an individual from either a Certified Application Assistance Site (CAAS), Medical Assistance (MA) Site or a Presumptive Eligibility (PE) Site who can help you fill out this application.
PEAK (Colorado Program Eligibility and Application Kit)	Is an online benefits portal where Coloradans can apply and manage their public benefits including food, cash and medical assistance.
Premiums	The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.
Spouse	A marriage partner such as a husband or wife.
Student Loan Interest	If you took out a loan to pay for qualified higher education expenses, then you may deduct either the amount of interest you paid on that student loan OR $2,500 from your income, whichever one is less. Qualified education expenses are the total cost of attending an eligible educational institution and includes items such as tuition and fees, room and board (as determined by the educational institution), books, supplies, equipment, and other necessary expenses.
TRICARE	A health care program for active-duty and retired uniformed services members and their families.
Unmarried Partner	A significant other to whom you are not legally married but with which you live.
Veterans Affairs (VA) Health Care Benefits	Health care programs operated by the United States Department of Veterans Affairs for eligible veterans.