



State of Colorado
Department of Human Services
Department of Health Care Policy and Financing

Application for Assistance Part 2 of 2

Please read and answer each question carefully.

This application is to help us collect information we need to determine whether you are eligible for public assistance programs. The information contained in this application and the information received from third-party resources will be used to determine your eligibility and benefit amount.

This application can be downloaded at:

www.cdhs.state.co.us or www.chcpf.state.co.us.

Full Name (last, first, middle initial; include maiden or any other names used)

Social Security Number

Check if you do not have a SSN

Phone Number

Message Number (or another number to contact you)

Home Address (street, PO Box, etc.)

Mailing Address (if different than home address)

City State ZIP Code

City State ZIP Code



Section 2: Application for Assistance

Please tell us about your living arrangement and shelter expenses: This section will collect information about your shelter expenses. Some programs will consider these costs when determining how much your benefits should be.

- 1. What is your current living arrangement?** *Check all boxes that apply to your situation.*
- Own/Buying a home
 Renting
 Living with relatives
 Living on an Indian reservation
 Living with friends
 Living in subsidized housing
 Migrant/seasonal farm worker
 No permanent home
 Living in a group home
 Staying at a shelter

- 2. Are you applying for benefits for anyone in a Medical Facility?** *(Hospital, Nursing Home, Mental Health Institution)* Yes No *If yes, please complete the following:*

a.	_____	_____	_____	_____
	Name	Name of Facility	Medical Facility Address	Date Entered
b.	_____	_____	_____	_____
	Name	Name of Facility	Medical Facility Address	Date Entered

- 3. Are you asked to pay or are you billed for rent or a mortgage?** Yes No

_____	\$	\$	_____	_____
Rent Payment(s)	Amount Billed	Amount Paid	How Often	Landlord Name/Address/Phone
_____	\$	\$	_____	_____
Mortgage Payment	Amount Billed	Amount Paid	How Often	Mortgage Company Name/Address/Phone
_____	\$	\$	_____	_____
2 nd Mortgage Payment	Amount Billed	Amount Paid	How Often	Mortgage Company Name/Address/Phone

- 4. Are your homeowner taxes, insurance, and homeowners' association (HOA) fees billed separately from the above house payment?** Yes No *If yes, please complete:*

_____	\$	\$	_____	_____
HOA	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent
_____	\$	\$	_____	_____
Insurance	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent
_____	\$	\$	_____	_____
Taxes	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent

Expenses

5. Are you billed for any of the following: heating, cooling, water, trash, sewage or phone expenses? Yes No *If yes, please complete the following:*

Heating	\$	\$		
Type	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent
Cooling	\$	\$		
Type	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent
Water	\$	\$		
Type	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent
Trash	\$	\$		
Type	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent
Sewer	\$	\$		
Type	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent
Phone	\$	\$		
Type	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent

6. Does anyone outside of the household help pay any shelter costs? Yes No

7. Do you, or anyone in your household, pay legally obligated support to someone outside of your household? Yes No *If yes, please complete the following:*

Child Support			
Type of Support	Name(s) of Child(ren)	Person paying child support	
\$	\$		
Legally obligated amount of child support	Amount Actually Paid	How Often	
		\$	
Date of Last Payment	County/State of Court Order	Amount of Arrearages	

Child Support			
Type of Support	Name(s) of Child(ren)	Person paying child support	
\$	\$		
Legally obligated amount of child support	Amount Actually Paid	How often	
Date of Last Payment	County/State of Court Order	Amount of Arrearages	

Alimony	\$	
Type of Support	Amount Paid	How Often
Date of Last Payment	County/State of Court Order	

8. Do you provide support to an individual not living in your household? Yes No
 If yes, do you also claim them on your Federal Income Tax? Yes No

Expenses

9. Is anyone in your household billed for child care? Yes No *If yes, please complete:*

a.

Name of Child Receiving Care Care Facility/Provider Name/Address

\$ _____ \$ _____
Amount Billed Amount Paid How Often

Are you receiving help with these costs? Yes No

b.

Name of Child Receiving Care Care Facility/Provider Name/Address

\$ _____ \$ _____
Amount Billed Amount Paid How Often

Are you receiving help with these costs? Yes No

10. Are you, or anyone in your household, disabled? Yes No

a.

Name of the Person with the Disability

Are you currently receiving treatment? Yes No

b.

Name of the Person with the Disability

Are you currently receiving treatment? Yes No

11. Has a medical provider told you, or anyone in your household, to cut back or limit activities? Yes No

Name of Person with Limitations

Limitations

12. Are you, or is anyone in your household, billed for care of an adult or disabled person? Yes No *If yes, please complete:*

a.

Name of Person Receiving Care Care Facility/Provider Name and Address

\$ _____ \$ _____
Amount Billed Amount Paid How Often

Are you receiving help with these costs?

Yes No

b.

Name of Person Receiving Care Care Facility/Provider Name and Address

\$ _____ \$ _____
Amount Billed Amount Paid How Often

Are you receiving help with these costs?

Yes No

12. Do you, or anyone in your household, have an injury? Yes No *If yes, please complete:*

Name of Injured Person

Date of Injury

12a. Was this injury work related? Yes No

12b. Have you filed a Workers' Compensation claim for this injury? Yes No

12c. Do you, or does anyone in your household, have a lawsuit or claim for any injuries?
Yes No *If yes, which household member and filing date of claim (if known)?*

Name

Date

Expenses

13. Do you have an attorney? Yes No N/A *If yes, please complete the following:*

Attorney Name			
Address	City	State	ZIP Code
Phone	Fax		

14. Are you, or anyone in your household, paying medical expenses? (such as prescriptions, co-pays, health insurance premiums, insurance deductibles) Yes No *If yes, please complete:*

a.			
Name of Person with Expense	Name of Provider of the Service	Type of Medical Expense	
\$			
Amount Paid	Date of Service	How Often	
b.			
Name of Person with Expense	Name of Provider of the Service	Type of Medical Expense	
\$			
Amount Paid	Date of Service	How Often	
c.			
Name of Person with Expense	Name of Provider of the Service	Type of Medical Expense	
\$			
Amount Paid	Date of Service	How Often	

Does anyone outside the household help pay medical costs? Yes No

15. Do you, or anyone in your household, have Medicare? Yes No *If yes, please complete:*

Name of Person Receiving Medicare	Which Part of Medicare?	Effective Date	Claim Number
	Part A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/>		
	Part A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/>		
	Part A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/>		
	Part A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/>		

16. Do you, or anyone in your household, have health insurance/medical coverage? Yes No

a			
Name of Person Covered	Name of Policy Holder	Policy Number	
\$			
Amount Paid Monthly	Date of Coverage	Insurance Company Name, Address, and Phone Number	
b			
Name of Person Covered	Name of Policy Holder	Policy Number	
\$			
Amount Paid Monthly	Date of Coverage	Insurance Company Name, Address, and Phone Number	

If you have more insurance companies, please use a blank sheet of paper.

Expenses

You can request retroactive Medicaid coverage for three months prior to this application date.

17. In the past three months did you, or anyone in your household, have any medical expenses? Yes No

You will be required to provide verification of income and resources for this benefit.

18. Do you (if under age 21) or your children, need medical services? Yes No Please check:

- Baby Shots
- Dental Check-Ups
- Eye Exams
- Hearing Tests
- Medical Check-Ups
- Pregnancy Care
- Sick Care/Medicine
- Supplemental Nutritional Program for Women, Infants and Children (WIC)

Please complete for children 18 and under and anyone in the household who is pregnant

19. Does a parent of the child(ren) applying for health insurance have access to health insurance benefits? Yes No

If yes, is he/she a State of Colorado government employee? Yes No

19a. Has any applicant had health insurance coverage through an employer plan in the last 3 months? Yes No If yes complete the following:

\$ _____ \$ _____
 Amount of Premium (What you paid) Employer's Contribution (What your employer paid)

19b. Choose an HMO for persons applying for health insurance coverage.

_____ HMO

For information on choosing an HMO call CHP+ customer service 1-800-359-1991 or visit www.chpplus.org

If you are not a U.S. Citizen, please complete this section

20. Do you, your spouse or child(ren), have Work Quarters in the United States? (A work quarter is equal to three months of work income recognized by Social Security). Yes No

a.			
Name	Relationship to Applicant	Social Security Number (optional)	
Date of Entry (mm-dd-yyyy)	Alien Registration Number	<input type="checkbox"/> Check if you do not have a SSN	
b.			
Name	Relationship to Applicant	Social Security Number (optional)	
Date of Entry (mm-dd-yyyy)	Alien Registration Number	<input type="checkbox"/> Check if you do not have a SSN	
20a. Do you, or anyone in your household, have a sponsor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
a.			
Sponsor's Name	Sponsor's Complete Address	Relationship to Applicant	
Sponsor's Phone Number	Gross Monthly Income	Resources/Assets	Number in Sponsor's Family
b.			
Sponsor's Name	Sponsor's Complete Address	Relationship to Applicant	
Sponsor's Phone Number	Gross Monthly Income	Resources/Assets	Number in Sponsor's Family

Income Tell us about the income in your household

21. Do you, or anyone in your household, have a job? Yes No *If yes, please complete the following for each person in the household who is working:*

a. Name of Employed Person		Employer's Name, Address, and Phone Number		
	\$	\$		
Date Started	Hourly Wage and Tips	Gross Monthly Income	How Often Paid	What Day?

b. Name of Employed Person		Employer's Name, Address, and Phone Number		
	\$	\$		
Date Started	Hourly Wage and Tips	Gross Monthly Income	How Often Paid	What Day?

c. Name of Employed Person		Employer's Name, Address, and Phone Number		
	\$	\$		
Date Started	Hourly Wage and Tips	Gross Monthly Income	How Often Paid	What Day?

22. Are you, or anyone in your household, self-employed? Yes No *If yes, please complete:*
Are there other owners or partners? Yes No

Name of Self-Employed Person			You will be asked to provide proof of your business earnings and expenses.
\$			
Average Monthly Income	Number of Hours Worked Per Week	Business Name, Address, and Phone Number	

23. Did you, or anyone in the household, leave or lose a job or reduce the number of hours per week worked, in the past 60 days? Yes No

Name of person who lost job		Reason for Leaving	Last Date Worked
\$			
Gross Amount of Last Paycheck	Date of Last Paycheck	Former Employer Name, Address, and Phone Number	

24. Are you, or anyone in the household, on strike? Yes No *If yes, please complete:*

Name		Employer Name, Address, and Phone Number	
\$			
Gross Income Before Strike	Date Person Began Strike	Union Name, Address, and Phone Number	

25. Have you, or anyone in the household, applied for unemployment benefits? Yes No

a. Name of Person Who Applied		Date Applied for Unemployment
b. Name of Person Who Applied		Date Applied for Unemployment

Income

26. Do you, or anyone in your household, receive any type of money other than income from work? Yes No *If yes, please complete:*

Type of Income	Name of Person Receiving Income	Gross Amount Received	How Often Received?	Claim or Account Number
Alimony, Maintenance, Income from Spouse		\$		
Annuity		\$		
Cash Contributions		\$		
Child Support		\$		
		\$		
Dividends/Interest		\$		
Income from Trust		\$		
Insurance/Lawsuit Settlement		\$		
Loans		\$		
Public Assistance (OAP, AND, AB Colorado Works—TANF)		\$		
Railroad Retirement Benefits		\$		
Rental Income		\$		
Retirement /Pension		\$		
Social Security Benefits		\$		
Unemployment Benefits		\$		
Veterans Benefits		\$		
Workers' Compensation		\$		
Other Income: (Please describe)		\$		
		\$		

Income

27. Does anyone pay you or any member of your household for meals, a room or both?

Yes No *If yes, please complete:*

a. _____ Room Only Room and Meals \$ _____
 Name of Person Receiving Payment Amount Received How Often?

b. _____ Room Only Room and Meals \$ _____
 Name of Person Receiving Payment Amount Received How Often?

27a. Do you, or anyone in your household, have expenses for providing meals, a room or both? Yes No *If yes, you will be asked to provide proof of your business earnings and expenses.*

a. _____ \$ _____
 Who Is Paying the Expense Type of Expense Amount of Expense Hours Spent Providing Meals, a Room, or Both

b. _____ \$ _____
 Who Is Paying the Expense Type of Expense Amount of Expense Hours Spent Providing Meals, a Room, or Both

28. Do you, or anyone in your household, attend college, technical school or trade school?

Yes No *If yes, please complete:*

a. _____ Enrollment Status Full Time Part-time _____
 Name of Person Attending School Expected Graduation Date Name of School

b. _____ Enrollment Status Full Time Part-time _____
 Name of Person Attending School Expected Graduation Date Name of School

29. Do you, or anyone in your household, receive financial aid? Yes No

a. _____
 Name of Person Type of Expense (books, transportation, lab fees): Type of Grants/Loans Received (Pell Grants, Stafford Loan, Perkins Loan, work study)

b. _____
 Name of Person Type of Expense (books, transportation, lab fees): Type of Grants/Loans Received (Pell Grants, Stafford Loan, Perkins Loan, work study)

30. Have you or anyone in your household applied for Social Security Benefits or Supplemental Security Income (SSI)? Yes No *If yes, please complete:*

a. _____
 Name of Person Date of Application Status of Application (pending, approved, denied)

b. _____
 Name of Person Date of Application Status of Application (pending, approved, denied)

Resources

31. Have you, or anyone in your household received a lump sum payment? (such as a lawsuit, settlement, insurance settlement or SSI settlement) Yes No *If yes, please complete:*

_____	_____	\$ _____	_____
Name of Person Who Received the Lump Sum	Type of Lump Sum	Amount Received	Date Received
_____	_____	\$ _____	_____
Name of Person Who Received the Lump Sum	Type of Lump Sum	Amount Received	Date Received

Tell us about the resources in your household

32. Do you or anyone in your household have the following? Yes No

Type	Owner	Account Number	Amount / balance	Name/Address of institution	Jointly owned
Annuity					<input type="checkbox"/> Yes <input type="checkbox"/> No
Cash					<input type="checkbox"/> Yes <input type="checkbox"/> No
Certificate of Deposit (CD)					<input type="checkbox"/> Yes <input type="checkbox"/> No
Checking Account					<input type="checkbox"/> Yes <input type="checkbox"/> No
Savings Account					<input type="checkbox"/> Yes <input type="checkbox"/> No
College Fund/ Educational Accounts					<input type="checkbox"/> Yes <input type="checkbox"/> No
Inheritance					<input type="checkbox"/> Yes <input type="checkbox"/> No
Investments, Mutual Funds					<input type="checkbox"/> Yes <input type="checkbox"/> No
PASS Account or Individual Development Account					<input type="checkbox"/> Yes <input type="checkbox"/> No
Proceeds from Sale of a home or other assets					<input type="checkbox"/> Yes <input type="checkbox"/> No
Promissory Note					<input type="checkbox"/> Yes <input type="checkbox"/> No
Retirement Account: IRA, Keogh, 401(k)					<input type="checkbox"/> Yes <input type="checkbox"/> No
Reverse Mortgage					<input type="checkbox"/> Yes <input type="checkbox"/> No
Safe Deposit Box					<input type="checkbox"/> Yes <input type="checkbox"/> No
Stocks/ Bonds					<input type="checkbox"/> Yes <input type="checkbox"/> No
Trusts					<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (Please describe)					<input type="checkbox"/> Yes <input type="checkbox"/> No

Resources

33. Do you, or anyone in your household, have a vehicle that you are buying, have registered or own? (such as: car, van, motorcycle, truck, RV, boat, trailer) Yes No

a.	Jointly Owned?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
_____	_____	_____	_____	_____
Name of Person with Vehicle			Vehicle Year	Vehicle Type
	\$	\$		
_____	_____	_____	_____	_____
What Is Vehicle Used for (work, medical, school)	Value	Amount Owed	Vehicle Make	Vehicle Model
b.	Jointly Owned?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
_____	_____	_____	_____	_____
Name of Person with Vehicle			Vehicle Year	Vehicle Type
	\$	\$		
_____	_____	_____	_____	_____
What Is Vehicle Used for (work, medical, school)	Value	Amount Owed	Vehicle Make	Vehicle Model
c.	Jointly Owned?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
_____	_____	_____	_____	_____
Name of Person with Vehicle			Vehicle Year	Vehicle Type
	\$	\$		
_____	_____	_____	_____	_____
What Is Vehicle Used for (work, medical, school)	Value	Amount Owed	Vehicle Make	Vehicle Model

34. Do you, or anyone in your household, have any life insurance? Yes No

a.			
_____	_____	_____	_____
Name of Insured Person	Name of Insurance Company	Insurance Company Address/phone	
_____	_____	_____	_____
Name of Policy Owner	Policy Number	Date Purchased Loan Against this Policy	
_____	_____	_____	_____
Type of Life Insurance (whole, term)	\$ Face Value	\$ Cash Surrender Value	
b.			
_____	_____	_____	_____
Name of Insured Person	Name of Insurance Company	Insurance Company Address/phone	
_____	_____	_____	_____
Name of Policy Owner	Policy Number	Date Purchased Loan Against this Policy	
_____	_____	_____	_____
Type of Life Insurance (whole, term)	\$ Face Value	\$ Cash Surrender Value	
c.			
_____	_____	_____	_____
Name of Insured Person	Name of Insurance Company	Insurance Company Address and phone	
_____	_____	_____	_____
Name of Policy Owner	Policy Number	Date Purchased Loan Against this Policy	
_____	_____	_____	_____
Type of Life Insurance (whole, term)	\$ Face Value	\$ Cash Surrender Value	

Resources

35. Do you or anyone in your household have a burial policy or any money set aside to be used for burial, cremation or other funeral expenses? Yes No

a. _____
 Name of Person the Money Is Being Held for Mortuary, Bank, Insurance Company or Person

\$ _____
 Amount Being held Mortuary, Bank, Insurance Company, or Person Address and Phone Number

_____ Yes No
 If you have a burial policy, is it irrevocable?

b. _____
 Name of Person the Money Is Being Held for Mortuary, Bank, Insurance Company or Person

\$ _____
 Amount Being held Mortuary, Bank, Insurance Company, or Person Address and Phone Number

_____ Yes No
 If you have a burial policy, is it irrevocable?

36. There may be help with funeral expenses for some recipients. If your family should need such help, what would you prefer? Cremation Burial No Preference

37. Did you, or anyone in your household, give away anything of value within the last 5 years or 3 months for Food Stamps? (land, home, money, buildings, cars, boats) Yes No

a. _____	_____	_____	\$ _____	\$ _____
Name of Person Who Gave Away Item	Item Given Away	Date Given Away	Value of Item	Amount Owed
b. _____	_____	_____	\$ _____	\$ _____
Name of Person Who Gave Away Item	Item Given Away	Date Given Away	Value of Item	Amount Owed
c. _____	_____	_____	\$ _____	\$ _____
Name of Person Who Gave Away Item	Item Given Away	Date Given Away	Value of Item	Amount Owed

38. Are you or anyone in your household buying or the owner of any real estate other than the property where you live? (Example: rental property, Timeshare, warehouse, empty lot) Yes No If yes, please complete the following for each piece of real estate:

a. _____	Jointly Owned? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Name of Owner(s)		Type of Real Estate
_____	\$ _____	\$ _____
Location (street, city, state, and country)	Value	Amount Owed
b. _____	Jointly Owned? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Name of Owner(s)		Type of Real Estate
_____	\$ _____	\$ _____
Location (street, city, state, and country)	Value	Amount Owed

Veteran's Information

39. Have you, or anyone in your household, ever been in the military? Yes No

39a. Are you the widow(er) or a survivor of anyone that has been in the military? Yes No

If Yes to either of the above questions, please complete the following:

- a. Veteran's name, address & phone number _____
- b. Veteran's date of birth and place _____
- c. If Deceased, Veteran's date and place of death _____
- d. Your Relationship to Veteran _____
- e. Dates of Service _____
- f. Branch of Service _____
- g. Date of last VA benefit application or receipt of VA benefits _____
- h. Serial Number _____

39b. If spouse of Veteran, what was the maiden name, date & place of marriage:

40. If we are in need of additional information regarding your application and are unable to contact you, whom may we contact?

Name of person, address and phone

Relationship to You

Your Signature

By signing this form, I certify that I have reviewed this application; I understand and agree to the Rights, Responsibilities and Penalties and that the information I have given is true.

Signature of Applicant

Date (mm-dd-yyyy)

Applicant's Printed Name

Signature of person who helped complete this form

Authorized Representative, Conservator, or Guardian's Signature

Date (mm-dd-yyyy)

Authorized Representative, Conservator, or Guardian's Printed Name