Colorado Indigent Care Program Manual

Fiscal Year 2016-17

Section I: Eligibility

Effective July 1, 2016

COLORADO
Department of Health Care Policy & Financing

The following major changes have been made to the FY 2016-17 Eligibility Section

No major policy changes

Contents

ARTICLE I. PROGRAM OVERVIEW

The Colorado Indigent Care Program (CICP) distributes federal and state funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding render discounted health care services to Colorado residents, migrant workers and legal immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under Health First Colorado or the Child Health Plan Plus (CHP+).

The Colorado Department of Health Care Policy and Financing (Department) administers the CICP by distributing funding to qualified health care providers who serve eligible persons who are indigent. The Department issues procedures to ensure the funding is used to serve the indigent population in a uniform method. Any significant departure from these procedures will result in termination of the contract with, and the funding to, a health care provider. The legislative authority for this program was originally enacted in 1983 and can currently be found under 25.5-3-101, et seq., C.R.S., the "Reform Act for the Provision of Health Care for the Medically Indigent." State rules implementing this legislation, 10 CCR 2505-10 8.900 – 8.908, are found at the Colorado Secretary of State's website.

Section 1.01 Provisions Applicable to Providers

Providers eligible for participation in the CICP must meet the following minimum criteria:

- Licensed as a community health clinic or certified as a general hospital, maternity hospital (birth center) by the Department of Public Health and Environment (DPHE).
- A federally qualified health center, as defined in section 1861 (aa) (4) of the federal "Social Security Act", 42 U.S.C sec. 1395x (aa) (4).
- A rural health clinic, as defined in section 1861 (aa) (2) of the federal "Social Security Act", 42 U.S.C sec. 1395x (aa) (2).
- Assure that emergency care is available to all CICP clients throughout the contract year.
- If the provider is a hospital, the hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services as Health First Colorado clients. In the case where a hospital is located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This obstetrics requirement does not apply to a hospital in which the patients are predominantly under 18 years of age; or which does not offer non-emergency obstetric services as of December 21, 1987.

ARTICLE II. PROVIDER AND APPLICANT RESPONSIBILITIES

Section 2.01 Provider's Statement of Responsibilities

Providers participating in the CICP shall:

1. Treat all clients with respect and with consideration for the client's dignity and privacy;
2. Inform clients of how to express opinions, compliments or concerns, and how to make a complaint without fear of reprisal;
3. Strive to provide timely resolutions to the client's complaints or concerns;
4. Protect the privacy and confidentiality of the client's health and financial records;
5. Offer clients information on all treatment options, and allow clients to participate in decisions regarding his or her health care;
6. Notify the client of the availability of sign language and interpreter services in accordance with applicable laws and regulations, when such services are necessary;
7. Ensure the availability of program information – applications, informational materials, forms and brochures;
8. Prohibit discrimination based on race, color, national origin, sex, age or disability;
9. Upon request, provide applicants with copies of all signed worksheets and documents; and
10. Explain to the client or guardian that discounted services may vary and that a rating based on financial resources will determine their portion of the bill.

CICP providers are encouraged to establish policies and procedures specific to their facility which do not directly contradict this manual.

- The Department is available for informational queries of a general nature.
- Providers are responsible for determining eligibility.
- Not all circumstances in determining client eligibility are covered in this manual and the manual is not meant to be all-inclusive.

Section 2.02 Client's Statement of Responsibilities

Clients applying for or receiving discounted CICP services shall:

1. Acknowledge that the CICP is not health insurance, does not offer a specific benefit package, is not an entitlement to medical benefits and that there are limitations to services discounted;

2. Acknowledge that discounted CICP health care services vary by provider location;

3. Give the CICP provider all the necessary financial information and documentation needed to complete the application;

4. Shall not give false information with the intent to commit fraud;

5. Tell the CICP provider if a CICP financial rating was issued by another provider and notify the CICP provider within 15 days if the CICP rating is disputed;

6. Be responsible for paying any money owed on time, and as required, or work with the CICP provider to make payment arrangements;

7. Notify the CICP provider promptly of changes in resources, income and all other household changes that may affect the CICP rating;

8. Communicate any information, concerns and/or questions related to the financial screening to the appropriate representative;

9. Respect the property of the CICP provider, fellow clients and others; and

10. Follow all other rules and regulations of the CICP provider's location relating to respectful treatment and rights of other clients and provider staff.

ARTICLE III. SERVICES OFFERED & SUBROGATION POLICY

Section 3.01 Services Provided Under the CICP

Health care services provided to CICP clients must be medically necessary, **as determined by the CICP provider**. Medical necessity is defined in 10 CCR 2505-10, Section 8.076.1.8., and means a good or service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects, of an illness, injury, or disability. It may also include a course of treatment that includes mere observation or no treatment at all. The good or service must be:

i. Provided in accordance with generally accepted standards of medical practice in the United States;

ii. Clinically appropriate in terms of type, frequency, extent, site, and duration;

iii. Not primarily for the economic benefit of the provider or for the convenience of the client, caretaker, or provider; and

iv. Performed in a cost effective and most appropriate setting required by the client's condition.

The Department does not determine Medical necessity. All health care services normally provided at the hospital and/or clinic shall be regularly available at a discount to CICP clients unless the provider sets a standardized policy that limits available services. Providers shall offer emergency services at a discount. Emergency services must be provided at a discount to any CICP client, even if that client resides outside the provider's service area.

If a CICP provider agrees to accept a client transfer from another CICP provider, the client must be provided discounted services from both providers. It is the receiving provider's decision to charge an additional copayment for the service provided. It would be appropriate to charge an inpatient copayment if the client was being admitted to a hospital and the client had only paid an outpatient copayment at the primary provider.

Section 3.02 CICP Subrogation Policy

The CICP does not have any subrogation rights concerning any settlements or judgments, but those rights are retained by the facility where the medical service was provided (the provider). The provider is obligated to make all reasonable efforts to collect amounts due from third party coverage and applicable co-payment amounts, and shall maintain auditable evidence of such efforts. The client's medical claims and service information, and any related charges, must be obtained directly from the provider and the client's attorney is obligated to request the relevant information directly from the provider. Through any settlement or judgment award, the provider has the right to recover all applicable charges related to the medical service provided, even if the initial charge was discounted under the CICP.

This document is available on line at colorado.gov/hcpf. Follow the link labeled For Our Providers, Get Info, FAQ's & More, Colorado Indigent Care Program (CICP),and then Attorney Subrogation Policy.

ARTICLE IV. EXCLUDED SERVICES

Section 4.01 Excluded Services

The following services are not reimbursable through the CICP:

1. Services not Medically Necessary as determined by medical professionals;
2. Elective surgeries that are not medically necessary;
3. Nursing home care;
4. Chiropractic services;
5. Sex change surgical procedures;
6. Cosmetic surgery;
7. Experimental and non-FDA approved treatments;
8. Non-urgent dental services;
9. Court-ordered procedures, such as drug testing;
10. Abortions, except as specified in Sec. 25.5-3-106, C.R.S.;
11. Mental health services as a primary diagnosis in an outpatient or clinic setting; the CICP can reimburse for the services if they are a secondary diagnosis; and
12. Prescription drugs included in the definition of Medicare Part-D are excluded from CICP eligible clients who are also eligible for Medicare;
13. Prescriptions for Medical Marijuana

ARTICLE V. HEALTH COVERAGE PLANS

Section 5.01 Health Coverage Plans

The CICP is not a health coverage plan as defined in Section 10-16-102 (22.5) C.R.S. The Colorado Department of Regulatory Agencies (DORA), Division of Insurance, defines a health coverage plan as a policy, contract, certificate or agreement of coverage offered to individuals. An insurance contract shall include a list of procedures and benefits covered under the policy. An insured individual shall be entitled to receive a contract and/or evidence of coverage as approved by the Insurance Commissioner as defined in 10-16-102, C.R.S. The CICP cannot be used as proof of medical insurance

The CICP does not offer a specified discounted medical benefit package or an entitlement to medical benefits or funding to individuals or medical providers. Medically indigent persons receiving discounted health care services from qualified health care providers are subject to certain limitations and requirements. The CICP makes "it possible to use state funds to partially reimburse providers for services given to the state's non-Health First Colorado medically indigent residents. Therefore, medically indigent persons accepting medical services from this program shall be subject to the limitations and requirements imposed in this article," Section 25.5-3-102 C.R.S. The CICP is not a health coverage plan as defined in Section 10-16-102 (22.5) C.R.S.

Section 5.02 HIPAA (Health Insurance Portability and Accountability Act)

The Department has determined that the CICP is NOT a "covered entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations (45 C.F.R. Parts 160 and 164). Because the CICP is not a part of Health First Colorado, and its principal activity is the making of grants to providers who serve eligible persons who are medically indigent, CICP is not considered a covered entity under HIPAA. The CICP provider is the covered entity and shall comply with all requirements under HIPAA regarding the rights of the clients they serve. Decisions made to protect the privacy rights of clients are solely those of the covered entity. The state personnel administering the CICP will provide oversight in the form of procedures and conditions, to ensure funds provided are being used to serve the target population, but they will not be significantly involved in any health care decisions or disputes involving a health care provider or client.

ARTICLE VI. CLIENT ELIGIBILITY FOR CICP

Section 6.01 Overview of Requirements

The "CICP Eligibility Section" contains the program guidelines for determining eligibility. The Department refers to eligibility determination as "the rating process." The Department intends that the rating process be uniform across the state.

- The rating process takes a "snapshot" of an applicant's financial resources as of the date the rating takes place and a signed application is obtained. Ratings usually occur on the initial date of service. (Full month of current income).
- Ratings are retroactive for services received up to 90 days prior to application, or if there are applicants with other health insurance coverage, when the third-party payer has an adjudicated claim. Therefore, when an applicant who has received services applies for the CICP, the applicant is applying for a discount on already incurred medical charges. Providers may extend the deadline for special circumstances under a policy determined and set by the provider.
- All CICP clients must have an initial rating which is usually valid for one year. However, initial ratings may change for various reasons. The most common method of changing a client's rating is "client re-rating." Clients are re-rated due to specific situations, household change, or when Management Exception rating expires. Re-rates do not apply to bills prior to the re-rate.

In general, all applicants aged 18 and older must:

1. Sign an affidavit indicating their citizenship status;
2. Provide **one** approved document to demonstrate that they are lawfully present in the country;
3. Be a resident of the State of Colorado or communicate "Intent to Remain in Colorado";
4. Furnish a Social Security number-**NOT CARD** (or documentation that they have applied for one); and
5. Meet all other CICP eligibility requirements (related to income, etc.).

Section 6.02 Instructions for Completing the Application

When completing the CICP client application (application), the provider must obtain as much documentation as possible to support the applicant's financial status. Documentation assures that State funds are used appropriately. Except in the event of an emergency, an application can be denied for non-compliance if the client refuses to provide required information or documentation.

The provider should schedule an appointment with the applicant to complete the application within 45 days after the date of service and must make a reasonable attempt to complete the application within 90 days after the date of service. It is in the provider's best interests to ask first-time clients whether or not they have received a CICP rating with a different provider.

Clients are responsible for notifying the provider's billing office if they have received a CICP rating from another CICP facility. Clients must report their CICP eligibility rating to the provider within 90 days of service. If a client fails to report his or her CICP eligibility rating within 90 days, the provider is not obligated to provide a discount.

Section 6.03 Emergency Application

Sometimes it may not be practical to rate an applicant using the regular CICP application process. For example, an individual seen in an emergency room because of an injury may be unable to provide all of the information or documentation required by the usual application process. The **CICP Emergency application should only be used for patients that appear not to be categorically eligible for Health First Colorado**. For emergency situations, complete the following steps.

1. Use the regular CICP application, ***but check "EMERGENCY"*** at the top (right corner) of the application;
2. Ask the applicant to respond verbally to all questions and to sign the application; and
3. Assign a CICP rating based on the verbal information provided.

By following the above steps, you have created an "Emergency application." An Emergency application is good for one episode of service in an emergency room and any subsequent or concurrent service (such as in inpatient hospital stay) related to the emergency room episode. The subsequent or concurrent service must immediately follow the emergency room service to qualify as part of an emergency episode. Treatment must be continuous to be considered part of the same emergency episode. If the client receives any care other than the emergency room visit that is not related to the emergency room episode, you must request the client to submit documentation to support all figures on the Emergency application OR complete a new CICP application. If the documentation submitted by the client does not support the verbal information, you must complete a new CICP application. If the client does not submit any supporting documentation or complete a new application upon the request of the provider, the provider shall use the information contained in the Emergency application, however, other unrelated services shall not be discounted.

An individual can only complete an Emergency application once a year. Any requests for medical care in the emergency room after the initial date of service or episode must include a completed application accompanied by the requested documentation. Any applicant who meets the definition of homeless (see CICP Regulations Section 8.907. B.a., for the definition of homeless) is not restricted to completing an Emergency application only once a rating year.

Providers must allow a client to complete an Emergency application once a year when the client seeks emergency services, even if the client does not reside in the geographical area where the provider typically offers CICP discounted health care services.

Section 6.04 Other Provider's Rating

Providers are not required to accept each other's rates if a provider believes the rate was determined inaccurately or that the person was rated incorrectly. If a discrepancy exists, providers are asked to contact each other and arrive upon the correct rating.

It is the burden of the provider of the original application to make available the applicant's application and supporting for auditing for 6 State fiscal years. The original application is the property of the original provider, and a copy of the card should suffice for any subsequent provider rendering medical services to client screened by another CICP provider.

ARTICLE VII. CICP CLIENT APPLICATION

Section 7.01 Applicant Name

The name entered should be that of the person responsible for paying incurred charges (The Guarantor). Any non-minor household member can be the responsible party. If an applicant is deceased, the executor of the estate or a family member can complete the application on behalf of the applicant. CICP Providers can complete the application on behalf of deceased patient, only as the last remedy. The executor or family member completing the application will not be responsible for any copayments incurred on behalf of the deceased member.

Section 7.02 Applicant Address

Applicant's address refers to the residence of all family members included in the rating. All members included under this rating must live at this address. This address cannot be a business address or an empty lot. The family address must be the primary place where the family resides. See "Colorado Resident" under Section 9.01 for more information on the family's primary home.

Clients with a Z-Rating are exempt from client copayments. Homeless clients are exempt from the income verification requirement, and providing proof of residency when completing the CICP application. Homeless applicants are not exempt from applying for Health First Colorado.

A person is considered homeless who lacks a fixed, regular, and adequate night-time residence or has a primary night time residency that is:

A. A supervised publicly or privately operated shelter designed to provide temporary living accommodations;

B. An institution that provides a temporary residence for individuals intended to be institutionalized; or

C. A public or private place not designed for or ordinarily used as, a regular sleeping accommodation for human beings. This does not include an individual imprisoned or otherwise detained pursuant to federal or state law.

Section 7.03 Household Member's Name

Record the name of each family member who has or will receive care through the CICP, or will be included in the family size calculation for Line 7, Section II of the application.

Determining family members to include on the application: The following information will assist in determining if a family member can receive care through the CICP and/or be counted in family size. The first table shows family members for whom financial support and dependency does not need to be demonstrated. The second table shows family members for whom at least 50% of their financial support must be demonstrated before they can be counted in the family for purposes of inclusion on the CICP application.

FAMILY MEMBERS FOR WHOM FINANCIAL SUPPORT DOES NOT NEED TO BE DEMONSTRATED

- Spouses (including Common-Law Marriage)
- Unborn children
- Grandparents
- Minor children
  (See Section. 7.04 Relationship Codes)
- Minor grandchildren
- Civil Union Partners
- Adopted minor children
- Parents

All other family members must receive at least 50% of their support from the responsible party in order to be included on the CICP application for the family. Proof of support includes the family member being listed on the prior year's tax return as a dependent and/or proof of support expenses through cancelled checks or copies of money orders.

FAMILY MEMBERS FOR WHOM FINANCIAL SUPPORT MUST BE DEMONSTRATED

- Step-children
- Step-parents
- Adult grandchildren
- Cousins
- Step-grandchildren
- Adult brothers and sisters
- Brothers-in-law and sisters-in-law
- Nephews and nieces
- Parents-in-law
- Adult children
- Sons-in-law and daughters-in-law
- All others not specifically listed in the first table, above

Section 7.04 Relationship Codes

Enter the appropriate Relationship Code number:

1 Self **2** Spouse/ Civil Union Partner **3** Child **4** Stepchild **5** Other

1. **Married Couples**: BOTH spouses must be included on the application. Married couples will receive the same CICP rating unless one of the spouses is Health First Colorado eligible or an undocumented immigrant; in which case, both are still included in family size.

   A married couple means that the couple is legally married. Proof of marriage is a marriage license or marriage certificate. Married couples may keep their finances separate, including payments for medical care. However, according to the Joint Liability for Family Expenses, 14-6-110, C.R.S., the expenses of the family and the education of the children are chargeable upon the property of both spouses, or either of them and in relation thereto they may be sued jointly or separately. If one spouse does not want to give the necessary financial information, rate the family based on the best information available. However, inform the non-compliant spouse that according to Colorado law spouses are responsible for each other's medical charges.

Married couples wishing to separate, divorce or have the marriage annulled must provide legal documentation of the separation, the dissolution of marriage, annulment or declaration of invalidity to be considered separate for CICP eligibility. For those who have not yet officially filed for a legal separation or dissolution of marriage, but intend to do so, or for those who have filed but an official court decree has not yet been issued, a letter from their attorney verifying their status will suffice. If an applicant cannot afford court associated costs, and can demonstrate to the court they are indigent, court costs owed to the state may be waived.

2. **Common Law Marriage**: If a person meets the requirements for common law marriage, the same rules apply as with married couples as stated in Section 7.04.1. All five of the following requirements must be met for a common-law marriage in Colorado:

    a. It must be the INTENT of both parties to be spouses;
    b. Both parties must be 18 years of age or older;
    c. Both parties must be free to marry (single, widowed or legally divorced);
    d. Both parties must live together; and
    e. Both parties, by reputation, must claim to be married

    - If one or more of these conditions are not met, a couple living together is not a "family" for CICP ratings. This means both partners must complete separate applications.
    - As with married couples, the spouse does not have to take the other spouse's last name for a common-law marriage.
    - Providers may request an affidavit of Common Law Marriage signed by both parties.
    - As with Married Couples, couples wishing to separate or divorce must provide legal documentation of the separation or the dissolution of marriage to be considered separate for CICP eligibility.

3. **Civil Union:** Both partners must be included on the CICP application. Partners in a Civil Union will receive the same CICP rating unless one of the partners is Health First Colorado eligible or an undocumented immigrant; in which case, both are still included in family size.

    A Civil Union includes any two unmarried adults, regardless of gender. Proof of the civil union is a certified civil union certificate. Partners may keep their finances separate, including payments for medical care. Parties to a civil union are responsible for the financial support, the expenses of the family, education of the children and medical charges of one another in the manner prescribed under law for spouses.

Parties wishing to dissolve a civil union must file an action for dissolution of a civil union, legal separation of a civil union, or declaration of invalidity of a civil union with the clerk of a court of record for the state of Colorado.

4. **Minors (under the age of 18):** Minors should not be rated separately from their parents or guardians unless they are emancipated. Exception to this requirement is made for the following reasons:

    a. A minor who has a child and obtains medical care for the child (the minor parent is legally responsible for the cost of care);

    b. Examination and treatment for sexually transmitted diseases;

    c. Examination and treatment for alcohol and/or drug addiction;

    d. Obstetrical and gynecological procedures, birth control procedures, supplies or information. If the parents of a minor child who is pregnant have insurance to cover that child, but the insurance excludes pregnancy of the minor and the parents are claiming financial responsibility for her, that child is not considered emancipated and should be rated based on the parent's income. If the parents do not qualify for the program, then she cannot be covered under CICP.

    e. Voluntary mental health services, but only if the minor is fifteen years old or older;

    f. Treatment or testing for HIV; and

    g. Confidential Teen Services Program - Minors in this program are rated without consideration of their parent's income under the conditions described. Therefore, when minors seek services and claim no income other than the parents' income, they will be rated category A. If the minor declares personal income, e.g., part-time job, that income will be used in determining the rating. If the rating is higher than category A, the higher rating will prevail.

5. **Emancipated Minors:** "Emancipated juvenile", pursuant to [19-2-511, C.R.S.], means "a juvenile over fifteen years of age and under eighteen years of age who has, **with the real or apparent assent of the juvenile's parents**, demonstrated independence from the juvenile's parents in matters of care, custody and earnings. The term may include, but shall not be limited to, any such juvenile who has the sole responsibility for the juvenile's own support, who is married, or who is in the military."

6. **Communal Groups:** Do not include unrelated members of religious orders and communal living groups on the same application. Each unrelated member must complete a separate application.

7. **Family Members Outside of Colorado:** If a family member lives outside of Colorado, including in a foreign country, that individual is not a Colorado resident. However, count the member in family size if the responsible party provides more than 50% of the member's support and claims the member as a dependent for income tax purposes.

8. **Family Members Eligible for SSI, Child Support and Foster Care:** Include family members receiving cash assistance. Family members receiving only cash assistance can receive care under the CICP if they are not Health First Colorado eligible.

9. **Family Members Eligible for Health First Colorado:** Family members eligible for Health First Colorado cannot receive care under the CICP, but can be included in the family size calculation.

10. **Additional situations involving children:**
    a. Unborn Children: Include the unborn child/children of a pregnant woman in family size on the family's application. Verification of pregnancy can be completed through visual observation or a letter from a physician.
    b. Children of Divorced Couples –In accordance with Health First Colorado policy, under CICP, children of parents who have joint custody should be counted in both parents' households.
    c. Children in School - Include children age 18 years or older who are attending high school or college and whose parents support them, on the parents' application. DO NOT count any income the child may earn, financial support does not need to be demonstrated for the child that is 18 years of age and in high school or in college.
    d. Disabled Children - Include a child with disabilities, regardless of age, on the parent's application if the parents support the child. If the disabled child is Health First Colorado eligible, the child cannot receive medical care through the CICP, but should be included in family size. Exception: An adult child with a disability and gainfully employed must complete a separate application.
    e. Adult Children - Adult children (defined as 18 years or older) living at home can be counted in the family unit only if the entire family is listed on the application, and the adult child receives 50% of their support from the responsible party. If the adult child has an income, and not in school, the amount must be included in determining the family financial status. Adult children may submit their own application if they desire, but in this case would not be included on the family application for income or household size.
    f. Newborns use the mother's Social Security number up to the age of 1 year.
    g. Family Members Eligible for CHP+ - Any family member eligible for CHP+ is included in the family size calculation for the CICP.

Section 7.05 Date of Birth

You must enter the date of birth for all family members included in family size or receiving discounted services through the CICP, except for unborn children.

Section 7.06 Health First Colorado State ID Number

If any family member listed receives Health First Colorado, record the state Health First Colorado ID number on the application.

Section 7.07 Social Security Number

All applicants must have a Social Security number. You must enter the Social Security number for all family members receiving discounted medical care through the CICP on the CICP application. The only exception to this is for unborn children. If an applicant does not have a social security number, effective July 1, 1997, a receipt of application for a Social Security number must be received at the time of CICP application. This receipt is only valid if the applicant already has a valid Social Security number. A CICP provider may choose to write only the last four digits of the applicant's Social Security number on the CICP card.

ARTICLE VIII. FINANCIAL ELIGIBILITY

The guidelines below should be followed when utilizing the written CICP Application. If the electronic copy of the application is used, refer to instructions contained inside the Excel spreadsheet regarding usability and functionality.

Include with the applicant's application the full names, phone numbers and addresses of all employers and retirement payments. Income sources include payments from employment, Social Security, pension funds, unemployment compensation and self-employment. List the income sources for all family members age 18 and over. Earned income from a working minor (under the age of 18) is exempt.

Section 8.01 Determining the Applicant's Income

The Department has three methods for determining an applicant's income and establishing financial status. The methods are (in order of priority):

Line 1 – Employment Income:

Line 2 - Unearned Income; and

Line 3 - Self-Employment

Calculate all income beginning with Line 1, "Gross Employment Income."

When calculating income, you must obtain as much documentation as possible (this documentation must comply with CICP policies) to substantiate amounts.

Section 8.02 Employment Income

Employment income is income earned (including overtime and bonuses) for providing services to another individual or company. Earned income from a working minor (under the age of 18) is exempt. Employment income for CICP does not include self-employment income which is addressed separately. Documentation of employment income is a pay stub, a letter on official letterhead from the applicant's employer, or on the CICP Provider's letterhead.

There are 3 steps to calculating current employment income.

Step 1. Obtain documentation for current month or previous months' employment income. The rating process looks at the financial circumstances of a household as of the date a signed application is completed. If an applicant has just started a new job, for example, and has less than one month's worth of pay stubs, or has not received a paycheck yet, utilize the information available to calculate the applicant's monthly income and convert to an annual income. The Department recommends calculating the monthly income using the Year to Date Method as described below. Complete Worksheet – 1 "Earned and Unearned Income" using gross amounts. "Gross" means the dollar amount before any deductions or losses are subtracted.

Step 2. Use one of the following methods to determine the monthly gross employment income. Write the total amount of gross employment income in the monthly total column on Line 1, Section II of the application.

Year to Date Method:

The Year-to-Date Method of calculating annualized gross income utilizes the applicant's cumulative year-to-date gross earnings on the pay stub. When utilizing this method, the applicant will need to provide their **most current year-to-date paystub**. It is not required to request a full month of paystubs when utilizing this method. To determine the annualized income, count the number of paychecks that have occurred since January 1, and then divide that number into the gross year-to-date earnings indicated on the pay stub. The result of this computation is then multiplied by the number of pay periods in a year to determine the annualized gross earnings.

Example:

The applicant provides you with a recent pay stub whose year-to-date earnings are $13,756. The pay frequency is bi-weekly. The pay period ended September 30th and since January 1st the applicant has been paid 19 times. The calculation would be as follows:

Divide $13,756 by 19 bi-weekly pay periods = $724.00

Multiply $724 by 26 bi-weekly pay periods in a year = $18,824

Average Pay Method:

The Average Pay method of calculating income utilizes the average gross earnings based upon the number of pay stubs provided. Paystubs should match the applicant's pay date as opposed to pay period. When utilizing this method the applicant will need to provide at least a full month of paystubs. To determine the average gross earnings, total all the gross earnings of all the pay stubs provided and divide the result by the number of pay stubs. The result will be the average gross earnings per pay period. Next, determine if the applicant is paid weekly, bi-weekly or semi-monthly (usually the 1st & 15th). Convert the average gross earnings to monthly income.

1. To convert weekly income to monthly income, multiply by 4.333

2. To convert bi-weekly income to monthly income, multiply by 2.1666

3. To convert semi-monthly income to monthly income, multiply by 2

Lastly, annualize the average monthly gross earnings.

Example:

An applicant provides you with six pay stubs with gross earnings of $534.00, $475.00, $398.00, $534.00, $498.00 and $534.00. The pay frequency is weekly. The calculation would be as follows:

Add: $534.00, $475.00, $398.00, $534.00, $498.00 and $534.00 = $2,973.00

Divide: $2,973.00 by 6 pay stubs = $495.50 average weekly gross earnings

Multiply: $495.50 by 4.333 = $2,147.00

Multiply: $2147.00 by 12 months = $25,764.00

Example:

The applicant is paid for two weeks and has received only one paycheck. The calculation would be as follows:

Monthly gross earnings = $200 x 2.1666 = $433.32 per month

Annual income = $433.32 x 12 months = $5,199.84 per year

Example:

If the applicant has just started a job but has not received a paycheck yet, a letter on official letterhead from the applicant's employer is allowable. Use the information in the letter to calculate the monthly income using the Average Pay Method. The calculation would be as follows:

Letter on employer's letterhead with hourly wage and hours to be worked per week:

Weekly earnings = $8.50 per hour x 20 hours per week = $170 per week

Monthly gross earnings = $170 x 4.333 = $736.61 per month

Annual income = $736.61 x 12 months = $8,839.32 per year

Monthly Pay Method:

Note that this method is only accurate for applicants with fixed salaries. Employees paid monthly on an hourly basis will likely have paychecks that vary in amount month to month. The monthly pay method of calculating income utilizes the most recent monthly pay stub. Utilize the monthly income and annualize.

Step 3. Write the annualized total income from Step 2 on Line 1 in the "Annualized Total" column of the application

Section 8.03 Unearned Income

Unearned income is countable gross cash received from sources other than employment. Complete Worksheet 1 – Employment Income and Unearned Income. Write the total amount of the unearned income on Line 2 of the application. This income can be self-declared; however, Provider will use the most recent monthly amount and calculate income as annual income.

Examples of Unearned Income include:

1. Unemployment Compensation or Workers Compensation;
2. Old Age Pension (OAP) benefits (financial assistance to low income individuals age 60 and over);
3. Social Security payments such as Supplemental Security Income (SSI), Social Security Disability Income (SSDI), Social Security Retirement, Social Security Survivors benefit, Social Security Dependent benefit are countable sources of income. Any Social Security income paid to a minor (under age 18) is exempt. The provider must receive verification that the Social Security benefit is payable to the child. If the checks do not include the child's name, then include these payments in other income sources on the application. Applicants who are Health First Colorado eligible cannot receive care under the CICP without providing a written Health First Colorado denial;
4. Payments from Retirement Plans and Pensions. Retirement plans and pensions come in many forms. Some examples are: PERA, Tax Sheltered Annuities, Deferred Compensation, Individual Retirement Accounts (IRAs), 401k plans and Social Security Benefits. Do not include Social Security Benefit payments to children when calculating other income sources on the application;
5. Commissions, Bonuses, Gifts and Tips. Include amounts from commissions, bonuses, gifts and tips when calculating unearned income on the application;
6. Court-Ordered Alimony Received;
7. Trust Accounts are income from other sources;
8. Income from rental properties and net of expenses incurred from rental operations, including boarding and lodging, when calculating other income sources on the application;
9. Interest Income includes interest earnings from savings accounts, stocks, bonds and similar securities when calculating other income sources on the application;
10. Monetary gains from selling an asset are counted as other income sources on the application;
11. Insurance policies that are revocable (with cash surrender value); and
12. Monetary settlements received not related to a medical injury accident.
13. Veterans Affairs (VA) Benefits.

Section 8.04 Exempt Unearned Income

The following types of unearned income are ***not included*** in determining total income:

1. Aid to the Needy and Disabled (AND) payments to Health First Colorado clients;
2. Payments to recipients of Colorado's Aid to the Needy and Disabled (AND) financial assistance program;

3. College grants, scholarships and work-study income. Work-study income is generally awarded based on financial need and is determined by completing a Federal Student Aid application;
4. Grants to CICP clients from non-profit, tax-exempt, charitable foundations specifically for CICP client copayments. The provider must honor these grants as CICP client copayments;
5. Child Support and Foster Care Payments. These payments are for the support of children. Many children receiving these payments are Health First Colorado eligible. Therefore, require a Health First Colorado denial before allowing these children to receive care under the CICP;
6. Food Stamps and Women, Infants and Children (WIC), TANF;
7. Assistance provided by non-profit organizations, if the assistance is need-based (i.e., the cost of meals at a soup kitchen);
8. Medical care provided for free or if a third-party made the payments;
9. Settlements received as a result of a prior medical injury; not related to the current CICP application;
10. Reimbursement for work- related personal expenses;
11. College loans;
12. Payments by credit life or credit disability insurance;
13. Proceeds of a loan;
14. Income from a reverse mortgage;
15. Disaster relief assistance;
16. Tax refunds;
17. IRAs, pensions and insurance policies (irrevocable policies) that are not available without penalty;
18. Moving expenses paid by employer for relocation;
19. Social Security income for a minor (under the age of 18);
20. Up to $2,000 per calendar year of income received by applicants of American Indian birth origin, which is derived from leases or other uses of individually-owned trusts or restricted lands pursuant to P. L 103-66 and P. L. 97-458 is exempt as income in the month received; For purposes of this provision, the exclusion of income shall be applied only to months for which an eligibility determination is being made;
21. Adoption Subsidy

Section 8.05 Self-Employment

If a self-employed applicant pays themselves just as they would their employees, and can document by pay stubs, use the figure from the pay stub.

To determine the net profit of a self-employed applicant, deduct the cost of doing business from the gross income. To obtain the gross income, request one month of gross bank business deposits. If bank business deposits are not available, a profit and loss worksheet OR a ledger is acceptable documentation for gross income and business expenses, however if a provider wishes to require documentation of business expenses, they should summit a waiver request to the Department. Gross income amount and business expenses listed on profit and loss or ledger documents should be transferred to Worksheet 2. Worksheet 2 must be signed, dated and attached to application. An expense is something that is necessary to keep a business in operation.

1. Expenses can include, but are not limited to:
    - Rent of business premises
    - Wholesale cost of merchandise
    - Utilities
    - Taxes
    - Labor
    - Upkeep of necessary equipment

2. Self-employment expenses do not include:
    - Depreciation of equipment.
    - Cost of payment on principal of loans for capital assets, or durable goods.
    - Personal income tax payments, lunches, transportation to and from work, and other personal expenses.

3. Self-employed licensed, certified or approved day care providers may receive the following deductions each month to compensate for wear and tear on the residence:
    - $55 for the first child for whom day care is provided; and
    - $22 for each additional child.

However, if the applicant can document a cost of doing business, which is greater than the amounts described above, use the expenses identified in Section 8.05 (1).

4. For businesses that are operating out of the home, ⅓ (one-third) of the expenses should be attributed to the business. For home expenses that can be used for personal and business purposes, designate a percent for the amount of time that a particular expense is used for the business.

Example:

A subcontractor works out of his primary residence. The subcontractor's gross monthly income is $2,000. The business expenses are as follows:

Internet $45

Phone $50

Mortgage $900

Utility $100

Supplies $60

Internet $45 Subcontractor uses the internet for 75% of the business

$45 multiplied by .75 = **$33.75**

$33.75 is the amount used for business expense

Mortgage $900 Subcontractor works from primary residence, deduct ⅓ as expense

$900 divided by 3 = **$300**

$300 is the amount used for business expense

Utility $100 Subcontractor works from primary residence, deduct ⅓ as expense

$100 divided by 3 = **$33.33**

$33.33 is the amount used for business expense

Phone $50 Subcontractor has a separate business telephone. Count entire expense for business purposes - **$50**

Supplies $60 Subcontractor only uses supplies for business purposes. Count entire expense for business purposes - **$60**

Total Monthly Business Expenses: $477.08

Total Monthly Gross Income: $2,000.00

Subtract $2,000.00 - $477.08 = $1,522.92 (monthly)

Annualize $1,522.92 x 12 months =$18,275.04 (yearly)

Write the annualized self-employment income on Line 3 of the application.

Section 8.06 Total Income

To calculate total income for Section II of the application, add "Gross Employment Income (line 1)" PLUS "Unearned Income (Line 2)" PLUS "Self-Employment Income (Line 3)". Take the total from lines 1, 2, and 3, and record the amount in "Total Income (line 4)".

Calculating Equity in Resources

The "Equity in Resources" portion of the application shows the amount of equity in resources available to an applicant.

1. Calculating Vehicle Equity

For calculating the amount of vehicle equity to record on the application, complete the following steps:

Step 1. Determine the total value of all vehicles owned by the applicant using the instructions included below. Write this amount on the "Value" line. To determine the value of vehicles, request a copy of the client's vehicle registration.

Step 2. Determine the total amount owed on all vehicles owned by the applicant. Write this amount on the "Amount Owed" line. You should receive confirmation (verbal or written) from the applicant's bank to confirm outstanding vehicle loans.

Step 3. The CICP protects a total of $7,500 ("Minus Protected Portion" column) for all vehicles owned.

Step 4. Subtract the "Amount Owed" and $7,500 FROM the "Value" of all vehicles. Write this amount on Line 5, under the "Vehicle Equity" portion of the application. If this amount is less than zero (a negative amount), you must record $0.

Vehicle Equity Pricing Instructions:

1. Navigate to the National Automotive Dealers Association (NADA) guide website.
2. Click on "New & Used Car Prices"
3. Under "Research by make", use the drop down menu to choose the make of the vehicle.
4. Select the year of the vehicle from the drop down menu.
5. You can now select the body style of the vehicle from the second drop down menu, or you can scroll through all vehicles shown and select the vehicle the applicant owns.
6. On the next screen, select the trim level of the applicant's vehicle (i.e. Coupe, Sedan, LS, LT, etc.).
7. Enter the current mileage of the applicant's vehicle.
   a. A rounded mileage will work, if the applicant is not sure of the exact mileage.

8. From the Optional Equipment list, check the options that are on the applicant's vehicle (i.e. Cruise Control, Leather Seats, Sunroof, etc.).
9. Click Continue at the bottom of the Optional Equipment list.
10. Now you should see various trade-in prices for the applicant's vehicle.
    a. The trade-in price that should be used as the Vehicle Equity is the one under the "Average Trade-In" column and "Price with Options" line.

Vehicle Equity - Example

An applicant has 2 vehicles. One vehicle is valued at $9,000 but the applicant owes $8,000 on this vehicle; the second vehicle is valued at $2,000 with no money owed. The "Value" is $11,000 ($9,000+$2,000). The "Amount Owed" is $8,000. Therefore, the equity is $3,000 ($11,000-$8,000) before subtracting the Protected Portion. The "Minus Protected Portion" is always $7,500. The "Amount to Use for the CICP" is $0 since $3,000-$7,500 is -$4,500. For the CICP, you cannot record negative numbers.

2. Liquid Resources

Liquid resources are resources that can be converted to cash immediately. Examples of liquid resources are: checking accounts, saving accounts, trust accounts (if funds are available immediately), the cash value of life insurance, short-term Certificate of Deposits (CD's) and partnership earnings kept in reserve. Retirement accounts and Tax Sheltered Annuities are liquid resources, if the applicant can draw funds out of the account without a penalty. Most retirement plans are subject to a penalty if the person withdrawing money is under the age of 59 ½.

For applicants with a partnership (i.e. partnership in a farm), request their Federal Income Tax Schedule K-1 and Schedule E. Schedule K-1 summarizes the total amount of cash available to all partners. Schedule E shows all partnership agreements and the amount earned by the partnership. Include that amount of cash available to the applicant in the liquid resource calculation on the application.

For applicants with a Certificate of Deposit (CD), count the principal (amount of original investment) of a CD as a resource regardless of the maturity date of the CD. All CD's should be considered liquid. The amount included should be the amount left after the penalty for withdrawal has been subtracted. If an applicant has recently cashed a CD that has reached its maturity date, count the principal in addition to the interest earned.

The following example explains how to calculate liquid resources for the CICP. An applicant has $3,000 in savings plus they can withdraw $2,000 from a Tax Sheltered Annuity without penalty. Their total liquid resources are therefore $5,000.

It should be made clear to applicants that liquid resources that can be made available without penalty must be used even if the applicants believe their savings are their "reserves".

3. Total Equity in Resources

"Total Resources" is Line 6 of the CICP Client application. This cannot be a negative number. If you get a negative number on either form, enter $0 (zero).

Section 8.07 Less Family Size Deductions

The CICP protects $2,500 in resource equity per family member on the application.

There are two steps to calculating the "Family Size Deduction:"

Step 1. Write the number of family members (including applicant) listed by the applicant in the "Household Members" section of the application in Line 7 - "Family Size".

Step 2. Multiply the family size obtained in Step 1 by $2,500. Write this amount on Line 7.

Section 8.08 Equity in Resources for the CICP

On the CICP application, Line 8 - "Equity In Resources" equals Line 6 - "Total Resources," MINUS Line 7 - "Less Family Size Deduction", If this amount is less than $0 (a negative amount), you must record $0 and not the negative amount.

Section 8.09 Total Family Financial Status

On the CICP application, Line 9 - "Total Family Financial Status" equals Line 4 - "Total Income" PLUS Line 8 - "Equity in Resources". This amount cannot be zero.

Section 8.10 Allowable Deductions (Expenses, self-declared)

The following are allowable deductions (expenses) and may be self-declared, however waivers may be granted from the Department to those providers who wish to require documentation.

1. Child support payments
2. Alimony paid by the applicant
3. Health (including dental and vision) insurance premiums
4. Daycare
5. Elderly care

The provider should request amounts paid in the past 90 days and annualize, if incurred from the application date back 365 days. **These figures do not include vacation or entertainment expenses.**

Section 8.11 Allowable Deductions (Must be documented)

The following allowable deductions must be documented:

1. Medical expenses for services received at a hospital, clinic, private physician's office and pharmacist are allowable deductions and must be documented. In addition,

allowable deductions include medical services prescribed by a physician rendered for vision, dental, durable medical equipment (DME) and pharmaceuticals.

a. Effective July 1, 2015, verifiable current monthly payments should be annualized as a deduction. Patients will be responsible for demonstrating their monthly payment amount toward outstanding bills. Bills may only be annualized up to the equivalent of 12 months of demonstrated payments. If on the current payment schedule the client will pay off the remaining balance in less than a year, then only deduct the remaining balance of the bill. Example: If a client is paying $100 a month on a bill that only has $900 remaining, then deduct $900 instead of the annualized amount of $1,200. Verifiable single payment medical expenses (copayments to non-CICP providers, prescriptions) incurred within 12 months prior to application, will be applied as a single, flat deduction.

b. The amount of medical bills if paid or outstanding from a CICP provider may not be deducted from the income if incurred within the 90 days prior to the application date. These medical bills will be received at the CICP discount to the client and cannot be included as a deduction on the application. Copayments to a CICP provider are not an allowable deduction.

2. Applicants who use their own personal vehicle in the course of performing their job may be allowed a deduction in the amount of $200 per month. The $200 per month personal vehicle use deduction should only be allowed if the applicant submits documentation from their employer which verifies the following:

   a. The applicant uses the personal vehicle in the performance of his or her job functions; and

   b. The applicant receives no reimbursement for mileage or the use of the vehicle.

Acceptable documentation is a signed and dated letter from the applicant's employer or the use of the Department's "Personal Vehicle Use Verification Form" found in Section V: Miscellaneous.

3. To calculate the deductions for Line 10 of the CICP Client application, perform the following steps:

   Step 1. Request amount paid in the previous month or previous year for allowable deductions (expenses).

   Step 2. Complete Worksheet 4 for the allowable deductions.

   Step 3. Record the Grand Total on Line 10 of the CICP Client application. Do not annualize one-time or annual payments.

Section 8.12 Net CICP Income and Equity in Resources

Line 11 determines the amount of income to use in the determination of the CICP rating. Line 11 equals Line 9 – "Total Family Financial Status" MINUS Line 10 – "Allowable Deductions."

Section 8.13 Liquid Asset Spend Down

The Liquid Asset Spend Down Provision enables applicants whose combined income and liquid resources precludes them from the CICP discount at 250% of the Federal Poverty Level. An applicant may be determined eligible if they have sufficient liquid resources to "spend down," or reduce their income enough to determine them eligible for the CICP. The amount an applicant must "spend down" is calculated as the difference between the CICP eligibility standard at 250% of the Federal Poverty Level and the applicant's income. The "spend down" reduces the amount of liquid resources available to the applicant and should be applied to the current medical bill (paid to the provider). The remainder of the medical bill is then discounted under the CICP. The client is still responsible for the CICP copayment.

Example:

Employment income of $16,000 per year

Bank account of $16,500.

Family size of 1, the Family Size Deduction is $2,500

Equity in Resources is $16,500 – $2,500 = **$14,000**

Total family financial status is $16,000 + $14,000 = **$30,000**, with no allowable deductions.

This person is currently ineligible for a CICP discount, but is unable to pay a current medical bill of $25,000.

Using the Liquid Asset Spend Down provision the client is eligible for a CICP discount at $29,425 (family size of 1, at 250% of Federal Poverty Level)

The liquid assets need to be reduced by $575 ($30,000 – $29,425 = $575).

The $575 is applied to the current medical bill of $25,000 and paid directly to the provider.

The remaining medical bill is $25,000 - $575 = **$24,425**

The client is now eligible for the CICP discount, with a total family financial status of $29,425 ($16,000 employment income and $13,425 in equity and resources).

When reporting information on the CICP Summary Spreadsheet, the provider may record the total bill of $25,000 and the client spend down of $575 as a third-party payment

ARTICLE IX. COLORADO RESIDENCY AND LAWFUL PRESENCE

Section 9.01 Colorado Resident

1. A Colorado resident is a person who currently lives in Colorado and intends to remain in the state. If the applicant is unable to provide actual proof of Colorado residency, they are **allowed to self-declare their intent to remain in Colorado**. The following questions can be used to assist in determining if the applicant is a Colorado resident:
   a. Where is the applicant's primary home? A primary home is the place of residence where a person lives and the place where that person, whenever absent, intends to return, regardless of the length of absence. A primary home cannot be a business address or a vacant lot or a post office box.
   b. Is the applicant's primary home address the same as the address on the applicant's motor vehicle registration and state income tax return? If yes, the applicant meets the CICP's residency requirements. Individuals who have recently moved to Colorado must apply for a Colorado title and registration for their vehicle within 30 days from establishing Colorado residency.
   c. Is applicant employed in the state of Colorado?
   d. Is there a current lease, mortgage bill, or utility bill for the applicant's primary home?
   e. Does the applicant have a current Colorado Driver's License or Identification Card?

Section 9.02 Residency Code

To qualify for the CICP, the applicant must be lawfully present in the United States either a U.S Citizen, a documented legal immigrant or a migrant worker, and a Colorado resident. Colorado residency is a separate determination from Lawful Presence.

The CICP has established residency codes to use with the application. The client must record one of the following residency codes for each family member.

1. Colorado Resident & U.S. citizen;
2. Colorado Resident & documented legal immigrant;
3. Migrant farm worker & U.S. citizen;
4. Migrant farm worker & documented legal immigrant;
5. Non-resident counted in family size only;
6. Health First Colorado or CHP+ eligible, counted in family size only; or
7. Counted in family size only.

If family members are non-residents (residency code - 5) or eligible for Health First Colorado (residency code 6), they cannot receive care under the CICP but can be included in family size. Family members who are eligible for CICP, but do not want to be covered under CICP may be counted in family size if they receive 50% of their support from the responsible party (residency code - 7).

Determining the CICP Residency Code

To determine which residency code to record on the application, use the three steps outlined below for each family member applying for the CICP. All applicants must meet steps 1 and 2 to comply with the CICP's residency requirements.

Step 1: Determine if the applicant is lawfully present using the guidelines listed in Section 9.03 below. If the applicant is lawfully present and is a U.S. Citizen or documented legal immigrant, go to step 2. If the applicant is not a U.S. Citizen or a documented legal immigrant, they cannot receive discounted care through the CICP, but can be used to determine family size.

Step 2: Determine if the applicant meets one of the following:

i. The applicant is a Colorado resident (see "Colorado Resident" under Section 9.01) OR

ii. The applicant is a migrant worker according to the criteria outlined under "Migrant Workers"

Step 3: Record the residency code for each family member.

Section 9.03 Lawful Presence

During the 2006 and 2007 legislative sessions House Bill 06S-1023 and HB 07-1314 were passed and directed the Department of Revenue to establish rules to ensure that recipients of public benefits demonstrate that they are legally residing in the United States. The Department of Revenue promulgated "Rules for Evidence of Lawful Presence" at 1 CCR 204-30, effective August 30, 2016. The CICP made corresponding rule changes effective September 9, 2016. The update to this section of the manual is effective as of September 9, 2016.

All applicants 18 years and older, must sign the "Affidavit for Lawful Presence, Colorado Indigent Care Program" (Affidavit) and provide a document that demonstrates they are lawfully present in the United States.

A copy of the Affidavit can be found in the application section of the CICP provider manual. In order to complete the Affidavit the applicant must do the following:

1. **Indicate Citizenship Status**. The applicant must indicate on the Affidavit whether he/she is a U.S. citizen OR whether he/she is a legal permanent resident, or otherwise lawfully present in the United States.
2. **Sign the Affidavit**. Each applicant must sign the top portion of the Affidavit and indicate that they are either a U.S. citizen, or otherwise lawfully residing in the United States. A family member or authorized representative may do this for a deceased client.

The Affidavit must be signed by each applicant within a household who is 18 years of age or older. Household members who do not apply in person must also sign the affidavit. Providers are not required to directly witness an applicant's signature. Therefore, a blank

Affidavit may be sent to a non-present applicant. The signed Affidavit may be returned to the provider by mail, fax or hand-delivered to the provider's facility.

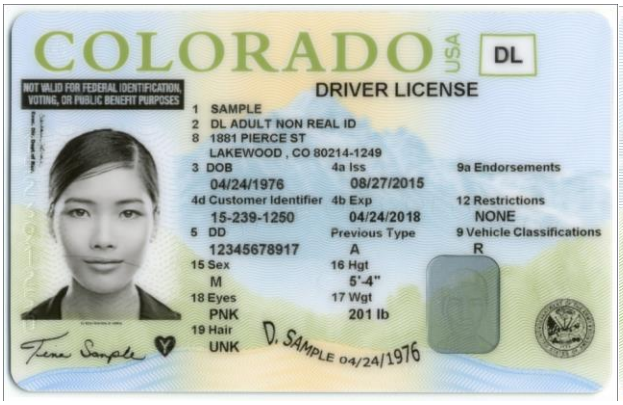
In order to prove lawful presence the applicant must do the following:

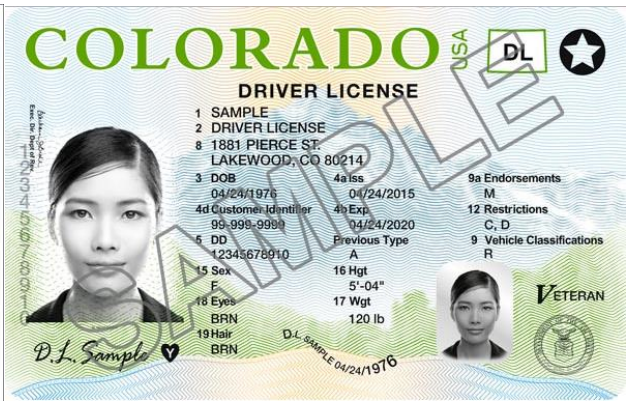
1. **Applicants Submit One Document**. To meet the lawful presence requirement, each applicant must provide one and only one acceptable document listed in Department of Revenue's rule located at 1 CCR 204-30 Rule 5, or any document listed on a Federal list of documents acceptable to establish lawful presence. No one lawful presence document is preferred over another. All are equally acceptable.
2. **Providers Establish Lawful Presence—Not Identity**. The rules pertaining to public benefits require only the establishment of lawful presence—not identity. Thus, it is not necessary for an applicant to provide a document with a photograph.
3. **Original Documents**. Lawful presence documentation may be accepted from the applicant, the applicant's spouse, parent, guardian or authorized representative in person, by mail or facsimile. In general, applicants must present original documentation. Notarized copies are not acceptable. However, providers shall accept copies of an applicant's lawful presence documentation that have been verified by other CICP providers, Medical Assistance sites, county departments of social services, or any other entity designated by the Department of Health Care Policy and Financing through an agency letter, provided that the verification identifies that the copy is from an original and that the individual who reviewed the document(s) signifies such by including their name, organization, address, telephone number and signature on the copy.

Providers shall develop procedures for handling original documents to ensure that the documents are not lost, damaged or destroyed. Providers shall develop and follow procedures for returning or mailing original documents to applicants within five business days of receipt.

Applicants must provide a Colorado Driver's License, Colorado Identification Card, Driver's License or State Identification Card issued in a REAL ID compliant state (https://www.dhs.gov/current-status-states-territories), United States Military Identification Card or Military Dependents' Identification Card, United States Coast Guard Merchant Mariner Card, Native American Tribal Document or any other document listed in the Colorado Department of Revenue rule for establishing lawful presence (http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=6860&fileName=1%20CCR%20204-30).

A sample of the new drivers license can be seen on the next page. The license on the right is acceptable to prove lawful presence for the holder. It has the star in the upper right hand corner indicates the ID is REAL ID compliant and that lawful presence has been established prior to the license being issued, whether the holder is a U.S. citizen or a non-U.S. citizen lawfully present in the country. The license on the left is not acceptable to prove lawful presence by itself, as indicated by the black box and white text above the picture on the license. There is also no star in the upper right hand corner. The new state identification card has the same format as the new drivers license.





Section 9.04 Expired or Missing Documents from Non-U.S. Citizens

1. Expired Documents or No Documents: If an applicant who is not a U.S. citizen presents expired documents or is unable to present any documentation evidencing his or her immigration status, the provider should refer the applicant to the local Department of Homeland Security office to obtain documentation of lawful presence status.
2. G-845 Document Verification Request: In unusual circumstances involving applicants who are hospitalized or medically disabled or who can otherwise show good cause for their inability to present documentation and for whom securing such documentation would constitute undue hardship, if the applicant can provide an alien registration number, the provider may file U.S.C.I.S. Document Verification Request Form G-845, along with the alien registration and a copy of any expired Department of Homeland Security document, with the local Department of Homeland Security office to verify status. To obtain the current G-845 Document Verification Request form, go to the U.S. Citizenship and Immigration Services website and enter G-845 in the search box.
3. Receipt for Replacement Document: If an applicant has lost a document and presents a receipt indicating that he or she has applied to the Department of Homeland Security for a replacement document, the provider should file U.S.C.I.S. Form G-845 and Supplement with a copy of the receipt with the local Department of Homeland Security office to verify lawful presence status.

Section 9.05 Options for Applicants without Acceptable Documentation

1. **Request Waiver from Department of Revenue (DOR):** Applying for a "Request for Waiver-Restrictions on Public Benefits" from the Colorado DOR authorizes the DOR to verify evidence of lawful presence for the applicant.

    a. **Who May Apply:** Any applicant, regardless of citizenship status, who does not provide a document permissible for establishing lawful presence may apply for a "Request for Waiver-Restrictions on Public Benefits" from the Colorado DOR.

    b. **Where to Find the Waiver Form:** For convenience, this Waiver may be found on the Department website under For Our Providers, Get Info, Colorado Indigent Care Program, Forms, "Lawful Presence Waiver".

c. **How to Apply:** The Waiver may be completed by the applicant or the applicant's representative. Applicants are not required to apply for this waiver in person. The waiver and supporting documents must be hand delivered to one of the approved driver's license offices listed on the waiver. Supporting documents may be any documents able to assist in the verification of lawful presence.

d. **Affidavit of Lawful Presence:** Applicants using the waiver process must still complete the "Affidavit of Lawful Presence, Colorado Indigent Care Program" form.

e. **Approved Waivers:** The Department of Revenue no longer notifies benefit agencies of approval or denial of waivers. Providers should require an approved waiver from Applicants before services are provided at the discount.

f. **Special Information for Non-U.S. Citizens:** Applicants requesting a waiver who are not U.S. citizens should be made aware of the following, which is excerpted directly from The DOR's "Rules for Evidence of Lawful Presence" at 1 CCR 204-30 Rule 5, effective August 30, 2016.

6.1 Each Benefit Agency is responsible for verifying that the Applicant is the same individual indicated as the person who received a Waiver.

6.2 Waivers may be cancelled by the Department, if the Department subsequently determines that the Applicant was not or is not lawfully present. Upon cancelling a Waiver, the Department will notify the Applicant and appropriate Benefit Agencies.

6.3 A person whose Waiver has been cancelled by the Department may appeal the Department's decision by requesting a hearing as provided in subsection 5.1 of this Rule within 60 days following the mailing date of the notice cancelling the Waiver.

6.4 Waivers issued by the Department since August 1, 2006, but prior to approval of this Rule, will continue in effect unless expired, or cancelled by the Department

2. **Self-Declaration of Lawful Presence**: Signing a self-declaration is a valid, acceptable way of establishing lawful presence for purposes of receiving discounted health care services under the CICP; however, the CICP Provider must first request acceptable Lawful Presence documents and it will not be necessary for the Provider to complete the shaded box on the Affidavit for Lawful Presence application.

a. **Who May Self Declare:** U.S. citizens and non-citizen nationals may self-declare that they are lawfully residing in the United States. Non-citizen nationals are defined in federal regulations as individuals from American Samoa, Swains Island, or Northern Mariana Islands.

b. **Who May Not Self Declare:** Non-U.S. citizens may not self-declare that they are lawfully residing in the country.

c. **Where to Find the Self-Declaration Form**: The Self-Declaration form is found under the optional section located at the bottom of the "Affidavit for Lawful Presence, Colorado Indigent Care Program" form.

Section 9.06 Non-Discrimination and Special Assistance

1. **Non-Discrimination:** CICP providers shall not discriminate against applicants on the basis of race, national origin, gender, religion, age or disability.
2. **Special Assistance:** If an applicant has a disability that limits the applicant's ability to provide the required evidence of lawful presence, the provider shall assist the individual to obtain the required evidence. Examples of reasonable assistance that may be expected include, but are not limited to, providing contact information for the appropriate agencies that issue required documents; explaining the documentation requirements and how the applicant may provide the required documentation; or referring the applicant to other agencies or organizations which may be able to provide assistance.

Additional assistance shall also be provided to applicants who are unable to comply with the documentation requirements due to physical or mental impairments or homelessness and who do not have a guardian or representative who can provide assistance. Examples of additional assistance include, but are not limited to, contacting any known family members who may have the required documentation; contacting any known health care providers who may have the required documentation; or contacting other social services agencies or organizations that are known to have provided assistance to the applicant.

The provider is not required to pay for the cost of obtaining required documentation. The provider shall document its efforts of providing additional assistance to the applicant and retain such documentation in the applicant's file.

Section 9.07 Administrative Procedures for Documents from U.S. Citizens

1. **Indication of Documents Verified:** Providers are to check the box on the "For Eligibility Use Only" section of the Affidavit indicating which document the applicant has provided for demonstrating evidence of lawful presence.
2. **Retain Copy of Document:** A photocopy of the lawful presence document presented should be retained in the applicant's file.
3. **Exception Process for Clients Reapplying:** If a U.S. citizen reapplies for CICP with the same provider, it is not necessary to make a new copy of their lawful presence document again if the following conditions are met:

    a. The provider verifies that the document presented at the time of renewal is identical to the copy of the lawful presence already on file;

    b. The provider makes a notation in the file that the original document was viewed again and found to be acceptable; and

    c. The provider signs and dates the notation.

This same process applies to providers who have electronically scanned client files.

This process may never be used for non-U.S. citizens. Lawful presence must be established for non-U.S. citizen clients each time they apply for the CICP.

Section 9.08 Administrative Procedures for Documents from Non-U.S. Citizens

1. **Verification of Documentation in SAVE**: Documentation submitted from applicants who have checked the second box on the "Affidavit for Lawful Presence, Colorado Indigent Care Program", indicating that they are not a U.S. citizen, must be verified through the federal Systematic Alien Verification for Entitlements (SAVE) web-based verification information system application. Providers must verify through SAVE within 30 days of receiving applications from non-U.S. citizens.

    a. **SAVE is Not for U.S. Citizens:** Only documents for non-U.S. citizens may be verified for authenticity in SAVE. It is not possible to verify documents applicable to U.S. citizens through SAVE.

    b. **Use Affidavit until SAVE Verification is Complete:** Until lawful presence is confirmed in SAVE, clients are eligible to receive discounted health care services through the CICP if they have signed the Affidavit stating that they are lawfully present in the United States.

    c. **No Match Found in SAVE**: In cases where a match in SAVE is not initially verified, yet the client asserts that they are legally residing in the country, the provider should begin the manual SAVE process and conditionally accept the client until status is confirmed or denied in SAVE. This provisional period of eligibility should be granted for not less than one month, but not more than three months. The length of the provisional acceptance is at the discretion of the provider. The provider shall take into consideration any known special circumstances of the client when setting the length of the conditional eligibility period. The provider should make the client aware of any information obtained through the SAVE process.

    d. The SAVE program also requires participating agencies, institutions and other entities to use manual verification when directed by an VIS/CPS system message or when the automated check or initial inspection of an applicant's/recipient's documentation, or information provided from such documentation, reveals material discrepancies. To conduct a manual verification, user agencies complete the Document Verification Request (Form G-845), attach copies of the non-citizen's immigration documentation, and mail it to their local immigration status verification office. Providers in Colorado would mail documents and form to: U.S. Citizenship and Immigration Services, 300 N. Los Angeles Street, B120, Los Angeles, CA 90012, Attention: Immigration Status Verification Unit. Once the immigration status verification office receives and processes the Form G-845, it is returned to the User Agency via the U.S. Postal Service.

2. **Indication of Documents Verified**: Providers are to check the box on the "For Eligibility Use Only" section of the Affidavit indicating which document the applicant has provided for demonstrating evidence of lawful presence.
3. **Retain Copy of Document:** A photocopy of the lawful presence document presented and used in the SAVE search should be retained in the applicant's file.
4. **Retain Copy of SAVE Documentation:** Providers should print the Verification Result Screen from the SAVE search and retain this printout in the applicant's case file. The provider should make the client aware of any information obtained through the SAVE process and note such in the application file.

Section 9.09 U.S. Citizen

A U.S. citizen is a person who has signed the Affidavit of Lawful Presence, checking the line indicating that he/she is a U.S. citizen and provides one acceptable document for proving evidence of lawful presence following Department of Revenue's rule located at 1 CCR 204-30 Rule 5.

Section 9.10 Documented Immigrants

Documented immigrants are people who reside in the United States, possess a Social Security Number, and one of the lawful presence documents listed in Department of Revenue's rule located at 1 CCR 204-30 Rule 5.

Section 9.11 Migrant Workers

Migrant workers and all dependent family members must meet all of the following criteria to comply with CICP residency requirements:

1. Do not live permanently in Colorado; temporary living in Colorado for employment reasons;
2. Meet lawful presence requirements; and
3. Employed in Colorado. Must have letter of employment.

Eligibility is extended to dependent family members of migrant workers when the residency requirements are met for the CICP including: if the family members establish a temporary home in Colorado and meet U.S. citizenship OR meet established immigration documentation requirements. Requirement number three may not be applicable to all family members.

ARTICLE X. APPLICANTS NOT ELIGIBLE FOR THE CICP

Section 10.01 Applicants Not Eligible for the CICP

1. Applicants for whom lawful presence cannot be verified.
2. **An applicant in custody of a law enforcement agency**. An applicant is not eligible when they are serving time for a criminal offense or confined involuntarily in a City, County, State or Federal prison, jail, detention facility, or other penal facility. This includes individuals who are being involuntarily held in detention centers awaiting trial, and involuntarily residing at a wilderness camp under any type of governmental control. Even if the medical condition is considered "pre-existing" prior to incarceration, once the applicant is held involuntarily under any type of governmental control they are not eligible for CICP.

    a. Prior to Incarceration: The applicant is eligible for CICP. If an applicant has been convicted of a crime but has not reported to the penal facility to start their sentence, the applicant remains eligible for CICP.

    b. Parole or Probation after Incarceration: An applicant on parole or probation is eligible for CICP. An applicant who is living in a halfway house is eligible for CICP if they have freedom of movement and association. Residents from all halfway houses in Colorado are eligible for CICP except for those residing at Gateway: Through the Rockies.

    c. Applicants on parole must present documentation of their parole status.

    d. CICP funds cannot be used to provide for medical care that the state, city, or county should otherwise be responsible for.

3. College students from outside Colorado or the United States who are in Colorado for the purpose of higher education. These students are not Colorado residents and cannot receive services under the CICP.
4. Visitors from other states or countries temporarily visiting Colorado who have primary residences outside of Colorado.
5. Persons who qualify for Health First Colorado or CHP+

ARTICLE XI. HEALTH INSURANCE

Applicants with other medical insurance may still qualify for CICP. Therefore, applications should be completed for applicants with other medical insurance. In some cases, other medical insurance may not cover certain medically necessary benefits or applicants may have used all of their benefits. Applicants may not know if their other medical insurance will cover certain charges until after the CICP application time limit of 90 days has expired. Charges for services received up to 90 days prior to application, or in the case of applicants with other health insurance coverage, when the third-party payer has adjudicated claim, can be reported to the CICP. Applicants cannot be denied CICP if they have other insurance, and **it is the responsibility of the provider's collection/claims office to bill all other medical insurance companies first before reporting the charges to CICP.**

Section 11.01 Health Insurance

Obtain all information related to the insurance policy and attach a copy of the policy or insurance card to the application. Required information includes the name of the insurance company, the address where the medical claim forms must be submitted, policy number and any other information determined necessary. The clinic or hospital will bill the commercial health insurance policy first for all medical expenses incurred. Unpaid medical expenses will be billed to the CICP minus the health insurance copayment or the CICP copayment, whichever is lower.

Providers can report contractual write-offs required under some commercial health insurance contracts in total charges and are only required to report payments due from the commercial health plan in third-party liability. Client liability is the payment due from third-party insurance, including Medicare. This is not payments actually received, but the amount owed by the client's primary insurance. CICP will reimburse for contractual adjustments; therefore, do not include these adjustments as liabilities or as payments due.

If an applicant receives **Veterans Benefits** they may also receive CICP benefits provided that the following is met:

- Recipient is unable to receive a specific medical service or treatment from the Veterans Administration (VA);
- Veterans Benefits have been verified. Call 1-877-222-8387 to verify health benefits; and
- If the veteran has primary insurance they must utilize this first. The VA requests that a veteran not utilize their Veterans Benefits if they have primary insurance.

Veterans receiving authorized services from a CICP provider cannot be charged an additional CICP copayment after VA reimbursement.

Examples of Primary Insurance:

- Group Health Insurance
- Military Health Insurance
- Medicare
- Workers' Compensation
- Veterans Benefits
- HMO
- Health First Colorado
- COBRA
- Other commercial health plans

ARTICLE XII. CICP RATING

The CICP rating determines a family's copayments and the client's annual copayment cap. CICP ratings are effective for one year from the date of the rating; unless the client's financial situation changes or the rating changes is issued due to a provider management exception.

The "CICP Rating Box" is where you record the CICP letter rating or "Denied" for the applicant. You must assign a rating or denial and notify the applicant of his/her status within five working days of the applicant completing the application.

The denial letter should include a statement informing the applicant that he/she has 15 days to appeal the rating. The denial letter should clearly identify to whom the letter is addressing, with an address and phone number of the person the applicant should contact regarding the appeal. Family members receiving CICP discounted services under the same application all have the same CICP rating.

CICP ratings are usually effective for 12 months from the date of the application. Extenuating circumstances sometimes requires that the rating be effective for a shorter period of time. When a client is rated for a period less than 12 months, it is the responsibility of the primary rating provider to perform the re-rating within the specified time.

Section 12.01 Determining the CICP Rating

To determine the CICP rating, complete the following steps:

On the CICP "Ability to Pay Scale" locate the appropriate family size corresponding to the family size recorded on Line 11 of the application.

Slide across the CICP "Ability to Pay Scale" until you find the range where the amount on Line 13 - "Grand Total Net CICP Income" of the application falls. The letter rating at the top of this column is the family's CICP rating.

The letter codes mean the following:

> **N** = 40% of the Federal Poverty Level (FPL) before qualified deductions. Families rated at this level should be referred to Health First Colorado before CICP is considered.
>
> **A, B, C, D, and E** = Families 133% of FPL before qualified deductions should be referred to Health First Colorado.
>
> Women rated at the **D** and **E** level and **who are pregnant are possibly eligible for Health First Colorado or other entitlement programs**. Refer those women to Health First Colorado and require them to have a denial letter prior to participating in the CICP.

F, G, H, and I = Families not eligible for Health First Colorado. However, children and pregnant women age 19 and over should be referred to CHP+.

Z = Applicants at or below 40% of FPL with the following conditions: Homeless individuals, or individuals living in transitional housing designed to promote self-sufficiency, or individuals who have no permanent residence of their own and are temporarily residing with others who have no legal obligation to financially support them, or recipients of Colorado's Aid to the Needy Disabled financial assistance program. There is no copayment required for this rating. Applicant should be referred to Health First Colorado prior to approval for CICP.

Record the family's CICP rating in the "CICP Rating" box of the application. If the family does not qualify for the CICP, write "Denied" in the "CICP Rating" box of the application.

Give the family a copy of the completed application.

Section 12.02 Client Re-rate

Clients are re-rated due to specific situations or household changes. Client re-ratings affect only future charges. Therefore, bills incurred after the initial rating but prior to the re-rating are discounted based on the client's initial rating.

When clients request a re-rating and can document that their circumstances have changed since the initial rating, you must re-rate them. Reasons for a re-rating to occur may include one or more of the following:

1. Family income has changed significantly;
2. Number of dependents has changed;
3. An error in the calculation; OR
4. The year rate has expired.

ARTICLE XIII. CLIENT COPAYMENT

Section 13.01 Client Annual Copayment and Cap

For all client ratings except the N-rating, annual copayments for CICP clients cannot exceed 10% of the family's "Grand Total Net CICP Income," recorded on Line 13 of the application. Annual copayments for clients with N-ratings can be up to, but cannot exceed, $120. The CICP Client Annual Copayment Cap (annual cap) is based on the client's application date. Only copayments that have been paid can be applied to the copayment cap. Clients are responsible for any charges incurred prior to receiving their CICP rating. Clients are responsible for tracking their copayments and informing the provider in writing (including documentation) when they meet their annual cap. However, if clients overpay their annual cap and inform the provider in writing, the provider's facility must reimburse the client for the amount overpaid. The client's annual cap is reset when the client completes a new application.

Annual caps apply to charges incurred only after a client is eligible for the CICP, and apply only to services incurred at a CICP provider. For example: A client received services from a provider's facility in March and did not qualify for the CICP. In November, the client receives services from a provider's facility and does qualify for the CICP. Payments made by the client for the services received in March do not apply to the annual cap.

Sometimes clients want to prepay their annual cap prior to receiving services. The Department does not support this practice because if the client does not incur charges equal to the prepaid copayment cap, the provider's facility will need to refund the overpayment to the client.

Section 13.02 Calculating the CICP Client Copayment Annual Cap

To calculate the "CICP Client Copayment Annual Cap," multiply Line 13 of the application by 0.10 (10%). (Do not round Line 13 up to the next highest dollar amount.) Enter this amount on the "Client Copayment Annual Cap" Line in the Client Copayment box

Example: In February, a family of four applies for the CICP. Their "Net CICP Income," Line 13, is $32,000. Their CICP rating is "F." Their CICP annual cap is $3,200 ($32,000 x 0.10). By July, the family has paid $2,700 in copayments. The mother loses her job in June, so the family can request to be re-rated. Although the client is eligible for a new rating, the copayments already paid will not count towards the new CICP copayment cap.

Section 13.03 Client Copayments General Policies

CICP clients are responsible for paying a portion of their medical bills. The client's portion is called the "client copayment." CICP providers must charge each CICP client a copayment (unless the client is a "Z" rating). The Department recommends that CICP providers require clients to pay their copayment prior to receiving care (except emergent care). For the CICP, there are different copayments for different service charges. The following information explains the different types of medical care charges and the related client copayments:

1. The **Inpatient Facility** copayment is required for charges related to non-physician (facility) services incurred while receiving care in a hospital for a continuous stay of 24 hours or longer. For a patient seen in the hospital setting, only the hospital inpatient or emergency room copayment, plus the physician copayment can be charged. The emergency room copayment covers all services received while in the emergency department.
2. **Ambulatory Surgery** copayment is for operative procedures received by a client who is admitted to and discharged from the hospital setting on the same day.
3. The **Inpatient and Emergency Room Physician** copayment is required for charges related to services provided directly by the physician in the hospital setting, including emergency room care.
4. The **Clinic** copayment is required for charges related to non-physician (facility) **and** physician services received in the clinic setting. This includes charges for primary and preventive medical care. It does not include charges for outpatient services provided in a hospital (i.e., emergency room care, outpatient surgery, radiology). If labs or x-rays are performed in the clinic, the additional lab or radiology copayment can be added.
    - For example, if a CICP client with an A rating was seen in the emergency department and had lab work done, the client would owe the $25.00 emergency room copayment plus the physician copayment of $35.00. If the same CICP client with an A rating was seen in the Provider's primary care clinic and not the emergency room and had lab work done, the client would owe the $15.00 outpatient clinic copayment plus the $10.00 laboratory services copayment.
5. The **Emergency Room** copayment is required for charges related to non-physician (facility) services incurred while receiving care in the hospital setting for a continuous stay of less than 24 hours.
6. **Specialty Outpatient Clinic** copayment is required for charges related to non-physician (facility) **and** physician services received in the specialty outpatient clinic setting, but does not include charges for outpatient services provided in the hospital setting (i.e., emergency room physician, ambulatory surgery). Specialty outpatient charges include distinctive medical care (i.e., oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventative medical care.
7. **Prescription** copayment is required for prescription drugs received at a qualified CICP health care provider's pharmacy.
8. **Laboratory Services** copayment is required for charges related to laboratory tests received by the client that are not associated with an inpatient facility or hospital outpatient charge during the same period. (clinic providers)
9. **Radiology and Imaging Services** copayment is required for charges related to radiology and imaging received by client in the clinic or specialty outpatient setting, but does not include charges from outpatient or inpatient services provided in the hospital setting.

10. **Inpatient Facility** copayment is required for charges related to a Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Positron Emission Tomography (PET), Sleep Studies, Catheterization Laboratory (cath lab or other Nuclear Medicine services in an Outpatient setting.
11. The **Emergency Transportation** copayment is required for charges related to emergency transportation/ambulance services from CICP providers approved to discount such services.
12. **Z-Rating** is no longer limited to only homeless clients. The Z-Rating encompasses clients who are at or below 40% of the Federal Poverty Level (qualify for an N-Rating) and are homeless, living in transitional housing, temporarily residing with others, or recipients of Colorado's Aid to the Needy Disabled financial assistance program.
    - Clients with a Z-Rating are exempt from client copayments.
    - Homeless patients are exempt from the income verification requirement, and providing proof of residency when completing the CICP application.
    - Transitional housing clients are clients who are participating in programs designed to assist individuals in becoming self-supporting. Clients living in transitional housing must provide a written statement from their counselor or program director asserting that they are participating in a transitional housing program. Transitional housing clients are exempt from client copayments. In addition, transitional housing clients are exempt from the income verification requirement when completing the CICP application.
    - Clients who have no permanent housing of their own and who are temporarily living with a person who has no legal obligation to financially support the client are exempt from client copayments. The individual allowing the client to reside with him or her may be asked to provide a written statement confirming that the client is not providing financial assistance to the household and that the living arrangement is not intended to be permanent. Clients residing with others are exempt from the verification of denied Health First Colorado benefits requirement when completing the CICP application. Clients residing with others are NOT exempt from the income verification requirement.
    - Recipients of Colorado's Aid to the Needy Disabled (AND) financial assistance program who are eligible and enrolled to receive the monthly grant award are exempt from client copayments. In addition, recipients of Colorado's Aid to the Needy Disabled (AND) financial assistance program are exempt from the income verification when completing the CICP application. The majority of applicants in this category should qualify for the Expansion Health First Colorado program.

Section 13.04 Determining a Client's Copayment

Using the client rating recorded in the "CICP Rating Box," look up the corresponding rating on the "CICP Client Copayment Table". The copayment amount is listed by service.

Section 13.05 Responsible Party Signature

The responsible party listed on the first line of the application must sign the application within 90 days of the date of service. If an applicant is unable to sign the application or has died, a spouse, relative or guardian can sign the application. CICP Providers can sign the application on behalf of deceased patient, only as the last remedy. An unsigned application means the application has not been completed, the applicant cannot receive a discount for services under the Program, and the applicant has no appeal rights. The application ***must be completed before the responsible party can sign***.

The prospective client has 15 days to provide requested information. The application completion process must be completed within 45 days. If requested documentation is not provided by the applicant, the provider has the right to deny CICP eligibility. The applicant has a right to obtain a copy of the completed application.

Section 13.06 CICP Policy on Fraudulent Applications

Clients should be notified of the following State Statutes prior to signing the CICP application:

Any person who represents that any medical service is reimbursable or subject to payment under this article when he or she knows that it is not and any person who represents that he or she is eligible for assistance under this article when he or she knows that he or she is not commits a class 2 misdemeanor and shall be punished as provided in section 18-1.3-501, C.R.S.

C.R.S. 18-5-102 – Forgery

1. A person commits forgery, if, with intent to defraud, such person falsely makes, completes, alters, or utters a written instrument which is or purports to be, or which is calculated to become or to represent if completed:
    a. A written instrument officially issued or created by a public office, public servant or government agency.

2. Forgery is a class 5 felony.

C.R.S. 18-1.3-401 Felonies classified - presumptive penalties

Class 5 Felonies carry a minimum sentence of one-year imprisonment up to a maximum sentence of three years imprisonment with a mandatory period of parole of two years. In addition, a minimum fine of one thousand dollars up to a maximum fine of one hundred thousand dollars may be imposed.

C.R.S 18-5-114 - Offering a false instrument for recording

1. A person commits offering a false instrument for recording in the first degree if, knowing that a written instrument relating to or affecting real or personal property or directly affecting contractual relationships contains a material false statement or material false information, and with intent to defraud, he presents or offers it to a public office or a public employee, with the knowledge or belief that it will be

registered, filed, or recorded or become a part of the records of that public office or public employee.

2. Offering a false instrument for recording in the first degree is a class 5 felony.
3. A person commits offering a false instrument for recording in the second degree if, knowing that a written instrument relating to or affecting real or personal property or directly affecting contractual relationships contains a material false statement or material false information, he presents or offers it to a public office or a public employee, with the knowledge or belief that it will be registered, filed, or recorded or become a part of the records of that public office or public employee.
4. Offering a false instrument for recording in the second degree is a class 1 misdemeanor.

Reporting fraud is the responsibility of the provider who completed the CICP application for the implicated client.

If a provider is notified that a client has possibly committed fraud on a CICP application, that provider is responsible for notifying the District Attorney of the client's county of residence, in writing. The provider should not turn over the CICP application, medical records or billing records without a direct request from the District Attorney. The CICP application is property of the State, stored and maintained by the provider. If the District Attorney requests the CICP application, that application and all supporting documentation must be provided.

If the provider is notified that a client has possibly committed fraud on a CICP application, but that provider did not complete the CICP application, that provider is responsible for notifying the CICP provider who did complete the application of the report. That notification should be in writing.

The Department should be copied on all correspondence. The Department has been directed to assist all inquiries from the District Attorney, but will not submit any formal request for an investigation to the District Attorney. There is no State Agency with the authority to investigate fraud on the CICP application.

Once the provider has notified the District Attorney, the provider is not responsible for any further action unless requested by the District Attorney or the Department.

If the provider receives any reimbursement on a claim previously reimbursed by the CICP due to fraud, or any other reason, the provider must notify the Department in accordance with the CICP Manual. (See Section II: Data Collection, Article VI. - Previously Charged Claim Adjustments).

ARTICLE XIV. APPEAL PROCESS

Section 14.01 Re-rating

To re-rate a client, you must complete a new CICP application.

Sometimes even though clients' financial situations may not have changed, they feel their initial ratings do not accurately reflect their current financial situations. The CICP has several methods for changing a CICP client's initial rating. The methods are listed in order below:

1. Provider Management Appeal
2. Provider Management Exception

Section 14.02 Instructions for Filing an Appeal

You must inform the client that they have the right to appeal if they are not satisfied with the rating. All appeals must be handled at the provider level. For example, the client must receive a written denial for a Provider Management Appeal and Provider Management Exception. A client can request a Provider Management Appeal and/or exception in the same letter. Each of these methods requires the client to submit a written request and provide documentation supporting the reasons for the request.

Section 14.03 Provider Management Appeals

A Provider Management Appeal means that an eligibility technician at your facility has found that the client's initial rating was inaccurate. Provider Management Appeals can result in higher or lower ratings depending on the documentation. A client has 15 days from the date of completing the application to request a Provider Management Appeal. If this time frame is not met and there was not a death in the client's immediate family, you do not have to review a Provider Management Appeal. However, please notify the client that the Provider Management Appeal was denied because the client did not submit the request by the deadline.

A client can request a Provider Management Appeal for the following reasons:

1. The initial rating contains inaccurate information or miscalculations because the family member or representative was uninformed, OR
2. Miscommunication between the client and the rating technician caused incomplete or inaccurate data to be recorded on the application.

Each provider must designate a manager to review client appeals and grant management exceptions. A Provider Management Appeal involves receiving a written request from the client and reviewing the application completed by the rating technician, including all back-up documentation, to determine if the CICP application is accurate. Your facility must notify clients in writing of the results of Provider Management Appeals within 15 working days of receipt of the appeal request from the client.

If the designated manager finds that the initial application is not accurate, the designated manager must correct the application and assign the correct rating to the client. The correct rating is effective retroactive to the initial date of application. This means that

charges incurred 90 days prior to the initial date of application must be discounted. If the initial application is accurate, the designated manager may grant a management exception to the client.

Section 14.04 Provider Management Exception

A Provider Management Exception means that the client has an unusual circumstance, which may justify the lowering of the CICP rating. **Provider Management Exceptions should not be used for applicants who do not qualify for the CICP because their resources exceed the limit (as an example, applicants earning $100 over income limit).** Clients can either request Provider Management Exceptions when requesting a Provider Management Appeal or within 15 days from receipt of a Provider Management Appeal notice. If this time frame is not met, the provider does not have to review the Provider Management Exception request. However, please notify the client in writing that the Provider Management Exception was denied because the client did not submit the request by the deadline.

Your facility must notify clients in writing of the results of Provider Management Exceptions within 15 working days of receipt of the exception request from the client.

Designated managers can authorize a three-month exception to a client's rating based on unusual circumstances. After the 90-day period ends, the client must be re-rated. You must note Provider Management Exceptions on the application and the designated manager must initial the application. The number of Provider Management Exceptions granted by a provider cannot exceed 5% of all ratings performed. Providers must treat clients equitably in the Provider Management Exception process.

Ratings from a Provider Management Exception are effective retroactive to the initial date of application. This means that charges incurred 90 days prior to the initial date of application must be discounted. CICP providers do not need to honor exceptions made by other CICP providers.

Section 14.05 Department Appeals

The Department has determined that the CICP is NOT a "covered entity" under the Health Insurance Portability and Accountability Act of 1996 privacy regulations (45 C.F.R. Parts 160 and 164). Because the CICP is not a part of Health First Colorado, and its principal activity is the making of grants to providers who serve eligible persons who are medically indigent, CICP is not considered a covered entity under HIPAA. The state personnel administering the CICP will provide oversight in the form of procedures and conditions, to ensure funds provided are being used to serve the target population, but **will not be significantly involved in any health care decisions involving a qualified health care provider or client.**

HIPAA prevents the Department from being involved in client issues due to the Personal Health Information (PHI) clause. Each provider should establish procedures at their facility that sets forth the manner for handling appeals. The applicant should also be notified of these procedures.

ARTICLE XV. APPENDIX

Section 15.01 Health First Colorado Programs and Child Health Plan (CHP+)

Health First Colorado is a state and federally funded program that pays for medical services for low-income families and individuals. Health First Colorado is a program for the categorically needy, meaning that an individual or family must fall below a certain income/resource limit.

CHP+ is a public health insurance for low-income children ages 18 and under and pregnant women. CHP+ is a program for applicants who are not eligible for Health First Colorado due to income limits, and must not have other health insurance.

Providers must screen CICP applicants for Health First Colorado eligibility and CHP+ prior to assigning a CICP rating. This is beneficial for both providers and applicants because under Health First Colorado and CHP+ providers receive higher reimbursement and applicants receive more benefits and may have lower copayments. The Provider Compliance Audit requires verification that the applicant was determined "not categorically eligible" for Health First Colorado or CHP+.

Section 15.02 Denial of Health First Colorado or CHP+ Eligibility

If the applicant appears to meet the eligibility criteria for CHP+ or any of the Health First Colorado eligibility categories, a denial letter from CHP+ or the local county Department of Human or Social Services must be received.

A letter from CHP+ or the local county Department of Human, Medical Assistance Site or Social Services indicating voluntary withdrawal or denial due to refusal to submit complete documentation is not sufficient proof that the applicant has applied for CHP+ or Health First Colorado and been denied.

Section 15.03 CICP Eligibility and Other Health Programs

The table below illustrates what program categories can be used in conjunction with CICP.

Children's Programs	Description of Programs	Federal Poverty Level	CICP Eligibility	Effective Date:
Child Health Plan Plus (CHP+)	Low-cost health insurance for children under 19. Enrollment fees may apply	250% FPL	No	First day of month of CHP+ application.
CHP+ Presumptive Eligibility (PE)	Access to immediate temporary medical coverage for children, for at least 45 days while eligibility for full health care benefits is determined.	250% FPL	No	N.A.

Children's Programs	Description of Programs	Federal Poverty Level	CICP Eligibility	Effective Date:
Health First Colorado Presumptive Eligibility (PE)	Access to immediate temporary medical coverage for children, for at least 45 days while eligibility for full health care benefits is determined.	133% FPL	No	N.A.
Children with low-income	Health First Colorado coverage for children under 19.	133% FPL	No	Backdates up to 90 days from application date. First day of the month of application, if no backdates are requested. Five year ban lifted as of 7-1-14.
Children with Disabilities	Under age of 19; meet Social Security Administration definition of disability. Premium amounts may apply.	300% FPL	No	Backdates up to 90 days from application date. First day of the month of application, if no backdates are requested.
Foster Care	Covers persons less than 21 years of age for whom a county is assuming full or partial financial responsibility; who are in foster care, in homes or private institutions, or in subsidized adoptive homes prior to the final decree of adoption.	N.A.	No	N.A.
Former Foster Care	Health First Colorado coverage to age 26 for youth who have aged out of foster care who were not adopted and who did not emancipate prior to turning 18.	N.A.	No	N.A.

Pregnant Women Programs	Description of Programs	Federal Poverty Level	CICP Eligibility	Effective Date
CHP+	Low-cost health insurance for pregnant women. Enrollment fees may apply.	250% FPL	No	First day of month of CHP+ application.
CHP+ Presumptive Eligibility	Access to immediate temporary medical coverage for pregnant women for at least 45 days, while eligibility for full health care benefits is determined.	250% FPL	No	N.A.
Health First Colorado Presumptive Eligibility (PE)	Immediate temporary Health First Colorado coverage for pregnant women.	185% FPL	No	N.A.
Health First Colorado	Health First Colorado coverage for pregnant women.	185% FPL	No	Backdates up to 90 days of application.

Health First Colorado Programs for Adults	Description of Programs	Federal Poverty Level	CICP Eligibility	Effective Date
Transitional Medical Assistance	Ineligible for Health First Colorado because new or increased income from employment, or hours of employment, provided an employed member of family continues to be employed.	185% FPL	No	Begins first month of ineligibility for Health First Colorado due to change in income.
Transitional Medical Assistance (4 Month Extended)	Ineligible for Health First Colorado because alimony income	185% FPL	No	Begins first month of ineligibility for Health First Colorado due to change in income.

Health First Colorado Programs for Adults	Description of Programs	Federal Poverty Level	CICP Eligibility	Effective Date
Caretaker of Dependent Children	Adults age 19 through 64. Must have dependent child in home.	133% FPL	No	Backdates up to 90 days of Health First Colorado application.
Health First Colorado for Adults	Adults age 19 through 64 without a dependent child in the home.	133% FPL	No	Backdates up to 90 days from Health First Colorado application.
Buy-In Program for Working Adults with Disabilities	If you work and earn too much to qualify for Health First Colorado you may qualify. Monthly premium is based on income.	450% FPL	No	Backdates up to 90 days from Health First Colorado application

Senior Adult Programs	Description of Programs	Federal Poverty Level	CICP Eligibility	Effective Date
Old Age Pension (OAP)- A and B)-Medical	Disabled or over 65. Financial payment entitles clients for a category of Medical Assistance, either Health First Colorado or Health Care Program.	76.9% FPL	No	Backdates up to 90 days from Health First Colorado application. Health First Colorado denial due to sponsor's income is required.
Old Age Pension (OAP-State Only) and HCP-B State Only	Not eligible for Health First Colorado.	76.9% FPL	Yes	Eligibility begins date of application or date eligibility is established, whichever is later.

Medicare Savings Programs (MSP)	Description of Programs	Federal Poverty Level	CICP Eligibility	Effective Date
Specified Low-Income Medicare Beneficiary Program (SLMB)	Age 65 or older or disabled, limited financial resources and income, State pays percentage of premium of Part B.	120% FPL	Yes	Backdates up to 90 days from application.
Qualified Individual Program (QI1)	Individuals must apply every year; does not qualify for any Health First Colorado program; State pays Part B premium.	120-135% FPL	Yes	Backdates up to 90 days from application.
Qualified Medicare Beneficiary Program (QMB)	State pays 20% Medicare Part B co-insurance.	100% FPL	Yes	Effective 1st day of month following the month of eligibility determination.
Medicare-Health First Colorado – QMB (Dual Eligibles)	65 years or older, or disabled, status under Social Security or Railroad Retirement assistance with Medicare premiums and out of pocket Health First Colorado expenses.	100% FPL	No	Effective 1st day of month following the month of eligibility determination.
Long-term Care	65 years or older, blind, or disabled people on SSI.	100% FPL	No	Backdates up to 90 days from application.
HCBS & Nursing Home Patients	Disabled individuals needing long-term care.	300% of Supplemental Security Income Level.	No	N.A. (Can be on wait-list for up to 5 years).