

Colorado Indigent Care Program Manual

Fiscal Year 2017-18

Section IV: Application

Effective July 1, 2017



COLORADO
Department of Health Care
Policy & Financing

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CICP

Colorado Indigent Care Program

CLIENT APPLICATION Hospitals and Hospital Based Clinics

Section I: APPLICANT

Homeless: _____

Today's Date: _____

Emergency Application: _____

Last Name		First Name			Middle Initial	
Address		City		Zip Code	County	Phone Number
List Household Members	Dependent Code	Date of Birth	Health First CO Number	Social Security Number	Residency Code	Health First CO/CHP+ Ineligibility Codes
1. APPLICANT						
2.						
3.						
4.						
5.						
6.						
7.						

Section II: Calculating Income

Income Source	Monthly Income	Annualized Total
1. Gross Employment Income	\$ _____	\$ _____
2. Unearned Income	\$ _____	\$ _____
3. Self-Employment Income	\$ _____	\$ _____
4. Total Income (Lines 1 + 2 + 3)	\$ _____	\$ _____
5. Total Liquid Resources	\$ _____	
6. Household Size Protected Amount	Household Size: _____ X _____ = \$ _____	
7. Available Resources (cannot be negative)	\$ _____	

8. Total Household Financial Status (Lines 4 + 7)	\$ _____
9. Allowable Deductions (See Worksheet 3)	\$ _____
10. Net Household Financial Status (Lines 8 - 9)	\$ _____
11. Liquid Asset Spend Down	\$ _____
12. Grand Total Net CICIP Income (Lines 10 - 11)	\$ _____

FPL Percentage: _____ **Client Copayment Annual Cap (Line 12 times percentage chosen):** \$ _____

PENALTY CLAUSE, CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the information provided to complete this application is true. I understand that if I make false statements on this application, I commit a Class 5 Felony. In addition, misrepresenting my eligibility for assistance under this program is a Class 2 Misdemeanor (26-15-112, C.R.S.). I authorize the provider to use any information contained in the application to verify my eligibility for assistance under this program, and to obtain records pertaining to eligibility from a financial institution as defined in section 15-15-201(4), C.R.S., or from any insurance company. I understand that the provider has a right to obtain any recovery or right of recovery for a patient who would have a right of recovery. This means that if I am found to have a claim for any benefits payable for any treatment, which is given, while I am eligible for assistance under this program that the provider has the right to be included in the claims process. If applicable, I understand that legal immigrants receiving assistance under this program shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997. **I understand it is my responsibility to notify the provider of an income or household change that may influence the rating on this application and failure to do so voids this application.**

YOU HAVE 15 DAYS TO APPEAL YOUR CICIP ELIGIBILITY DETERMINATION
 (Ask your eligibility technician for more information on the appeal process)

_____ Print Applicant Name	_____ Applicant Signature and Date
_____ Print Eligibility Technician Name	_____ Eligibility Technician Signature and Date
_____ Print Facility Name	_____ Facility Phone Number

Application Notes:

Section 1.02 Ineligibility Code Legend

Dependent Codes

1. Self
2. Spouse/Civil Union Partner
3. Minor
4. Senior
5. Adult Student
6. Other

Residency Codes

1. Colorado Resident & U.S. Citizen
2. Colorado Resident & Lawfully Present
3. Migrant Farm Worker & U.S. Citizen
4. Migrant Farm Worker & Lawfully Present
5. Counted in Household Size Only

Medicaid/CHP+ Ineligibility Codes

- A. Has the Applicant Received a Medicaid/CHP+ Denial Letter?
- B. Applicant is not a U.S. Citizen, has not been a legal resident for at least 5 years, or does not have refugee status
- C. Transitional Medical Benefits have been discontinued
- D. Over Income for Medicaid and is:
 - a. **NOT A CHILD**
 - b. **NOT PREGNANT**
 - c. **NOT DISABLED**
- E. Has Primary Insurance - NOT Eligible for CHP+
- F. **Other - Provide a brief Explanation**

[illegible]

Annual or One Time Income Sources:Documented Self-Declared

_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>

Earned Income Total \$ _____ \$ _____

Unearned Income Total \$ _____ \$ _____

Total Income \$ _____ \$ __________
Applicant Signature_____
Date_____
Eligibility Technician Signature_____
Date_____
Facility_____
Phone

Rev July 2017



CICP

Colorado Indigent Care Program

Worksheet 2 - Net Self-Employment Income

	<u>Monthly</u>	<u>Annualized</u>
<u>Revenue:</u>		
Gross Business Income	\$ _____	\$ _____
<u>Business Property Expenses:</u>		
Mortgage/Rent of Business Property	\$ _____	\$ _____
Utilities	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
<u>Other Expenses:</u>		
Advertising	\$ _____	\$ _____
Business Phone	\$ _____	\$ _____
Business Taxes (non-personal)	\$ _____	\$ _____
Fuel for Business-related Travel	\$ _____	\$ _____
Gross Wages	\$ _____	\$ _____
Insurance	\$ _____	\$ _____
Legal Fees	\$ _____	\$ _____
License/Certification Fees Paid	\$ _____	\$ _____
Merchandise/Cost of goods	\$ _____	\$ _____
Office Supplies	\$ _____	\$ _____
Repairs/Upkeep of Equipment	\$ _____	\$ _____
Tools/Equipment	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
Day Care Provider Reductions (if applicable)	\$ _____	\$ _____

Monthly

Annualized

Total Expenses: \$ _____ \$ _____

Total Expenses Attributed to Business: \$ _____ \$ _____

Net Profit \$ _____ \$ _____

(use this figure on
line 3, Section II of
the CICP Application)

Applicant Signature

Date

Eligibility Technician Signature

Date

Facility

Date

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Worksheet 3 - Allowable Deductions

[illegible]

Applicant Signature

Date _____

Eligibility Technician Signature

Date _____

Facility

Phone

Worksheet 4 - Liquid Resources - HOSPITAL AND HOSPITAL BASED CLINIC USE ONLY

Liquid Resources

[illegible]

Applicant Signature

Date _____

Eligibility Technician Signature

Date _____

Facility

Date _____

**CICP**

Colorado Indigent Care Program

**CLIENT APPLICATION
Clinics****Section I: APPLICANT**

Homeless: _____

Today's Date: _____

Emergency Application: _____

Last Name		First Name			Middle Initial	
Address		City		Zip Code	County	Phone Number
List Household Members	Dependent Code	Date of Birth	Health First CO Number	Social Security Number	Residency Code	Health First CO/CHP+ Ineligibility Codes
1. APPLICANT						
2.						
3.						
4.						
5.						
6.						
7.						

Section II: Calculating Income

Income Source	Monthly Income	Annualized Total
1. Gross Employment Income	\$ _____	\$ _____
2. Unearned Income	\$ _____	\$ _____
3. Self-Employment Income	\$ _____	\$ _____
4. Total Income (Lines 1 + 2 + 3)	\$ _____	\$ _____
5. Allowable Deductions (See Worksheet 3)	\$ _____	
6. Grand Total Annual Income	\$ _____	

FPL Percentage: _____

Client Copayment Annual Cap (Line 6 times percentage chosen): \$ _____

PENALTY CLAUSE, CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the information provided to complete this application is true. I understand that if I make false statements on this application, I commit a Class 5 Felony. In addition, misrepresenting my eligibility for assistance under this program is a Class 2 Misdemeanor (26-15-112, C.R.S.). I authorize the provider to use any information contained in the application to verify my eligibility for assistance under this program, and to obtain records pertaining to eligibility from a financial institution as defined in section 15-15-201(4), C.R.S., or from any insurance company. I understand that the provider has a right to obtain any recovery or right of recovery for a patient who would have a right of recovery. This means that if I am found to have a claim for any benefits payable for any treatment, which is given, while I am eligible for assistance under this program that the provider has the right to be included in the claims process. If applicable, I understand that legal immigrants receiving assistance under this program shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997. **I understand it is my responsibility to notify the provider of an income or household change that may influence the rating on this application and failure to do so voids this application.**

YOU HAVE 15 DAYS TO APPEAL YOUR CICP ELIGIBILITY RATE
(Ask your eligibility technician for more information on the appeal process)

Print Applicant Name

Applicant Signature and Date

Print Eligibility Technician Name

Eligibility Technician Signature and Date

Print Facility Name

Facility Phone Number

Application Notes:

Section 2.02 Ineligibility Code Legend

Dependent Codes

1. Self
2. Spouse/Civil Union Partner
3. Minor
4. Senior
5. Adult Student
6. Other

Residency Codes

1. Colorado Resident & U.S. Citizen
2. Colorado Resident & Lawfully Present
3. Migrant Farm Worker & U.S. Citizen
4. Migrant Farm Worker & Lawfully Present
5. Counted in Household Size Only

Medicaid/CHP+ Ineligibility Codes

- A. Has the Applicant Received a Medicaid/CHP+ Denial Letter?
- B. Applicant is not a U.S. Citizen, has not been a legal resident for at least 5 years, or does not have refugee status
- C. Transitional Medical Benefits have been discontinued
- D. Over Income for Medicaid and is:
 - d. **NOT A CHILD**
 - e. **NOT PREGNANT**
 - f. **NOT DISABLED**
- E. Has Primary Insurance - NOT Eligible for CHP+
- F. **Other - Provide a brief Explanation**

Annual or One Time Income Sources:Documented Self-Declared

_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>

Earned Income Total \$ _____ \$ _____

Unearned Income Total \$ _____ \$ _____

Total Income \$ _____ \$ __________
Applicant Signature_____
Date_____
Eligibility Technician Signature_____
Date_____
Facility_____
Phone

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Colorado Indigent Care Program

Worksheet 2 - Net Self-Employment Income

	<u>Monthly</u>	<u>Annualized</u>
<u>Revenue:</u>		
Gross Business Income	\$ _____	\$ _____
<u>Business Property Expenses:</u>		
Mortgage/Rent of Business Property	\$ _____	\$ _____
Utilities	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
<u>Other Expenses:</u>		
Advertising	\$ _____	\$ _____
Businesses Phone	\$ _____	\$ _____
Business Taxes (non-personal)	\$ _____	\$ _____
Fuel for Business-related Travel	\$ _____	\$ _____
Gross Wages	\$ _____	\$ _____
Insurance	\$ _____	\$ _____
Legal Fees	\$ _____	\$ _____
License/Certification Fees Paid	\$ _____	\$ _____
Merchandise/Cost of goods	\$ _____	\$ _____
Office Supplies	\$ _____	\$ _____
Repairs/Upkeep of Equipment	\$ _____	\$ _____
Tools/Equipment	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
Day Care Provider Reductions (if applicable)	\$ _____	\$ _____

	<u>Monthly</u>	<u>Annualized</u>
Total Expenses:	\$ _____	\$ _____
Total Expenses Attributed to Business:	\$ _____	\$ _____
Net Profit	\$ _____	\$ _____ (use this figure on line 3, Section II of the CICP Application)

Applicant Signature

Date

Eligibility Technician Signature

Date

Facility

Date

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Worksheet 3 - Allowable Deductions

[illegible]

Applicant Signature

Date _____

Eligibility Technician Signature

Date _____

Facility

Phone

AFFIDAVIT FOR LAWFUL PRESENCE
Colorado Indigent Care Program

I, _____, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check one):

- ☐ I am a United States citizen.
- ☐ I am not a United States citizen, but I am a Permanent Resident of the United States.
- ☐ I am not a United States citizen, but I am lawfully present in the United States pursuant to federal law.

I understand that this sworn statement is required by law because I have applied for a "state public benefit", as that term is defined under section 24-76.5-102(3), C.R.S. (2016). I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this state public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under section 18-8-503, C.R.S. (2016) and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Applicant Signature

Date

FOR INTERNAL USE ONLY

Please mark the box that indicates which document was verified for lawful presence and keep a photocopy of the document presented in the applicant's file.

- ☐ A current, valid Colorado driver's license or a Colorado identification card, issued pursuant to article 2 of title 42, C.R.S., unless the applicant holds a license or card that states, "Not Valid for Federal Identification, Voting, or Public Benefit Purposes", or
- ☐ Any out-of-state driver's license or state issued identification if that state requires that the Applicant prove lawful presence prior to issuance of the license or identification card, or
- ☐ A United States military card or a military dependent's identification card, or
- ☐ A United States Coast Guard Merchant Mariner card, or
- ☐ A Native American tribal document, or
- ☐ Other documentation pulled from SAVE or found on a Federal list of acceptable documentation for establishing lawful presence (see 1 CCR 204-30 sections 2.1.4 and 2.1.6)
Name of document accepted (include document number):

Date verified in SAVE (if applicable): _____

Please Note: If the applicant is a United States citizen or non-citizen national and is unable to present any of the documents listed on this form they may submit a written declaration or a third-party written declaration. These options should be used with caution.

SELF DECLARATION

I, _____, self-declare and swear or affirm under penalty of perjury, and possibly subject to later verification of status, that I am a United States citizen or non-citizen national.

Signature

Date

THIRD-PARTY DECLARATION

I, _____, swear or affirm under penalty of perjury, and possibly subject to later verification of status, that I have personal knowledge that the Applicant is a United States citizen or non-citizen national.

Signature

Date

For Colorado Department of Revenue's Lawful Presence Rule, see 1 CCR 204-30 Rule 5:
<http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=6860&fileName=1%20CCR%20204-30>

States that require Applicants to prove lawful presence prior to issuing a driver's license or identification card are also called REAL ID compliant states. A list of REAL ID compliant states can be found at:

<https://www.dhs.gov/current-status-states-territories>

**Declaración Jurada de Presencia Legal
Programa de Atención para Indigentes de Colorado**

Yo, _____, juro o afirmo bajo pena de perjurio según las leyes del estado de Colorado queque (marque un opción):

- ☐ Soy ciudadano de los Estados Unidos, O
- ☐ No soy un ciudadano de Estados Unidos pero soy residente permanente de los Estados Unidos
- ☐ No soy un ciudadano de Estados Unidos pero estoy legalmente presente en Estados Unidos bajo de la Ley Federal

Entiendo que esta declaración jurada es requerida por la ley porque he solicitado una "prestación pública estatal", como ese término se define en la sección 24-76.5-102(3), C.R.S. (2016). Entiendo que la ley estatal requiere que demuestren que estoy legalmente presente en Estados Unidos antes de recibir este beneficio público del estado. Además, reconozco hacer una declaración falsa, ficticia o fraudulenta o representación en esta declaración jurada jurada está penado por las leyes penales de Colorado como perjurio en el segundo grado en la sección 18-8-503, C.R.S. (2016) y constituirá un delito separado cada vez que fraudulentamente se recibe un beneficio público.

Firma del Solicitante

Fecha

SÓLO PARA USO INTERNO

Por favor marque la casilla que indica que documento se verificó presencia legal y fotocopia del documento en el archivo del solicitante.

- ☐ Un válido y corriente licencia de conductor de Colorado o un Colorado tarjeta de identificación, emitido de conformidad con el artículo 2 del título 42, C.R.S., a menos que el solicitante es titular de una licencia o tarjeta que dice, "no son válidos para identificación federal, votar o beneficio público", o
- ☐ Un licencia de cualquier conducir fuera del estado o estado emitido identificación si ese estado requiere que el solicitante probar presencia legal antes de la expedición de la licencia o tarjeta de identificación, o
- ☐ Una tarjeta militar de Estados Unidos o tarjeta de identificación de dependiente militar o
- ☐ Una tarjeta de Estados Unidos guardacostas Merchant Mariner, o
- ☐ Un documento tribal americano nativo, o
- ☐ Otra documentación tirado de SAVE o se encuentran en una lista Federal de documentación aceptable para establecer presencia legal (véase 1 CCR 204-30 secciones 2.1.4 y 2.1.6)
Nombre de document aceptado (incluir número):

Fecha verificado en SAVE (si corresponde): _____

Por favor nota: Si el solicitante es un ciudadano o no ciudadano nacional y es incapaz de presentar cualquiera de los documentos listado en este formulario puede enviar una declaración escrita o un declaración por escrito del tercero. Estas opciones deben usarse con precaución. El solicitante debe firmar abajo.

Declaración del uno mismo

Yo, _____ mismo-declara y juro o afirmo bajo pena de perjurio y posiblemente sujeta a verificación posterior de la situación, que yo soy un ciudadano o no ciudadano nacional.

Firma del Solicitante

Fecha

Tercero Declaración

Yo, _____ juro o afirmo bajo pena de perjurio y posiblemente sujeta a verificación posterior de la situación, que tengo conocimiento personal que el solicitante es un ciudadano o no ciudadano nacional.

Firma del Solicitante

Fecha

Estado de presencia legal del Departamento de ingresos de Colorado, véase 1 CCR 204-30 regla 5:

<http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=6860&fileName=1%20CCR%20204-30>

Estados que requieren los aspirantes probar presencia legal antes de la expedición de licencia de conducir o tarjeta de identificación también se llaman Estados compatibles con ID REAL. Una lista de Estados conformes ID REAL puede encontrarse en:

<https://www.dhs.gov/current-status-states-territories>

ARTICLE IV. Other

Section 4.01 Optional CICIP ID Card Template

Colorado Indigent Care Program (CICP) <i>This is not Health Insurance</i>	
Name: _____	
Rate: _____ SSN: _____	
Copay Cap: _____ County Code: _____	
Begin Date _____	
End Date: _____	
Technician's Signature _____	Phone _____

The following family members are covered under the FPL on the front of this card. (Family members eligible for Medicaid or CHP+ are not listed)	
Name _____	SSN _____
Name _____	SSN _____
Name _____	SSN _____
Name _____	SSN _____
Name _____	SSN _____
Name _____	SSN _____
Present card each time you receive services at a CICP Provider	

Section 4.02 County Codes

01 Adams	23 Garfield	45 Otero
02 Alamosa	24 Gilpin	46 Ouray
03 Arapahoe	25 Grand	47 Park
04 Archuleta	26 Gunnison	48 Phillips
05 Baca	27 Hinsdale	49 Pitkin
06 Bent	28 Huerfano	50 Prowers
07 Boulder	29 Jackson	51 Pueblo
08 Chaffee	30 Jefferson	52 Rio Blanco
09 Cheyenne	31 Kiowa	53 Rio Grande
10 Clear Creek	32 Kit Carson	54 Routt
11 Conejos	33 Lake	55 Saguache
12 Costilla	34 La Plata	56 San Juan
13 Crowley	35 Larimer	57 San Miguel
14 Custer	36 Las Animas	58 Sedgwick
15 Delta	37 Lincoln	59 Summit
16 Denver	38 Logan	60 Teller
17 Dolores	39 Mesa	61 Washington
18 Douglas	40 Mineral	62 Weld
19 Eagle	41 Moffat	63 Yuma
20 Elbert	42 Montezuma	64 Broomfield
21 El Paso	43 Montrose	
22 Fremont	44 Morgan	

Section 4.03 Copay Category

Percent of FPL	0 - 40% and Homeless	0 - 40%	41 - 62%	63 - 81%	82 - 100%	101 - 117%	118 - 133%	134 - 159%	160 - 185%	186 - 200%	201 - 250%
Ambulatory Surgery	\$0	\$15	\$65	\$105	\$155	\$220	\$300	\$390	\$535	\$600	\$630
Inpatient Facility	\$0	\$15	\$65	\$105	\$155	\$220	\$300	\$390	\$535	\$600	\$630
Hospital Physician	\$0	\$7	\$35	\$55	\$80	\$110	\$150	\$195	\$270	\$300	\$315
Emergency Room	\$0	\$15	\$25	\$25	\$30	\$30	\$35	\$35	\$45	\$45	\$50
Emergency Transportation	\$0	\$15	\$25	\$25	\$30	\$30	\$35	\$35	\$45	\$45	\$50
Outpatient Hospital Services	\$0	\$7	\$15	\$15	\$20	\$20	\$25	\$25	\$35	\$35	\$40
Clinic Services	\$0	\$7	\$15	\$15	\$20	\$20	\$25	\$25	\$35	\$35	\$40
Specialty Outpatient	\$0	\$15	\$25	\$25	\$30	\$30	\$35	\$35	\$45	\$45	\$50
Prescription	\$0	\$5	\$10	\$10	\$15	\$15	\$20	\$20	\$30	\$30	\$35
Laboratory	\$0	\$5	\$10	\$10	\$15	\$15	\$20	\$20	\$30	\$30	\$35
Basic Radiology & Imaging	\$0	\$5	\$10	\$10	\$15	\$15	\$20	\$20	\$30	\$30	\$35
High-Level Radiology & Imaging	\$0	\$30	\$90	\$130	\$185	\$250	\$335	\$425	\$580	\$645	\$680

The following information explains the different types of medical care charges:

- **Ambulatory Surgery** charges are for all non-physician (facility) Ambulatory Surgery operative procedures received by a Client who is admitted to and discharged from the hospital setting on the same day. The Client is also responsible for the corresponding Hospital Physician charges.
- **Inpatient Facility** charges are for all non-physician (facility) services received by a Client while receiving care in the hospital setting for a continuous stay of 24 hours or longer.
- **Hospital Physician** charges are for services provided directly by a physician in the hospital setting, including inpatient, ambulatory surgery, and emergency room care.
- **Emergency Room** charges are for all non-physician (facility) services received by a Client while receiving Emergency Care or Urgent Care in the hospital setting for a continuous stay less than 24 hours (i.e., emergency room care).
- **Emergency Transportation** charges are for transportation provided by an ambulance.
- **Outpatient Hospital Service** charges are for all non-physician (facility) and physician services received by a Client while receiving non-Emergency Care or non-Urgent Care in the outpatient clinic setting. Charge includes primary and preventive medical care; does not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.
- **Clinic Services** charges are for all non-physician (facility) and physician services received by a Client while receiving care in the outpatient clinic setting. Charges include primary and preventive medical care. Charge does not include radiology or laboratory services performed at the clinic.
- **Specialty Outpatient** charges are for all non-physician (facility) and physician services received by a Client while receiving care in the specialty outpatient setting. These services can be provided in standalone clinics and outpatient hospital settings. Specialty Outpatient charges include distinctive medical care (i.e., oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventive medical care. Charges do not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.
- **Prescription** charges are for prescription drugs received by a Client at a Qualified Health Care Provider's pharmacy as an outpatient service.
- **Laboratory Service** charges are for all laboratory tests received by a Client while receiving care in the outpatient hospital or clinic setting. Laboratory Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.
- **Basic Radiology and Imaging Service** charges are for all radiology and imaging services received by a Client while receiving care in the outpatient hospital or clinic setting. Basic Radiology and Imaging Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.
- **High-Level Radiology and Imaging Service** charges are for Clients receiving a Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Positron Emission Tomography (PET) or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory (cath lab) in the outpatient hospital, emergency room, or clinic setting.

Clients who are seen in the hospital setting in an observation bed should be charged the emergency room copay if their stay is less than 24 hours and the inpatient facility copay if their stay is 24 hours or longer.

Section 4.04 Ability to Pay Table

Family Size					
1	\$0 - \$4,824	\$4,825 - \$7,477	\$7,478 - \$9,769	\$9,770 - \$12,060	\$12,061 - \$14,110
2	\$0 - \$6,496	\$6,497 - \$10,069	\$10,070 - \$13,154	\$13,155 - \$16,240	\$16,241 - \$19,001
3	\$0 - \$8,168	\$8,169 - \$12,660	\$12,661 - \$16,540	\$16,541 - \$20,420	\$20,421 - \$23,891
4	\$0 - \$9,840	\$9,841 - \$15,252	\$15,253 - \$19,926	\$19,927 - \$24,600	\$24,601 - \$28,782
5	\$0 - \$11,512	\$11,513 - \$17,844	\$17,845 - \$23,312	\$23,313 - \$28,780	\$28,781 - \$33,673
6	\$0 - \$13,184	\$13,185 - \$20,435	\$20,436 - \$26,698	\$26,699 - \$32,960	\$32,961 - \$38,563
7	\$0 - \$14,856	\$14,857 - \$23,027	\$23,028 - \$30,083	\$30,084 - \$37,140	\$37,141 - \$43,454
8	\$0 - \$16,528	\$16,529 - \$25,618	\$25,619 - \$33,469	\$33,470 - \$41,320	\$41,321 - \$48,344
9	\$0 - \$18,200	\$18,201 - \$28,210	\$28,211 - \$36,855	\$36,856 - \$45,500	\$45,501 - \$53,235
10	\$0 - \$19,872	\$19,873 - \$30,802	\$30,803 - \$40,241	\$40,242 - \$49,680	\$49,681 - \$58,126
11	\$0 - \$21,544	\$21,545 - \$33,393	\$33,394 - \$43,627	\$43,628 - \$53,860	\$53,861 - \$63,016
12	\$0 - \$23,216	\$23,217 - \$35,985	\$35,986 - \$47,012	\$47,013 - \$58,040	\$58,041 - \$67,907
13	\$0 - \$24,888	\$24,889 - \$38,576	\$38,577 - \$50,398	\$50,399 - \$62,220	\$62,221 - \$72,797
14	\$0 - \$26,560	\$26,561 - \$41,168	\$41,169 - \$53,784	\$53,785 - \$66,400	\$66,401 - \$77,688
15	\$0 - \$28,232	\$28,233 - \$43,760	\$43,761 - \$57,170	\$57,171 - \$70,580	\$70,581 - \$82,579
16	\$0 - \$29,904	\$29,905 - \$46,351	\$46,352 - \$60,556	\$60,557 - \$74,760	\$74,761 - \$87,469
Poverty Level	0 - 40%	41 - 62%	63 - 81%	82 - 100%	101 -117%

Family Size					
1	\$14,111 - \$16,040	\$16,041 - \$19,175	\$19,176 - \$22,311	\$22,312 - \$24,120	\$24,121 - \$30,150
2	\$19,002 - \$21,599	\$21,600 - \$25,822	\$25,823 - \$30,044	\$30,045 - \$32,480	\$32,481 - \$40,600
3	\$23,892 - \$27,159	\$27,160 - \$32,468	\$32,469 - \$37,777	\$37,778 - \$40,840	\$40,841 - \$51,050
4	\$28,783 - \$32,718	\$32,719 - \$39,114	\$39,115 - \$45,510	\$45,511 - \$49,200	\$49,201 - \$61,500
5	\$33,674 - \$38,277	\$38,278 - \$45,760	\$45,761 - \$53,243	\$53,244 - \$57,560	\$57,561 - \$71,950
6	\$38,564 - \$43,837	\$43,838 - \$52,406	\$52,407 - \$60,976	\$60,977 - \$65,920	\$65,921 - \$82,400
7	\$43,455 - \$49,396	\$49,397 - \$59,053	\$59,054 - \$68,709	\$68,710 - \$74,280	\$74,281 - \$92,850
8	\$48,345 - \$54,956	\$54,957 - \$65,699	\$65,700 - \$76,442	\$76,443 - \$82,640	\$82,641 - \$103,300
9	\$53,236 - \$60,515	\$60,516 - \$72,345	\$72,346 - \$84,175	\$84,176 - \$91,000	\$91,001 - \$113,750
10	\$58,127 - \$66,074	\$66,075 - \$78,991	\$78,992 - \$91,908	\$91,909 - \$99,360	\$99,361 - \$124,200
11	\$63,017 - \$71,634	\$71,635 - \$85,637	\$85,638 - \$99,641	\$99,642 - \$107,720	\$107,721 - \$134,650
12	\$67,908 - \$77,193	\$77,194 - \$92,284	\$92,285 - \$107,374	\$107,375 - \$116,080	\$116,081 - \$145,100
13	\$72,798 - \$82,753	\$82,754 - \$98,930	\$98,931 - \$115,107	\$115,108 - \$124,440	\$124,441 - \$155,550
14	\$77,689 - \$88,312	\$88,313 - \$105,576	\$105,577 - \$122,840	\$122,841 - \$132,800	\$132,801 - \$166,000
15	\$82,580 - \$93,871	\$93,872 - \$112,222	\$112,223 - \$130,573	\$130,574 - \$141,160	\$141,161 - \$176,450
16	\$87,470 - \$99,431	\$99,432 - \$118,868	\$118,869 - \$138,306	\$138,307 - \$149,520	\$149,521 - \$186,900
Poverty Level	118 - 133%	134 - 159%	160 - 185%	186 - 200%	201 - 250%

Poverty Level refers to the percent of Federal Poverty Level.

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