Revised 10/2024

Application for Public Assistance

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

Please remove pages A-S to keep for your records

You have the option to answer only those questions relevant to the program for which you are applying.

Supplemental Nutrition Assistance Program (SNAP)-
previously known as Food Assistance
Questions marked with a ■ are NOT required for SNAP.

- You have the right to file your application today. **You can start the process by filling out your name, address, and signature or that of an authorized representative on this form and turning it into a county office.** You can give us your application in person, by fax, through the mail or you can apply through PEAK. **An interview will be required before receiving SNAP** and you may be required to provide proof of some information given on the application. ***Benefits will begin from the date any county office receives your signed application.***

- You may receive SNAP within 7 days if the household has less than $100 in assets and less than $150 income per month, OR if your monthly shelter costs are more than your monthly income plus any cash on hand or in the bank, OR if anyone in the home is a migrant or seasonal farm worker and the household has less than $100 in cash on hand and in the bank.

- If you do not qualify for expedited SNAP processing, benefits can begin within 30 days if all requested proof of the information that was given on your application was

provided. If expedited assistance is denied, you may ask for an informal hearing.

Cash Programs Questions marked with a ♦ are NOT required for Cash Assistance.

- **Colorado Works (CW),** known federally as Temporary Assistance for Needy Families (TANF) – For households with a child or a pregnant mother. Provides a cash benefit to families in need. With a few exceptions, parents must participate in work activities. A referral may be made to Child Support Services based on your household circumstances. If you feel this could cause hardship to you or your child(ren), you may request good cause for waiving this referral.
- **Colorado Supplement to SSI** – Provides an additional cash supplement to eligible persons not receiving the full SSI grant from the Social Security Administration.
- **Aid to the Needy Disabled (State AND)**– Provides a cash benefit for persons ages 18-59 who have been determined totally disabled for at least six months or persons under the age 59 who meet the definition of a person who is blind.
- **Old Age Pension (OAP)** – Provides a cash benefit for low-income persons age 60 or over.
- **Home Care Allowance (HCA)**- For persons who need help on a regular basis with some or all of their daily self-care (such as bathing, dressing, eating, getting around, and using the bathroom). Provides a cash benefit that used must be to pay the provider for services. A functional assessment is required.

Medical Assistance Questions marked with a ● are NOT required for Medical Assistance.

MedicalAssistance includes free or low-cost insurance from **HealthFirst Colorado (Colorado's MedicaidProgram)** or the **Child Health Plan *Plus* Program (CHP+).** It also includes affordable private health insurance plans that offer you comprehensive coverage through **Connect for Health Colorado (the Marketplace).** This includes tax credits that can immediately lower your premiums for health coverage. It also includes assistance for paying your Medicare Premiums.

Instructions:

List EVERYONE in your home and on your federal tax return, even if you are not applying for them. Use more paper if necessary. If you are a non-citizen who has a sponsor, you will list the sponsor's information in a question later in this application.

If you are applying for benefits and you have a Social Security Number (SSN), we need this information. If you provide your SSN, it may speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778. Providing a SSN or immigration status is optional for SNAP. If a SSN or immigration status is not provided for a person, that person will not receive benefits. Even if the person's SSN or proof of immigration status was not provided, they must provide their income, resources, and expenses they pay because that information will be used to determine eligibility and benefits for eligible household members.

What I Should Know

By completing and signing the State of Colorado Application for Public Assistance and other documents required to determine whether I'm eligible for public assistance benefits **AND** by accepting benefits that I am eligible to receive, I understand the following information and agree to the following requirements:

- I must tell the truth; it is a crime to lie on this application.
- I may have to give papers that show what I've told you is true.
- I may have to tell you of any changes to the information I gave you on my application. If I think you made a mistake, I can ask for an appeal or fair hearing.
- The department will not discriminate.
- The department will confirm citizenship and immigration status for everyone applying for benefits.
- The department will tell you if your benefits change.
- The department or relevant federal agency will take back any benefits you should not have received.

1. The Department of Health Care Policy and Financing (HCPF) is the state agency responsible for Medical Assistance Programs in Colorado. The Department of Human Services is the state agency responsible for the other public assistance programs. The County Departments of Human/Social Services and Medical Assistance Sites are the agencies that receive and process applications for all public assistance programs. In this statement, the term "department" is used to refer to all agencies.

2. I must give the department all needed proof and documents before qualifying for benefits.

3. The information I give on the application and in the application interview is confidential. However, the department can use or share the information with another program that any of my family and/or household members are getting or are applying for. The information can only be used for purposes of treatment, payment, determining eligibility, other program and administrative operations, or other purposes permitted by law for my family and/or household members or me. Additionally, this information may be disclosed to other Federal and State agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. It will also be determined if the information is factual. If any information is incorrect, SNAP may be denied and the applicant may be subject to criminal prosecution for knowingly providing incorrect information.

4. It is a crime to lie on the application or to take benefits that I know that my family and I are not eligible to receive and I may be subject to criminal prosecution for knowingly providing false information. Giving false information may be punished by a fine of up to $250,000 or a jail term of up to 20 years, or both.

5. A person found to have intentionally given false information cannot get SNAP and/or Cash Programs for 12 months for the first offense, 24 months for the second offense, and permanently for the third offense. If a person is found to have intentionally violated program rules in SNAP or Cash Programs, that person is also disqualified from Cash Programs for the same period of time. A court

can also stop a person from getting SNAP for another eighteen months. This crime is subject to prosecution under other state and federal laws. Receiving duplicate benefits of SNAP by lying about identity or residence will result in a ten (10) year disqualification for the first offense, a ten (10) year disqualification for the second offense, and a permanent disqualification for the third offense. If I omit or provide any information (other than lying about identity or residence) that leads to duplicate benefits being issued, I can be disqualified for 12 months for the 1st offense, 24 months for the 2nd offense, and permanently for the 3rd offense. A person convicted by a court or whose disqualification was obtained through an Intentional Program Violation (IPV) waiver for misrepresenting their residence in order to obtain assistance in two states at the same time will have their Colorado Works assistance denied for ten (10) years.

6. The department will notify me in writing of how and when to tell the department of any changes. If I am receiving Cash Programs, I know that I must tell the organization providing the assistance if the information I listed on this application changes by the 10th of the month following the change. I am aware I have 10 calendar days to report any changes if I am enrolled in Health First Colorado or Child Health Plan Plus (CHP+). Changes are to be reported to my local county office for Health First Colorado or to CHP+. I am responsible for paying fees, premiums and co-payments for myself and my family if they are required for Medical Assistance benefits. I know I have 30 calendar days to report any change to Connect for Health Colorado if I am receiving Advance Premium Tax Credits, Reduced Co-Pays or Deductibles, or I am enrolled in a Qualified Health Plan. If my family is enrolled in multiple

insurance affordability programs, I must report changes to each organization in the appropriate time frame. I understand that a change in information could affect my eligibility and eligibility of member(s) of my household.

7. If I do not tell the truth on my application or if information is left off of the application, or if I do not report changes to the department, as required, I may lose my assistance, and I may have to pay back the department for the assistance received when I was not eligible. If I have to pay back money to the department, I understand that state or federal salaries, rebates, or tax refunds that would be received by me or another person on this application may be taken.

8. The law says the department must check the immigration status and citizenship of anyone who is applying. They will not check the immigration status of family members who are not applying for benefits. I may be requested to give proof of non-citizen registration documentation received from the United States Citizen and Immigration Service (USCIS) for every non-citizen member in my house who is applying for benefits. The department will confirm information with USCIS and any information received from USCIS may affect my eligibility and benefits. Federal law (Public Law 97-98) requires me to give the department the Social Security number and/or alien registration number of all persons who are applying for public assistance. I must also provide the Social Security number and/or alien registration number for all sponsors. **For Adult Financial and Colorado Works programs, sponsor information will be confirmed with USCIS and the information received from USCIS may affect sponsor repayment for my eligibility and benefits. My sponsor and I may be responsible for reimbursing the state for the benefits that I receive.**

9. I do not have to be a U.S. citizen to apply for assistance. **Please do not let the fear about immigration status stop you from seeking benefits for your family.**

10. If I am a resident of an institution and jointly applying for SSI and SNAP prior to leaving the institution, the filing date of the application is my date of release from the institution. Processing time will begin from the date the application is received in the SNAP office.

11. Privacy Act Information: The department is authorized to collect information on the application, including Social Security numbers, and will confirm information that may affect initial or ongoing eligibility and payments for all persons listed on my application. **I am allowing the department to use Social Security numbers (SSN) and other information from my application to request and receive information or records to confirm the information in my application.** SNAP will be denied to individuals that do not provide a Social Security number, and Social Security numbers will be used and disclosed in the same manner for both eligible and ineligible members. **I release the department from all liability for sharing this information with other agencies for this purpose.** For example, the department may get and share information with any of the following agencies: Social Security Administration; Internal Revenue Service; United States Customs and Immigration Services; Colorado Department of Labor and Employment; financial institutions (banks, savings, and loans, credit unions, insurance companies, landlords, leasing agents, etc.); child support services; employers; courts; and other federal or state agencies; and for SNAP, law enforcement officials for the purposes of apprehending persons fleeing to avoid the law.

12. If a SNAP, Colorado Works, and/or Adult Financial over-payment occurs against my household, the information on this application, including all Social Security numbers, may be referred to Federal and State agencies, as well as private claims collection agencies for claims collection action.

13. The EBT (or Quest) card is used to pay me most of my public assistance benefits. I cannot trade or sell EBT cards. The only people allowed to use my household's EBT card are members of my household, my authorized representative(s), and individuals outside my household that have my permission to use my EBT card to access benefits for the people in my household. I cannot use my EBT card to access my cash benefits at locations identified as prohibited locations including licensed gaming establishments, in-state simulcast facilities, tracks for racing, commercial bingo facilities, stores or establishments in which the principal business is the sale of firearms, retail establishment licensed to sell malt, vinous, or spirituous liquors, establishments licensed to sell medical marijuana or medical marijuana-infused products, or retail marijuana or retail marijuana products, establishments that provide adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment. **Continued misuse of my EBT card at prohibited locations will cause my cash benefits to be suspended on my EBT card and/or my cash benefits to be terminated for a period of 30 days requiring a new application.**

14. I can name someone or an organization to be my representative. For SNAP, Cash, and Medical Assistance programs I must do this in writing, online through my PEAK account, or through the mail. For Medical Assistance I can also do this over the Phone. The person and/or organization I designate to be my authorized representative may help me

apply for assistance, get my benefits, and use my benefits to buy food for me. I may name one person to help me with each separate task or I may name one person to help me with all of these tasks.

15. If I think the department made a mistake, I can ask for a Fair Hearing. The department will tell me in writing how to make an appeal. I can ask for a Fair Hearing either verbally or in writing. My case may be presented by a member of my household or my representative, such as legal counsel, friend, or relative. I may request an appeal for any action on any program except for the CHP+ program

16. If I think the CHP+ program made a mistake, I can ask for an appeal. CHP+ tells me about how to make an appeal in writing.

17. Colorado Works is not an entitlement program and benefits are not guaranteed. To remain eligible, I may be required to complete an assessment and develop a plan. Unless exempted, I will be required to participate in work readiness activities

18. As an applicant for Colorado Works, if I refuse to cooperate with Child Support Services at the time I apply or while receiving cash assistance through Colorado Works, without good cause, I will not receive assistance or a basic cash assistance grant for my family. If I think that cooperating will harm me or my children, I can tell Child Support Services and I may not have to cooperate. Reasons for not cooperating with Child Support include but are not limited to: potential physical or emotional harm to a child(ren), parent or caretaker relative; pregnancy or birth of a child related to incest or forcible rape; legal adoption before the court or a parent receiving pre-adoption services; or other reasons determined to be in the best interest of the child. In order to cooperate with Child Support

Services, I will be required to complete additional documentation concerning the child(ren), the parentage of the child(ren), and provide all court documents that concern the child(ren).

19. If I am an adult between the ages of 18 and 49, with no children under the age of 18 in my SNAP household, I will only be eligible to receive SNAP benefits for three months, unless one of the following applies: I work in a job 80 hours each month and report my hours worked to my local Employment First office, or I meet the Workfare program requirements or work program requirements set by the Employment First office. Additionally, I may continue to receive my SNAP benefits if I am determined to be physically or mentally unable to work or if the SNAP office identifies other applicable exemptions. If I meet any of these criteria, I will be able to continue receiving SNAP as long as I remain eligible.

20. I understand and agree that to receive SNAP, certain members of the household need to register for work. This means that certain members of the household must:

a) Report to the Employment First (work program) when the SNAP office schedules an appointment.

b) Comply with the instructions the Employment First (work program) gives including reporting for all scheduled appointments and following through on the written agreements signed.

c) Provide information to the SNAP office or the Employment First (work program) about any jobs I or my household member(s) get while on SNAP.

d) Tell the SNAP office or the Employment First (work program) if me or my household member(s) are not able to work – I will be asked to provide verification; work any workfare hours assigned; go to job interviews arranged for me or my household member(s). Anyone who does not follow the work requirements may be disqualified from receiving SNAP.

21. I must cooperate fully with state and federal staff if my case is reviewed. My information on this application may be reviewed and confirmed by the department, or its representatives. My household will not be eligible for SNAP if I refuse to cooperate with any review of my case, including a quality control review.

22. I cannot use SNAP benefits to buy non-food items, such as alcohol or cigarettes. I can be disqualified for using SNAP to pay for items purchased on credit. **If a court of law finds a person guilty of using SNAP benefits to illegally purchase or receive controlled substances that individual shall be disqualified for two years for a first offense and permanently for a second offense. Individuals found by a Federal, State, or local court to have used or received benefits in a transaction involving the sale of firearms, ammunition, or explosives shall be permanently ineligible to receive SNAP upon the first occasion of such violation. If a court of law finds a person guilty of having trafficked benefits for an aggregate amount of $500 or more, that individual will be permanently ineligible to receive SNAP upon the first occasion of such violation.**

23. The trafficking of benefits means:

a. The buying, selling, stealing, or otherwise affecting an exchange of SNAP benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual

voucher and signature, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone; or,

b. The exchange of SNAP benefits or EBT cards for firearms, ammunition, explosives, or controlled substances; or,

c. A SNAP participant, including the participant's designated authorized representative, who knowingly transfers SNAP benefit to another who does not, or does not intend to, use the SNAP benefits for the SNAP household for whom the SNAP benefits were intended; or

d. The reselling of food that was purchased with SNAP benefits for cash; or

e. Obtaining a cash deposit when returning water or other containers that were purchased with SNAP benefits. Purchasing water containers is an eligible food item that can be paid for with SNAP benefits; however, when the container is returned, the deposit should be returned to the client's EBT card and not given to the client in cash.

f. Attempting to buy, sell, steal, or otherwise affect an exchange of SNAP benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signatures, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone.

24. If I do not report and provide proof of mortgage, housing fees, property insurance, property taxes, court-ordered child

support payments, child or adult care, and medical expenses paid by people in my household who are elderly or who have a disability, I am stating that I do not want that specific deduction used to determine my SNAP benefit amount.

25. I can ask for SNAP apart from asking for benefits from other programs. My eligibility for SNAP will be determined apart from any other programs. The SNAP office shall process all SNAP applications in accordance with SNAP timeliness, noticing, and fair hearing requirements, even if I am applying for other programs.

26. Colorado residents who have a qualifying disability, such as persons receiving SSI or SSDI benefits, or residents who are at least 65 years of age (or a surviving spouse age 58 or older) might also qualify for a Property Tax/Rent/Heat Rebate from the Department of Revenue. Visit www.TaxColorado.com and click on the PTC button at the top of the page or call 303-238-7378 for details.

27. IEVS refers to the Income Eligibility Verification System. IEVS reports discrepancies between the information you provide and information in the Department of Labor's system as well as Social Security Administration's various systems. Information available through IEVS will be requested, used, and may be verified through collateral contacts when discrepancies are found. This information may affect your eligibility and benefit level.

28. I will immediately notify the State of any medical claim or lawsuit I have. I will cooperate with the State in collecting the medical bills the State has paid. The state may collect from any insurance company or court settlement for medical bills that the State has paid. If I am on Medical Assistance and receive money for the same medical bills that the State has paid, I will

give the money to the State. I assign to the State all rights to payment for medical expenses and treatment. I also assign my right to appeal a denial of benefits by another party responsible for payment for the benefits to the State.

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

30. I understand that if I get cash assistance under Colorado Works, I must assign the rights to any current and past-due child support due under an existing order to the State, along with any medical support, to reimburse Medicaid for costs paid out for my family. If I receive any current child support, medical support, or spousal support directly while receiving cash assistance, I will give this to the child support unit (CSU). For Health First Colorado, I know I’ll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell child support and I may not have to cooperate. If current child support is collected by the CSU, while I am receiving Colorado Works, I may receive this money through the Pass-Through program. Once I have discontinued Colorado Works, the CSU will continue to collect and send to

me any current child support, medical support, and spousal support until I tell the CSU in writing to close my case.

USDA Nondiscrimination Policy

Do Not Send Applications Here

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil

rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334 Alexandria,
   VA 22314; or
2. **fax:**

   (833) 256-1665 or (202) 690-7442; or
3. **email:**

   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

Do Not Send Applications Here

Medical Assistance Nondiscrimination Policy

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

Department of Health and Human Services Office for Civil Rights at http://www.hhs.gov/ocr/filing-with-ocr/index.html.

For Other Programs: For information about the Colorado Department of Human Services policies, to request free disability and/or language aids and services, or to file a discrimination complaint, contact: 504/ADA Coordinator, 1575 Sherman St Denver, CO 80203, Phone: 303-866-7129, Fax: 303-866-6080, State Relay: 711, Email: CDHSCR@state.co.us. For additional information please visit www.colorado.gov/cdhs.

Civil rights complaints can also be filed with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf or by mail, phone, or fax at: 1961 Stout Street Room 08-148 Denver, CO 80294, Telephone: 800-368-1019, Fax: 202-619-3818, TDD: 800-537-7697. Complaint forms are available at http://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

Domestic violence information and services are available to me. If I ever feel I am in immediate danger I should call 911. If I would like to receive information regarding safety and services in Colorado, I will call the Colorado Coalition Against Domestic Violence at 303-831-9632 or toll-free at 1-888-778-7091. I may also find the location of services near me by going to www.colorado.gov/cdhs/dvp. The National Domestic Violence Hotline at 1−800−799−SAFE (7233) or TTY 1−800−787−3224 or www.thehotline.org can also provide information. If I am a survivor of domestic violence, sexual assault, or stalking, the Address Confidentiality Program (ACP) can provide me with a

legal substitute address to use instead of my physical address for use with state and local government agencies. I can find out more about the ACP at acp.colorado.gov. If I need or receive either of these services, I should tell my department worker.

VERIFICATION OF INFORMATION

Please provide as much of the following information as you can. All bills and proof of information must be current. We will tell you if we need any other information at the time your application is processed or at the time of the interview. **If you have a sponsor, you may need to provide proof of your sponsor's income and resources.**

If you have trouble getting any of these documents or have questions, we can help you. We can suggest other ways to verify this information. If you cooperate with us, we will do everything we can to help get the needed documents.

1. PROOF OF ALL INCOME RECEIVED BY YOU OR OTHER MEMBERS OF YOUR HOUSEHOLD

If you are only applying for medical assistance, you may be required to provide proof of income. Income is any money your household receives. Proof of income may include but is not limited to:

- Wages/Tips Retirement/ Pension
- Gifts/Allowances/ Contributions
- Self-Employment
- Veterans Benefits
- Interest from savings, CDs, etc.
- Child Support
- Military Allotment
- Educational Loan/Grant
- Unemployment
- Rental Income
- Social Security
- Roomer/Boarder
- Alimony/Maintenance Child Support
- Colorado Works Cash

2. SOCIAL SECURITY NUMBERS (SSN)

The SSN, or proof of applying for an SSN, should be provided for each household member who is applying for benefits. You do not need to include an SSN for household members who are not applying for benefits or those who do not have a Social Security Number because they do not qualify for one, or because they object to having one for religious reasons.

3. PROOF OF AGE AND IDENTITY

You *may* be required to provide identification for all household members applying for benefits:

- Birth Certificate ID for Health Benefits
- Baptismal Record Work ID
- US Passport Other Documents
- Driver's License
- Identification Cards for US Citizens (I-179 or I-197)
- Certificate of US Citizenship (N-560 or NH-561)
- Certificate of Naturalization (N-550 or N-570)
- Certificate of birth abroad of a citizen in the US (Department of State forms FS-545 or DS-1350)

4. PROOF OF CITIZENSHIP AND RESIDENCY

You *may* be required to provide proof of citizenship and residence.

If you are a US citizen, you may be required to provide proof, such as a:

- Birth Certificate
- ID for Health Benefits
- Client Statement
- Work ID
- US Passport
- Baptismal Record
- Driver's License
- Forms from the United States Citizenship and Immigration Services (USCIS) such as:
    - Identification Cards for US Citizens (I-179 or I-197)
    - Certificate of US Citizenship (N-560 or NH-561)
    - Certificate of Naturalization (N-550 or N-570)
    - Certificate of birth abroad of a citizen in the US (Department of State forms FS-545 or DS-1350)

If you are a legal non-citizen, you may be required to provide proof of your status, such as:

- USCIS Documents

- I-551 Resident Alien Card
- I-94 Arrival/Departure Record
- I-688B or I-766 Employment Authorization Document
- A letter from USCIS indicating a person's status

5. PROOF OF RESOURCES. (Not required for Colorado Works programs)

You *may* be required to provide proof of resources. Proof of expenses may include but are not limited to the following types:

- Vehicles
- Trust Funds
- Checking/Savings
- Real Estate
- Life Insurance Accounts
- Stock and Bonds
- Burial Insurance
- Retirement Funds
- Property where you do not live

6. PROOF OF EXPENSES

You *may* be required to provide proof of expenses. Proof of expenses may include but are not limited to the following types:

- Rent or mortgage

- Utilities
- Medical
- Child support payments
- Dependent care payments (adults or children)

7. LIVING ARRANGEMENTS (For SNAP Only)

If you are living with other people in the same house, an explanation of your living arrangements will be helpful. The explanation should include who purchases and prepares food together and how expenses are paid.

8. CHILD SUPPORT INFORMATION (For SNAP and Colorado Works Only)

If a parent to your child(ren) is out of the home, you must bring copies of any court orders. These court orders include orders involving divorce, child support, or paternity establishment. In addition to social security numbers for you and your children, please provide social security number(s) for the absent parent(s), if available.

Application for Public Assistance

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

Check the box for each program you would like to apply for.

☐ **Supplemental Nutrition Assistance Program (SNAP)-**previously known as Food Assistance

Questions marked with a ■ are NOT required for SNAP.

☐ **Cash Programs**

☐ **Colorado Works**- Known federally as Temporary Assistance for Needy Families (TANF)

☐ **Adult Financial** – Includes Colorado Supplement to SSI, Aid to the Needy Disabled (State AND), Old Age Pension (OAP), and Home Care Allowance (HCA)

Questions marked with a ♦ are NOT required for Cash Assistance.

☐ **Medical Assistance-** Includes Health First Colorado (Colorado's Medicaid Program), Child Health Plan **Plus** (CHP+), Tax Credits, and Cost-Sharing Reductions

Questions marked with a ● are NOT required for Medical Assistance.

Your Legal Name (First, Middle Initial, Last)

_____

Maiden Name _____

Social Security Number[1] _____

Date of Birth _____

Home address (Number, Street) _____

City _____

State _____

Zip _____

Phone number _____

Mailing address (if different) _____

City _____

State _____

Zip _____

Other phone number _____

Do you speak and read English? ☐Yes No☐ If no, what language do you speak? _____

Are you homeless? ☐Yes No☐

■ Are you a resident of Colorado? ☐Yes No☐

[1] If you are applying for any program and have an SSN, we need this information. Even if you are not applying for benefits, providing your SSN will help us to quickly process your application. We use SSNs to check income and other information to see what you and your household may qualify for.

Under penalties of perjury, I state that I have examined this application, and to the best of my knowledge and belief, my answers are true, including household composition, citizenship, and non-citizenship information. I have listed all amounts and sources of income and property I receive/own. I have the right to declare an Authorized Representative. If I am declaring an Authorized Representative, by signing below, I allow this person to

sign my application, get official information about this application, and act for me on all future matters with this agency. I read, understand, and agree to "What I Should Know."

Your signature _____

Date _____

Authorized Representative, Conservator, Guardian Printed Name _____

■●Authorized Representative Signature _____

Date _____

■●Spouse's/Co-Applicants signature (optional)

_____

Date _____

Authorized Representative, Conservator, Guardian Printed Name: _____

■●Authorized Representative Signature _____

Date _____

Name, address, and phone number of the person who helped you complete this application _____

We can send links that allow you to view electronic notices about your case. You may choose more than one option, but if you do not choose, you will receive paper notices by standard mail. I would prefer:

☐ **Paper notices** ☐ **An email with a link to view your notices sent to** _____@_____

Household Demographics

Legal Name (First, Middle, Last) _____

Relation to you SELF

Birth Date Provided on Page 3

■ **Male/ Female (M/F)** _____

What program is this person applying for? Check all that apply.

☐ SNAP
☐ Cash Programs
☐ Medical Assistance
☐ Not applying for benefits

■ **Married, Civil Union, Domestic Partnership, Single, Divorced, Separated, Widowed** _____

● **Hispanic or Latino?**[1]

☐Yes
☐No

● **Race**[1] _____

■● **Social Security Number**[2] Provided on Page 1

US Citizen or US National[3]

☐Yes
☐No
Certificate number:

Legal Name (First, Middle, Last) _____

Relation to you _____

Birth Date __/___/___

■ **Male/ Female (M/F)** _____

What program is this person applying for? Check all that apply.

☐ SNAP
☐ Cash Programs
☐ Medical Assistance
☐ Not applying for benefits

■ **Married, Civil Union, Domestic Partnership, Single, Divorced, Separated, Widowed** _____

● **Hispanic or Latino?**[1]

☐Yes
☐No

● **Race**[1] _____

■● **Social Security Number**[2] _____

US Citizen or US National[3]

☐Yes
☐No

Certificate number:

Legal Name (First, Middle, Last) _____

Relation to you _____

Birth Date __/___/___

■ **Male/ Female (M/F)** _____

What program is this person applying for? Check all that apply.

☐ SNAP
☐ Cash Programs

☐ Medical Assistance
☐ Not applying for benefits

■ **Married, Civil Union, Domestic Partnership, Single, Divorced, Separated, Widowed** _____

● **Hispanic or Latino?**[1]
☐Yes
☐No

● **Race**[1] _____

■● **Social Security Number**[2] _____

US Citizen or US National[3]
☐Yes
☐No
Certificate number:

Legal Name (First, Middle, Last) _____

Relation to you _____

Birth Date __/___/___

■ **Male/ Female (M/F)** _____

What program is this person applying for? Check all that apply.
☐ SNAP
☐ Cash Programs
☐ Medical Assistance
☐ Not applying for benefits

■ **Married, Civil Union, Domestic Partnership, Single, Divorced, Separated, Widowed** _____

● **Hispanic or Latino?**[1]
☐Yes
☐No

● **Race**[1] _____

■● **Social Security Number**[2] _____

US Citizen or US National[3]
☐Yes
☐No
Certificate number:

Legal Name (First, Middle, Last) _____

Relation to you _____

Birth Date __/___/___

■ **Male/ Female (M/F)** _____

What program is this person applying for? Check all that apply.
☐ SNAP
☐ Cash Programs
☐ Medical Assistance
☐ Not applying for benefits

■ **Married, Civil Union, Domestic Partnership, Single, Divorced, Separated, Widowed** _____

● **Hispanic or Latino?**[1]
☐Yes
☐No

● **Race**[1] _____

■● **Social Security Number**[2] _____

US Citizen or US National[3]
☐Yes
☐No
Certificate number:

[1]Race and ethnicity information is optional and will not affect eligibility; rather it is collected to ensure that benefits are provided to all eligible applicants regardless of race/color/national origin. **Race options include**: American Indian/Alaskan Native- **AI**; Asian - **A**; Black/African American- **B**; Native Hawaiian/ Other Pacific Islander- **NH**; White- **W**

[2]If you are applying for any program and have an SSN, we need this information. Even if you are not applying for benefits, providing your SSN will help us to quickly process your application. We use SSNs to check income and other information to see what you and your household may qualify for.

[3]For households applying for medical assistance only, any household member who is not applying for medical assistance doesn't have to answer questions about citizenship. If you are applying for medical assistance and you are a naturalized or derived citizen, please provide your certificate number.

Is anyone in the home considered a roomer or boarder (they rent a room from you)?

☐Yes No☐ **If yes, list below**

●Name _____

Amount paid for rent $_____

●Are meals included with the rent? ☐Yes No☐

●Name _____

Amount paid for rent $_____

●Are meals included with the rent? ☐Yes No☐

Is there any household member temporarily out of the home in any type of facility or institution?

☐Yes No☐

If yes, list below. Examples of types of institutions are listed be at the bottom of the table

Name _____

Date entered _____

●Name of facility _____

●Type of facility _____

Is this person pending disposition of charges? ☐Yes No☐

●Are meals provided? ☐Yes No☐

Name _____

Date entered _____

●Name of facility _____

●Type of facility _____

Is this person pending disposition of charges? ☐Yes No☐

●Are meals provided? ☐Yes No☐

Examples: Nursing home• Hospital • Mental health institution • ●Incarceration

Expedited SNAP Details

Even if you are behind on paying bills, let us know how much you are responsible to pay when answering questions about your expenses.

Including yourself, how many people in your home do you purchase and prepare food for? _____

Is anyone in the home a migrant or seasonal farm worker?

☐Yes No☐

Total money my household expects to get this month (before deductions) $_____

Total cash on hand and money in your checking/savings account $_____

Mortgage per month $_____

Rent per month $_____

● Do you have any of these utilities? If so, cost per month?

Electricity ☐ $_____ Water ☐ $_____ Phone ☐ $_____
Trash ☐ $_____ Sewer ☐ $_____ Other☐ $_____

● Did anyone in the home get any SNAP or cash benefits in any other state in the last 30 days? ☐Yes No☐

■ If you are applying for Colorado Works, have you received benefits from any other state since 1996?

☐Yes No☐ *If yes, list below*

Name(s) _____

_____

Date of receipt _____ City _____

County _____

State _____

Name(s) _____

_____

Date of receipt _____ City _____

County _____

State _____

EBT Card

●Does the person completing this application need an Electronic Benefits Transfer (EBT) card? ☐Yes No☐

●How does the person completing this application like to receive an EBT card?

By postal mail ☐ In-person at the local office ☐

REGISTER TO VOTE HERE

If you are not registered to vote where you live now, would you like to register to vote here today? Check YES if you would like to apply to register to vote or update your voter registration information. If you check the NO box or do not check a box, you will be considered to have decided not to apply to register to vote or update your voter registration information. Checking

YES, NO, or leaving this question blank, will not affect your receipt of benefits. ☐ **Yes No** ☐

NOTICE OF RIGHTS

Help: If you would like help in filling out your voter registration application, we will help you. The decision of whether to seek or accept help is yours. You may fill out the voter registration application in private.

Benefits: If you are applying for public assistance from this agency, applying to register, or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

Privacy: Your decision not to register or update your record and the location where you applied to register or update your voter registration record is confidential and may only be used for voter registration purposes.

Dependent Children

■ Do you live with at least one child under the age of 19, and are you the main person taking care of this child?

☐Yes No☐

●■ Do any of the children living in the home have a parent living outside the home?

☐Yes
☐No

If yes, have you tried to get medical support from the child's parent living outside the home?

☐Yes
☐No

Name of Parent _____

Address _____

Phone _____

For which child? _____

Name of Parent _____

Address _____

Phone _____

For which child? _____

Name of Parent _____

Address _____

Phone _____

For which child? _____

I would like to apply for good cause from pursuing Child Support Services Assistance allowable under the Family Violence Option Waiver (as described in the “What I Should Know” section)
☐Yes No☐

Foster Care

■ Is anyone in the home who is applying for Medical Assistance or Colorado Works benefits in foster care now or in the past?

☐Yes No☐ *If yes, list below*

Name _____

Current Age _____

Dates when in foster care _____

If no longer in foster care, age when you left, if known. _____

Name _____

Current Age _____

Dates when in foster care _____

If no longer in foster care, age when you left, if known. _____

♦■ Did anyone in the home who is applying for medical assistance receive Former Foster Care Medical Assistance on their 18th birthday while living in a state other than Colorado, and turn 18 on or after January 1, 2023?

☐Yes No☐ If yes, list the state you lived in when you aged out of foster care: _____

Name used in out of state foster care (if different):

_____

Date you left Foster Care, if known? __/___/___

Were you adopted? ☐Yes No☐

If adopted, did you return to foster care after the adoption?

☐Yes No☐ If yes, when: __/___/___

Date you became a Colorado resident __/___/___

Do you need help paying for medical bills from the last 3 months?

☐Yes No☐ If yes, what months: _____

Current or former foster care applicants who are applying for Medical Assistance only do not need to fill out the rest of this application and may STOP HERE.

Family Planning

♦■ **Does anyone want to apply for Family Planning Benefits?** ☐Yes No☐ *If yes, list below*

Family planning provides health care and counseling for preventing, delaying, or planning a pregnancy.

Name(s): _____

Pregnancy Details

■**Is anyone in the home pregnant?**

☐Yes No☐ *If yes, list below*

Name: _____

Due date: _____

Number of babies expected: _____

●Name of the father, if known: _____

●Would you like to pursue a good cause from pursuing Child Support Services Assistance? ☐Yes No☐

Disability Details

Does anyone in your home who is applying for benefits have a disability?

☐Yes No☐ Name: _____

■ **If yes, does this person need help with self-care activities (bathing, dressing, eating, using the bathroom, etc.)?**

☐Yes No☐

■ **Does anyone who is applying for medical assistance have a medical or developmental condition that has lasted, or is expected to last more than 12 months?**

☐Yes No☐ Name: _____

■ **Have you or anyone in the home applied for Supplemental Security Income (SSI) or other Social Security benefits?**

☐Yes No☐ *If yes, list below*

Name _____

Program Name _____

☐SSI
☐_____

Application Date ___/_____/___

Application Status
☐Pending
☐Approved

☐Denied
☐Appealed

Name _____

Program Name _____

☐SSI
☐_____

Application Date ___/_____/___

Application Status
☐Pending
☐Approved
☐Denied
☐Appealed

If no, has anyone who is disabled ever received SSI or SSDI?

☐Yes No☐

If yes, when did SSI or SSDI end? ___/_____/___

Non-Citizen Details

Is anyone who is applying for benefits a non-citizen?

☐Yes No☐

If yes, you may be asked to provide a copy of your U.S. Citizenship and Immigration Services card.

Non-Citizen 1

Name of Non-Citizen [1]: _____

Non-Citizen Status: ___

Document Type: _____

Document/Card/Passport Number: _____

Alien or I-94 Number: _____

Document Expiration Date: _____

Country of Issuance: _____

♦■ Has this person lived in the US since 1996?

☐Yes No☐

♦■ Is the non-citizen's spouse or parent a veteran or active-duty member of the US military?

☐Yes No☐

Non-Citizen 2

Name of Non-Citizen [2]: _____

Non-Citizen Status: _____

Document Type: _____

Document/Card/Passport Number: _____

Alien or I-94 Number: _____

Document Expiration Date: _____

Country of Issuance: _____

♦■ Has this person lived in the US since 1996?

☐Yes No☐

♦■ Is the non-citizen's spouse or parent a veteran or active-duty member of the US military?

☐Yes No☐

♦■ Does anyone want to apply for Emergency Medicaid and Reproductive Benefits?

☐Yes No☐ *If yes, list below*

Applicants who are not a U.S. citizen, or a legal resident for at least 5 years, may not receive full Medicaid benefits, but they may qualify for Emergency Medicaid and/or Reproductive Benefits. Emergency Medicaid and/or Reproductive Benefits can cover life-threatening emergencies, labor and delivery for pregnant people, and birth control.

Name(s): _____

Are any of the non-citizens listed above sponsored to remain in this country?

☐Yes No☐ If no, skip this section.

Sponsor (please add additional pages if there is more than one sponsor)

Has the sponsored individual been abandoned, mistreated or abused by their sponsor?

☐Yes No☐

If you are only applying for medical assistance and you answered yes, you do not have to answer anymore sponsor questions.

Are you pregnant or 20 years old or younger?

☐Yes No☐

If you are only applying for medical assistance and you answered yes, you do not have to answer anymore sponsor questions.

Who is sponsored? _____

Name of sponsor: _____

Name of sponsor's spouse: _____

Sponsor's Social Security Number _____

●Sponsor's spouse's Social Security Number _____

Sponsor's address: _____

Total number of people in sponsor's household? _____

Does the sponsored individual live with the sponsor?

☐Yes No☐

Does the sponsored individual receive free room and board from the sponsor? ☐Yes No☐

Does the sponsored individual receive any support from their sponsor?

☐Yes No☐

Earned Income

Does anyone work or is anyone starting a new job?

☐Yes No☐ *If yes, list below*

Job 1: Name of the person who is or will be working:

_____

Employer name and phone number: _____

Monthly wages/tips (before taxes): _____

Hourly wage: _____

Average hours worked each week: _____

How often is this person paid? ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly ☐Daily

Is this job considered temporary and expected to last less than 3 months? ☐Yes No☐

♦ Is this income from? ☐ Seasonal Employment
☐ Commission-based Employment (including tip jobs)

Job 2: Name of the person who is or will be working:

_____

Employer name and phone number: _____

Monthly wages/tips (before taxes): _____

Hourly wage: _____

Average hours worked each week: _____

How often is this person paid? ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly ☐Daily

Is this job considered temporary and expected to last less than 3 months? ☐Yes No☐

♦ Is this income from? ☐ Seasonal Employment
☐ Commission-based Employment (including tip jobs)

Is anyone in the home considered self-employed? This includes, but is not limited to, earning money from babysitting, selling goods such as make-up or kitchenware, selling goods on the internet or selling homemade/homegrown food products?

☐Yes No☐ *If yes, list below*

Name of individual that is self-employed: _____

Business name (if applicable): _____

One month's gross income $_____

Month of this income: _____

Type of self-employment: ☐ Sole Proprietor ☐ LLC ☐ S-Corp ☐Independent Contractor

Utilities paid for business: $_____

Business taxes paid: $_____

Interest paid for business: $_____

Gross business labor costs: $_____

Cost of merchandise $_____

Other business cost: Type: $_____

Other business cost Type: $_____

Other business cost: Type: $_____

Total Net Income (Subtract your expenses from your gross income): _____

Has anyone in the home quit a job, lost a job, or reduced their work hours in the past 60 days?

☐Yes No☐ *If yes, list below*

Name of person: _____

Employer name and phone number:

_____

Start date of job: _____

End date of job: _____

Monthly wages/tips (before taxes): _____

Date and amount of last paycheck: _____

How often was this person paid? ☐Monthly ☐Yearly ☐Hourly ☐Weekly ☐Every two weeks ☐Twice a month

Unearned/Other Income

Does anyone have other types of income?

☐Yes No☐ *If yes, list below. Examples of other types of income are listed at the bottom of the table*

Name _____

Type of Money/Income _____

Monthly Amount _____

Name _____

Type of Money/Income _____

Monthly Amount _____

Name _____

Type of Money/Income _____

Monthly Amount _____

If you are applying for medical assistance only, do **not** include income from SSI, Veterans' benefits, Workers' Comp, and Gifts.

Examples include but are not limited to: Unemployment benefits • SSI • Veterans' benefits • Widow Benefits •

Workers' Comp • Railroad Retirement •●Child Support • Survivor's Benefits • Dividends/Interest • Rental income • Money from a boarder • Disability benefits • Retirement/pension • SSDI • Alimony • In-kind income (Working for rent) • Social Security benefits • Public Assistance • Plasma donations • Gifts • Loans • Foster Care payments • Tribal Benefits

Has anyone who is applying received (or expects to receive) a lump sum payment?

☐Yes No☐ *If yes, list below.*

Name _____

Date Received _____

Type of Lump Sum _____

Amount _____

Name _____

Date Received _____

Type of Lump Sum _____

Amount _____

Examples: Lawsuit settlement • Insurance settlement • Social Security, SSI, SSDI Payment • Veterans • Inheritance • Surrender of Annuity • Life Insurance payout • Lottery/ gambling winnings

●Is anyone in the home on strike?

☐Yes No☐ *If yes, list below*

Name: _____

Date strike began: _____

Date of the last paycheck: _____

Amount of the last paycheck: _____

Expense Details *Even if you are behind, tell us how much you are responsible to pay when answering questions about your expenses.*

Rent

●Does anyone pay rent, renter's insurance, or additional rental fees (pet, washer/dryer, condo or maintenance fees, etc.)? List each rent expense or rent-related fee separately.

☐Yes No☐ *If yes, list below*

Expense Type (Rent/Fees) _____

Who Pays ___________________________________

Is this person in the home? ☐Yes No☐

Who is this expense for? _____________________

Expense Month _____

Amount Paid $_____

Expense Type (Rent/Fees) _____

Who Pays ___________________________________

Is this person in the home? ☐Yes No☐

Who is this expense for? _____________________

Expense Month _____

Amount Paid $_____

Expense Type (Rent/Fees) _____

Who Pays ___________________________________

Is this person in the home? ☐Yes No☐

Who is this expense for? _____________________

Expense Month _____

Amount Paid $_____

●**Are utilities included in the rent you pay or are you billed separately?** ☐ Utilities are included ☐ Billed separately for utilities☐

●**Does anyone responsible for rent receive Section 8 or public housing assistance?** ☐ Section 8 Public Housing☐

Mortgage

●**Does anyone pay a mortgage, homeowner's insurance, property taxes, or HOA fees? List each mortgage or mortgage-related expense separately.**

☐Yes No☐ *If yes, list below*

Expense Type _____

Who Pays _____________________________________

Is this person in the home? ☐Yes No☐

Who is this expense for? _____________________

Expense Month _____

Amount Paid $_____

Expense Type _____________________

Who Pays ___

Is this person in the home? ☐Yes No☐

Who is this expense for? __

Expense Month __

Amount Paid $_____

Expense Type ___

Who Pays ____

Is this person in the home? ☐Yes No☐

Who is this expense for? __

Expense Month ___

Amount Paid $_____

●**Does anyone responsible for the mortgage receive Section 8 or public housing assistance?**
☐ Section 8 Public Housing☐

Utilities

●**How do you heat and cool your home?**

Electric ☐ Gas ☐ Firewood ☐ Propane ☐Swamp Cooler
☐ Other (**please list type**) ☐__

●**Have you received LEAP (energy assistance) at this address in the past 12 months?** ☐Yes No☐

Additional Expenses

●Does anyone pay child or adult daycare, legally obligated child support, child support arrears, medical expenses[1], ■student loan interest, and/or alimony?

☐Yes No☐ *If yes, list below*

Expense ______________________________

Who Pays ______________________________

Is this person in the home? ☐Yes No☐

Who is this expense for? ______________________

Month of expense _______________

Amount Paid $______

Legally Obligated Amount $______

Expense ______________________________

Who Pays ______________________________

Is this person in the home? ☐Yes No☐

Who is this expense for? ______________________________

Month of expense _______________

Amount Paid $______

Legally Obligated Amount $______

Expense ______________________________

Who Pays ______________________________

Is this person in the home? ☐Yes No☐

Who is this expense for? _____

Month of expense _____

Amount Paid $_____

Legally Obligated Amount $_____

[1]*For SNAP, medical expenses are only allowable for persons aged 60 or older and persons with disabilities.*
Examples of allowable medical expenses: prescriptions, medical/dental/eye, co-pays, insurance premiums, and in-patient care. Amounts reimbursed by a 3rd party are not allowable.

Student[1] Details

Does anyone in the home attend high school, vocational, trade school, or college?

☐Yes No☐ *If yes, list below*

Name _____

●Name of School _____

●Last Grade Completed _____

●Start date _____

●Expected Graduation Date _____

Full-time student? ☐Yes No☐

Name _____

●Name of School _____

●Last Grade Completed _____

●Start date _____

●Expected Graduation Date _____

Full-time student? ☐Yes No☐

Is anyone receiving financial aid (grants or scholarships), work-study income, or income through a GI Bill? ☐Yes No☐
If yes, list below

Who? _____

■What is the amount ($) of Grants, Scholarships, and/or Work Study used for living expenses[2] this month? $_____

■What is the taxable amount ($) of Grants, Scholarships, and/or Work-Study this person received for the year? $_____

- If you need Medical Assistance, you will need this information

[1] *For SNAP, student information is only required for individuals between the ages of 18 and 49 unless a person under the age of 18 is the head of the household.*

[2]*Student Living Expenses Examples: Food, Clothing, Housing, Transportation, Utility Costs, Insurance, Other*

Resources

INFORMATION ABOUT RESOURCES IS NOT REQUIRED FOR COLORADO WORKS

Medical Assistance only applicants: The below resource sections are not required for those who are not over the age of 65, or blind, or disabled.

Does anyone in the home have any resources[1], including those that are jointly owned with someone else?

☐Yes No☐ *If yes, list below.*

Name _____

Type of resource _____

Name of financial institution _____

Account number _____

Current value $_____

Name _____

Type of resource _____

Name of financial institution _____

Account number _____

Current value $_____

Name _____

Type of resource _____

Name of financial institution _____

Account number _____

Current value $_____

[1]Examples: Cash on-hand, Checking and Savings accounts, Stocks, Bonds, Mutual funds, 401Ks, IRAs, Trusts, CDs, Annuities, College funds, PASS accounts, IDAs, Promissory notes, Education accounts

■Does anyone own a vehicle, including cars, trucks, motorcycles, trailers, boats, snowmobiles, and other recreational vehicles?

☐Yes No☐ **I***f yes, list below*

Name _____

Year, make, and model _____

Current value $_____

Name _____

Year, make, and model _____

Current value $_____

Does anyone have life insurance policies or burial insurance policies?

☐Yes No☐ *If yes, list below*

Who _____

Company & Policy Number _____

Type

☐Burial policy
☐Insurance policy

Revocable or Irrevocable?
☐Revocable
☐Irrevocable

Value $_____

Who _____

Company & Policy Number _____

Type
☐Burial policy
☐Insurance policy

Revocable or Irrevocable?
☐Revocable
☐Irrevocable

Value $_____

Does anyone in the home own any property (including your home)?

☐Yes No☐ *If yes, list below*

Name/owner of property __________

Property type _____

Property address __________

Value $_____

Primary use for this property (choose one)
☐Primary Home☐Rental income ☐Business/self-employment
☐Other: _____

Name/owner of property _____

Property type _____

Property address _____

Value $_____

Primary use for this property (choose one)
☐Primary Home☐Rental income ☐Business/self-employment
☐Other: _____

Has anyone in the home sold, transferred, or given away cash, property, or other assets within the last five years? [1]

☐Yes No☐ *If yes, list below*

Name _____

Date of Transfer _____

What Asset? _____

Amount Received $_____

Fair Market Value $_____

Name _____

Date of Transfer _____

What Asset? _____

Amount Received $_____

Fair Market Value $_____

[1]If you are only applying for SNAP; you only need to declare for the last 3 months. For AND, OAP, HCA and CS-SSI, you only need to declare for the last 36 months (3 years).

Prior Convictions

THESE QUESTIONS ARE ONLY REQUIRED FOR SNAP, COLORADO WORKS, AND ADULT FINANCIAL

If you are applying for Medical Assistance, please skip to the next section.

1. Have you or any member of your home been convicted of, or disqualified for, fraudulently receiving duplicate SNAP benefits in any state after 9/22/1996?

☐Yes Who: ______________________________ No☐

2. Are you or any member of your home hiding or running from the law to avoid prosecution, being taken into custody, or will be going to jail for either a felony crime, attempted felony crime, or violating a condition of parole or probation?

☐Yes Who: ______________________________ No☐

3. Have you or any member of your home been convicted of a felony under federal or state law for possession, use, or distribution of a controlled drug substance (felony drug conviction) or for a crime while under the influence of a controlled drug substance after 8/ 22/1996?

☐Yes Who: ______________________________ No☐

4. Have you or any member of your home been convicted of, or disqualified for, buying or selling, or attempting to buy or sell, SNAP benefits for more than $500 after 9/22/1996?

☐Yes Who: ______________________________ No☐

5. Have you or any member of your home been convicted of trading SNAP benefits for guns, ammunition, explosives, or drugs after 9/22/1996?

☐Yes Who: ______________________________ No☐

6. Have you or any member of your home applying for assistance ever been disqualified for an Intentional Program Violation or been convicted of welfare fraud in a criminal case?

☐Yes Who: ______________________________ No☐

7. Have you or any member of your home been convicted of aggravated sexual abuse, murder, sexual exploitation and

abuse of children, sexual assault as defined in the Violence Against Women Act of 1994, or similar state law, and is also not in compliance with the terms of their sentence?

☐Yes Who: _____ No☐

IF YOU ARE ONLY APPLYING FOR SNAP, YOU MAY STOP HERE.

Has anyone in the home been in the military? ☐Yes No☐ If yes, who? _____

If you need help to pay your burial/funeral costs, would you prefer: ☐ Cremation ☐ Burial ☐ No Preference

IF YOU ARE ONLY APPLYING FOR ADULT FINANCIAL, YOU MAY STOP HERE.

IF YOU ARE ONLY APPLYING FOR COLORADO WORKS, YOU MAY STOP HERE.

Retroactive Medical Coverage

Does anyone who is applying for medical assistance want help paying for medical bills from the last 3 months?

☐Yes No☐

Who ____

Month(s) ____________

Household income in that month(s) ____________

Who ____

Month(s) ____________

Household income in that month(s) ____________

Tax Filer Information

Instructions: Please complete for yourself, your spouse/partner, and children who live with you and/or anyone on the same federal income tax return, if you file one. If you don't file a tax return, remember to still add family members who live with you. Use more paper if necessary.

Do you plan to file a Federal Income Tax Return NEXT YEAR?

☐Yes No☐ *If yes, list below*

Filing jointly with a spouse? ☐Yes No☐

Name of spouse: ____

Claiming dependent(s)? ☐Yes No☐

Name of dependent(s): ____________________________________

Expects to be claimed as a dependent on someone else's tax return that does not live at your address?
☐Yes No☐ *If yes, **list** below*

Claimed as a dependent? ☐*Yes No*☐

Name of person claiming you: ____________________________

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

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

If you indicated that you are a tax filer and that you are Married, Filing Separately on your tax forms, do Exceptional Circumstances (that you have been a victim of domestic violence) apply to your case? ☐Yes No☐

Does anyone else in the home plan to file a Federal Income Tax Return NEXT YEAR?

☐Yes No☐

Name: _____

Filing jointly with a spouse? ☐Yes No☐

Name of spouse: _____

Claiming dependent(s)? ☐Yes No☐

Name of dependent(s): _____

Expects to be claimed as a dependent on someone's else's tax return that does not live at your address? ☐Yes No☐ If yes, list below

Claimed as a dependent? ☐Yes No☐

Name of the person claiming them: _____

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

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

If they indicated that they are a tax filer and that they are Married, Filing Separately on your tax forms, do Exceptional Circumstances (that you have been a victim of domestic violence) apply to their case? ☐Yes No☐

Does anyone else in the home plan to file a Federal Income Tax Return NEXT YEAR?

☐Yes No☐

Name: _____

Filing jointly with a spouse? ☐Yes No☐

Name of spouse: ____

Claiming dependent(s)? ☐Yes No☐

Name of dependent(s): ________________________________

Expects to be claimed as a dependent on someone's tax return that does not live at your address? ☐Yes No☐ *If yes, list below*

Claimed as a dependent? ☐Yes No☐

Name of person claiming them: ___________________________

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

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

If you indicated that you are a tax filer and that you are Married, Filing Separately on your tax forms, do Exceptional Circumstances (that you have been a victim of domestic violence) apply to your case? ☐Yes No☐

Health Insurance Coverage

Does anyone in your home qualify for or have health insurance/coverage?[1]

☐Yes No☐ *If yes, list below*

Name(s) ______________________________________

Type of Coverage ___________________________________

Coverage Dates ____________

Is this person enrolled? ☐Eligible ☐Enrolled

Name(s) ______________________________________

Type of Coverage ___________________________________

Coverage Dates _____

Is this person enrolled? ☐Eligible ☐Enrolled

Name(s) _____

Type of Coverage _____

Coverage Dates _____

Is this person enrolled? ☐Eligible ☐Enrolled

Name(s) _____

Type of Coverage _____

Coverage Dates _____

Is this person enrolled? ☐Eligible ☐Enrolled

[1]Types of coverage: Medicare •TRICARE • VA Health Care •

Peace Corps • COBRA • Retiree Health Plan
•Current Employer-Sponsored Health Coverage •
Railroad Retirement Insurance

If you listed that someone in your home is enrolled in TRICARE, Peace Corps, VA Health Care Program, or other state or Federal Health Benefit Program, complete the table below.

Type/Name of Program: _____

Who is currently enrolled in this health coverage? _____

Insurance Company Name: _____

Policy number: _____

If you listed that someone in your home has access to health insurance from a job, complete the table below. This

includes if the coverage is from someone else's job such as a parent or a spouse OR if you have COBRA or a Retiree Health Plan.

Employer Name: _____

Employer Identification Number: _____

Employer Address: _____

Employer Phone: _____

Who can we contact about your coverage? _____

Date you could start coverage: _____

Date you lost coverage: _____

Who else in the Household had access to this coverage?

_____

Who else in the Household was enrolled in this coverage?

_____

How much would you need to pay in premiums:
$_____ ☐ I don't know

How often would you pay them? ☐Weekly ☐Every 2 Weeks ☐Twice a month ☐Monthly ☐Yearly

Do you have access to an employee-only health plan that meets the minimum value standard[1] health plan? ☐Yes ☐No

If Yes, what is the name of the lowest-cost plan that meets the minimum value standard offered only to the employee?
☐I don't know ☐No plans meet the minimum value standard

[1] An employer-sponsored health plan meets the "minimum value standard" if the employer pays for 60% of the allowed health plan benefits. You would pay 40%.

If you or anyone in your household is enrolled in Medicare, complete the table below. For Part C coverage, please complete if you will be entitled to or enrolled in the month in which you would like to purchase private health insurance.

Medicare Part A

Are you entitled to or receiving Part A? ☐Yes No☐

When did your Part A begin? _____

Are you currently enrolled? ☐Yes No☐

Who pays for your Part A premium? _____

Is your Part A Premium Free? ☐Yes No☐

Medicare Part B

Are you entitled to or receiving Part B? ☐Yes No☐

When did your Part B begin? _____

How much is your Part B premium? $ _____

Who pays for your Part B premium? _____

Medicare Part C

Are you entitled to or receiving Part C (Medicare Advantage)

☐Yes No☐

When did your part C begin? _____

Medicare Part D

Are you entitled to or receiving Part D? ☐Yes No☐

When did your Part D begin? _____

How much is your Part D Premium?

$_____

Who pays for your Part D Premium? _____

Are you or anyone in your home being treated for an injury that you have brought or may bring a legal claim?
☐Yes No☐

Name: _____

Individuals that are 18 years or older can get their own mail about their health coverage at a different address. Do any individuals that are over 18 want to receive their own mail?

☐Yes No☐ *If yes, list below*

Name _____

Address _____

Name _____

Address _____

Expected Income Change

Does the income in your household change from month to month?

☐Yes No☐ *If yes, list below*

Name _____

Annual income from your job and employer name $_____

Will the Annual income be the same or lower in the next calendar year? ☐Yes No☐

Name ____

Annual income from your job and employer name $_____

Will the Annual income be the same or lower in the next calendar year? ☐Yes No☐

Reasons for Income Differences

After you submit your application, we will verify your income. Please tell us, if any of the following has happened to you in the past few months to help us with the verification process:

Name ____

What Happened?
☐Stopped working a job ☐Hours changed at a job
☐Change in employment ☐Married, legal separation, or divorce
☐Other

Name ____

What Happened?
☐Stopped working a job ☐Hours changed at a job
☐Change in employment ☐Married, legal separation, or divorce
☐Other

Does anyone in your household have any job or non-job related deductions? Check all that apply. Provide the amount and how often you pay it. Telling us about these deductions could make the cost of your health insurance lower. You should not include a cost that you already

considered in your previous answer to job income and net self-employment.

Do the deductions change month to month? ☐Yes No☐

If yes, fill out both the current amount and the actual annual amount

Deduction Type and How Often

Type _____

☐One Time only ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly

Current Amount $ _____

Actual Annual Amount $ _____

Type _____

☐One Time only ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly

Current Amount $ _____

Actual Annual Amount $ _____

Type _____

☐One Time only ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly

Current Amount $ _____

Actual Annual Amount $ _____

Example: • Alimony Paid • Capital Losses • Penalty on Early Withdrawal of Savings •Student Loan Interest • Domestic Production Activities • Reimbursement of

Expenses • HSA deduction • Moving Expenses •Contribution made to your Traditional IRA •Certain Business Expenses of Reservists, Performing Artists, or Fee-based Government Officials

Did anyone in your household have income and deductions from a past job, self-employment, or other sources during the coverage year which is not listed as current income that you will need to include on your tax return?

☐Yes No☐

If yes, tell us the amount of the past income and deductions. ***Do not*** *include any ongoing or future income or deductions.*

Amount of past Income: $_____

Amount of past Deductions: $_____

American Indian or Alaska Native Information

American Indians and Alaska Natives can get services from the Indian Health Service, tribal health programs, urban Indian health programs, or through a referral from one of these programs. They also may not have to pay cost-sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible. Certain money received may not be counted as income for receiving insurance affordability programs. List any income that includes money from these sources:

- *Per capital payments from a Tribe that come from natural resources, usage rights, leases, or royalties*

- *Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)*
- *Money from selling things that have cultural significance*

Is anyone in your home an American Indian or Alaska Native?

☐Yes No☐ *If yes, list below*

Name ____

Tribe Name _______________________________________

Tribe State ___________________________

Type of Income Received _______

Frequency and Amount _______

Name ____

Tribe Name _______________________________________

Tribe State ___________________________

Type of Income Received _______

Frequency and Amount _______

Has anyone in the household ever received a service from the Indian Health Service, a Tribal health program, Urban Indian Health program or through a referral from one of these programs?

☐Yes No☐ *If yes, list below*

Name: _____

Name: _____

If none, who in the household is eligible to receive services from Indian Health Service, Tribal health programs, Urban Indian Health Programs, or through a referral from one of these programs?

☐Yes No☐ *If yes, list below*

Name: _____

Name: _____

Permission to Validate Income

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

☐ **I DO NOT give Connect for Health Colorado permission to validate my income data against federal sources.**

AUTHORIZED REPRESENTATIVE INFORMATION FOR MEDICAL ASSISTANCE

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

Is your Authorized Representative an: ☐ Individual ☐ Organization

Authorized Individual/Organization Name:

_____

Company/Organization ID Number (is applicable): _____

Authorized Individual/Organization's Address:

_____

In Care Of (If applicable): _____

City, State, Zip Code, County: _____

Telephone Number: _____

Email Address: _____

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

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

Applicant's Signature _____

Date: (mm/dd/yyyy) _____

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

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

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

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

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

Authorized Representative/Organizational Contact Signature

_____

Date: (mm/dd/yyyy) _____

Revised 10/2024