Application for Public Assistance

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

Please check the programs you want:

Food	**Food Assistance** – Helps you buy food. **You have the right to file your application today. You can complete your name, address, and signature and turn this form into the county office where you live. An interview is required. Benefits begin from the date the office receives your signed application.** A decision will be made as quickly as possible, but no later than 30 days from the date the office receives your signed application. If expedited assistance is denied, you may ask for an informal hearing.	▪
Cash Programs	**Colorado Works** – 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. You will be required to work with or receive Child Support Services.	▪
	Aid to the Needy Disabled Colorado Supplement to SSI (AND-CS) – Colorado Supplement provides an additional cash supplement to those persons not receiving the full SSI grant.	▪
	Aid to the Needy Disabled and **Aid to the Blind (AND-SO)** – For persons ages 18-59 who are totally disabled for at least six months or persons under age 59 who meet the definition of blindness. Provides a cash benefit.	▪
	Old Age Pension (OAP) – For low income persons age 60 or over. Provides a cash benefit and may include medical assistance.	▪
	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) or who need 24 hour supervision in a non-medical facility. Provides a cash benefit that must be used to pay the provider for services. A functional assessment is required.	▪
	Personal Needs Allowance (PNA) – For persons residing in a nursing home who have income less than $50 per month for personal needs.	▪
Medical	**Medical** - Free or low-cost insurance from Medicaid or the Child Health Plan *Plus* Program (CHP+). - Affordable private health insurance plans that offer comprehensive coverage to help you stay well. - A new tax credit that can immediately help pay your premiums for health coverage.	▪

Your Legal **FIRST** Name	Middle Initial	Legal **LAST** Name	**MAIDEN** Name	Social Security Number	Date of Birth
				- -	

Home Address (Number, Street)	City	State	ZIP	Phone Number Leave blank if you do not have one

Mailing Address (If Different from Home Address)	City	State	ZIP	Other Phone Number

Do You Speak and Read English?	Are You Homeless?	Are You a Resident of Colorado?
❑Yes No❑ If No, What Language(s) Do You Speak?	❑Yes No❑	❑Yes No❑

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, and I have listed all amounts and sources of income and property I receive/own. 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	Spouse's/ Co-Applicant Signature, if Applying (Not Required for Food Assistance)	Date
Authorized Representative, Conservator, Guardian Printed Name	Date	Authorized Representative, Conservator, Guardian Printed Name	Date
Authorized Representative Signature	Date	Authorized Representative Signature	Date
Person Who Helped Complete Application		Address/Phone	Date

Is Anyone in the Home Pregnant?	❑Yes No ❑	*If yes, please complete below.*			
Who is Pregnant?		What is the Due Date?		How Many Babies Are Expected?	
List the Name of the Father.					

Does Anyone in Your Home Have a Disability? *If Yes, Please List the Name Below.*	❑Yes No❑	If Yes, Does This Person Need Help with Self-Care Activities? (Such as Bathing, Dressing, Eating, Using the Bathroom)
Who?		❑Yes No❑
Who?		❑Yes No❑
Do anyone have a medical or developmental condition that has lasted, or is expected to last, more than 12 months?		❑Yes No❑
		If yes, who?

Have You or Anyone in the Home Applied for Supplemental Security Income (SSI) or Other Social Security Benefits?	❑Yes No❑	*If yes, please complete below.*					
Who		What program?	❑ SSI ❑ _____	Date of Application	/ /	Application Status	❑Pending ❑Denied Approved ❑ Appealed ❑
Who		What program?	❑ SSI ❑ _____	Date of Application	/ /	Application Status	❑Pending ❑Denied Approved ❑ Appealed ❑
If **No**, has anyone who is disabled ever received SSI or SSDI?	❑Yes No ❑	If yes, when did SSI or SSDI end?	/ /				

Is Anyone in the Home a Non-Citizen?	❑Yes ❑ No	*If yes, please include a copy of the front and back of your U.S. Citizenship and Immigration Services card and complete below.* ***If you have a sponsor, please provide that information.***
Name of Non-Citizen		Sponsor(s)' SSN, Name, Address, Phone Number
Alien Number		
Does the Non-Citizen Live with His or Her Sponsor? ❑Yes No ❑		Does the Non-Citizen Receive Free Room and Board? ❑Yes No ❑
Document Type, *such as I-94,*	Is their spouse or parent a veteran or an active-duty member of the US military?	❑Yes No ❑
Document ID number		Has this person lived in the US since 1996? ❑Yes No ❑

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Document Type, *such as I-94,*	Is their spouse or parent a veteran or an active-duty member of the US military?	❑Yes No ❑
Document ID number		Has this person lived in the US since 1996? ❑Yes No ❑

Is Anyone in the Home currently in Foster Care or Has Ever Been in Foster Care?	❑Yes No❑	*If yes, please complete below.*			
Who?		Age?		When?	
Who?		Age?		When?	

Does Anyone Have Other Income? ❑Yes No❑ If yes, check all that apply and complete below

❑ *Unemployment Benefits*	❑ *SSI*	❑ *Veteran Widow*	❑ *Worker's Compensation*	❑ *Railroad Retirement*
❑ *Child Support*	❑ *Survivor Benefits*	❑ *Dividends/Interest*	❑ *Disability Benefits*	❑ *Rental Income*
❑ *Retirement/Pension*	❑ *SSDI*	❑ *Alimony*	❑ *Financial Aid*	❑ *In-Kind Income (working for rent)*
❑ *Social Security Benefits*	❑ *Veterans Benefits*	❑ *Loans/Gifts*	❑ *Public Assistance*	❑ *Other Cash Received Monthly*

Person Getting Money	Money From	Monthly Amount	Person Getting Money	Money From	Amount
		$			$
		$			$
		$			$

Has Anyone Who is Applying Received a Lump Sum Payment? *(Lawsuit or Insurance Settlement, Social Security, SSI, SSDI, Veterans, Inheritance, Surrender of Annuity, or Life Insurance, Other)* ❑Yes No❑ *If yes, please complete below.*

Who	When Received	Type of Lump Sum	Amount
			$
Who	When Received	Type of Lump Sum	Amount
			$

Does Anyone Pay Child or Adult Daycare, Student Loan Interest, Child Support, Alimony *(Alimony Does Not Apply to Food Assistance Eligibility)*, **or Medical Expenses** *(such as Insurance Premiums, Prescription Medicines, or Copays)?* ❑Yes ❑No *If yes, please complete below.*

Expense	Who Pays Expense	Who it is for	Their Date of birth	Month	Amount Paid

Does Anyone in the Home Attend High School, Vocational, Trade School, or College? ❑Yes ❑No *If yes, please complete below.*

Name of Person	Name of School	Last Grade Completed	Expected Date of Graduation	Enrollment Status
				❑Half Time Full Time ❑
				❑Half Time Full Time ❑
				❑Half Time Full Time ❑

Is There Any Household Member Temporarily out of the Home in a Medical Facility *(such as a Nursing Home, Hospital, a Mental Health Institution, or a Group Home)*? ❑Yes No❑ *If yes, please complete below.*

Name of Person	Date Entered	Name of Facility	Phone

Are You Applying for Food Assistance or Colorado Works? ❑Yes No❑ *If yes, please complete below*

1. Have You or Any Member of Your Home Been Convicted of Fraudulently Receiving Duplicate Food Assistance Benefits in Any State After 9/22/1996? ❑Yes No❑
2. Are You or Any Member of Your Home Hiding or Running from the Law to Avoid Prosecution, Being Taken into Custody, Going to Jail for a Felony Crime or Attempted Felony Crime, or Violating a Condition of Parole or Probation? ❑Yes 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 No❑
4. Have You or Any Member of Your Home Been Convicted of Buying or Selling Food Assistance Benefits for More than $500 After 9/22/1996? ❑Yes No❑
5. Have You or Any Member of Your Home Been Convicted of Trading Food Assistance Benefits for Guns, Ammunitions, Explosives, or Drugs After 9/22/1996? ❑Yes No❑
6. Have You or Any Member of Your Home Been Convicted of a Felony? *(Only Required for Colorado Works)* ❑Yes No❑
7. Have You or Any Member of Your Household Applying for Assistance Been Disqualified for an Intentional Program Violation or Been Convicted of Welfare Fraud in a Criminal Case? ❑Yes No❑

Is Anyone Buying or Does Anyone Own Land, Property, House, Rental Property, Timeshare, Cabin, or Lot?	☐Yes ☐No	*List them below.*

Person Who is Buying/Owns	Address or Property Description	Value	Person Who is Buying/Owns	Address or Property Description	Value
		$			$

Does Anyone Have Life Insurance Policies?	☐Yes No ☐	*List policies below.*

Who	Company and Policy Number		
		☐Revocable ☐Irrevocable	Value $
Who	Company and Policy Number		
		☐Revocable ☐Irrevocable	Value $

Does Anyone Have Burial Insurance Policies?	☐Yes No ☐	*List policies below.*

Who	Company and Policy Number		
		☐Revocable ☐Irrevocable	Value $
Who	Company and Policy Number		
		☐Revocable ☐Irrevocable	Value $

Is Anyone enrolled in health coverage now from the following?	☐Yes. If yes, complete the following section. ☐No. If no, skip this section.
☐ Medicaid	Name: _____
☐ Child Health Plan *Plus* (CHP+)	Name: _____
☐ Medicare	Name: _____ Medicare claim number: _____ Check for: ☐Part A ☐Part B ☐Part D *Please include a copy of the front and back of the Medicare card if it is available.*
☐ TRICARE *(Do not check if you have direct care of Line of Duty)*	Name: _____ Policy Number: _____
☐ VA Health Care Programs	Name: _____ Policy Number: _____
☐ Peace Corps	Name: _____
☐ Employer Insurance	Name: _____ Policy number: _____ Start date of coverage (mm/dd/yyyy): _____ Is this COBRA coverage? ☐Yes No☐ Is this a retiree health plan? ☐Yes No☐ If eligible for Medicaid, do any members of this home have access to group health insurance and want help paying the monthly premium? ☐Yes No☐
☐ Other	Name: _____ Policy Number: _____ Name of health plan: _____ Start date of coverage (mm/dd/yyyy): _____

Does Anyone want help paying for medical bills from the last 3 months?	☐Yes No☐

Voter Registration Choice Form

For office use only

Date: _____

The applicant completed a voter registration form

☐ Yes ☐ No

The applicant requested and was given a voter registration form for later delivery

☐ Yes ☐ No

Employee Initials: _____

Instructions

Please read the following information and complete and sign the form below. This agency will keep the form for its records.

Important Notice

You may file a complaint with the Colorado Secretary of State if you believe that someone has interfered with your right to:

- register or decline to register to vote,
- privacy in deciding whether to register or in applying to register to vote, or
- choose your own political party or other political preference.

Send complaints to:

Colorado Secretary of State
1700 Broadway
Denver, CO 80290
Phone: (303) 894-2200

You may apply to register to vote or update your current registration today

- If you are not registered to vote where you live now, you may apply to register to vote here today.
- If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

Does filling out or not filling out the registration form affect services I am applying for?

No. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

How private is this process?

The name and location of the agency or public office where you received the voter registration application will not appear on your records. If you decide not to use this application to register to vote, that is also confidential.

Complete and sign below

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

Please check only one of the following boxes. *If you do not check either box, you will be considered to have decided not to register to vote at this time.*

☐ **Yes, I want to apply to register to vote today. (Please fill out the Voter Registration Form)**

You are eligible to register to vote if you:

- Are a United States citizen.
- Are or will be a resident of the state of Colorado for at least 22 days immediately before an election in which you intend to vote,
- Are at least 16 years of age but you must be 18 years of age or older on the date of an election in which you intend to vote,
- Are NOT serving a sentence (including parole) for a felony conviction.

☐ **No, I do not want to apply to register to vote today.**

_____
Your full name (please print)

_____ _____
Signature Today's date (MM/DD/YY)

STATE OF COLORADO

Authorization to Release Information

By signing this form, I understand that I am allowing this agency to get records from financial institutions, past and present employers, physicians, healthcare providers, hospitals, schools, and loan companies in order to provide documentation or verify information I have given to the agency. I am also allowing the agency to receive documentation and information from other persons or agencies not previously mentioned. I release these persons, agencies, or institutions from all liability for supplying such information pertaining to me or members of my household.

The members who are receiving or applying for assistance in this household are

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
Signature of Applicant Date

_____
Printed Name

What I Should Know

PLEASE KEEP THIS FOR YOUR INFORMATION

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 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. But, the department can use or share the information with other program(s) that any of my family members are getting or are applying for. The information can only be used for purposes of treatment, payment, determining eligibility, and other program and administrative operations, or other purposes permitted by law for my family members or me.
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 food assistance and/or Colorado Works/TANF for 12 months for the first offense, 24 months for the second offense, and permanently for the third offense.** A court can also stop a person from getting food assistance for another eighteen months. This crime is subject to prosecution under other state and federal laws. Receiving duplicate benefits of food assistance by lying about identity or residence will result in a 10 – year disqualification for the first and second offense and a permanent disqualification for the third offense.
6. **The department will notify me in writing of how and when to tell the department of any changes.**
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 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 for anyone who is applying. They will not check 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 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 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 food assistance 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 food assistance 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 and other information from my application to request and receive information or records to confirm the information in my application.** Food assistance 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 enforcement agencies; employers; courts; and other federal or state agencies; and for food assistance, law enforcement officials for the purposes of apprehending persons fleeing to avoid the law.

    If a food assistance 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.

12. The EBT (or Quest) card is used to pay me most of my public assistance benefits. I cannot trade or sell EBT cards. I cannot use or have in my possession EBT cards that are not mine. Unless I have an authorized representative, I cannot let someone else use my EBT card. I can only let my authorized representative use my EBT card.
13. For food assistance, I can name someone to be my representative. I must do this in writing. The person 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.
14. 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.

COUNTY OF MONTROSE
DEPARTMENT OF HEALTH & HUMAN SERVICES

NOTICE OF PRIVACY PRACTICES

Effective Date: May 1, 2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY

The Montrose County Department of Health & Human Services (Montrose HHS) provides many types of services, including health and other social services. Montrose HHS staff must collect information about you to provide these services. Montrose HHS knows that information we collect about you and your health is private. Montrose HHS is required to protect this information by Federal and State law. We call this information "protected health information (PHI)."

The Notice of Privacy Practices will tell you how Montrose HHS may use or disclose information, about you. Not all situations will be described. Montrose HHS is required to give you a notice of our privacy practices for the information we collect and keep about you. Montrose HHS is required to follow the terms of the notice currently in effect.

Montrose HHS May Use and Disclose Information Without Your Authorization

- **For Treatment.** Montrose HHS may use or disclose information with health care providers who are involved in your health care. For example, information may be shared to create and carry out a plan for your treatment.
- **For Payment.** Montrose HHS may use or disclose information to get payment or to pay for the health care services you receive. For example, Montrose HHS may provide PHI to bill your health plan for health care provided to you.
- **For Health Care** Operations. Montrose HHS may use or disclose information in order to manage its programs and activities. For example, Montrose HHS may use PHI to review the quality of services you receive.
- **Appointments and Other Health Information.** Montrose HHS may send you reminders for medical care or checkups. Montrose HHS may send you information about health services that may be of interest to you.
- **For Health Oversight Agencies.** Montrose HHS will provide PHI as requested to government agencies who have authority to audit or investigate health care operations and providers.
- **As Required by Law and for Law Enforcement.** Montrose HHS will use and disclose information when required or permitted by federal or state law or by a court order.
- **For Abuse Reports and Investigations.** Montrose HHS is required by law to receive and investigate reports of abuse.

Montrose HHS to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request.

- **Right to File a Complaint.** You have the right to file a complaint if you do not agree with how Montrose HHS has used or disclosed information about you.
- **Right to Get a Paper Copy of this Notice.** You have the right to ask for a paper copy of this notice at any time.

How to Contact Montrose HHS to Review, Correct, or Limit Your Protected Health Information (PHI)

You may contact your local Montrose County Dept. of Health & Human Services or the Montrose County Privacy Officer at the address listed at the end of this notice to:

- Ask to look at or copy your records
- Ask to correct or change your records•
- Ask to limit how information about you is used or disclosed
- Ask for an accounting of the information Montrose HHS has disclosed about you
- Ask to cancel your authorization

Montrose HHS may deny your request to look at, copy or change your records. If Montrose HHS denies your request, the department will send you a letter that tells you why your request is being denied and how you can ask for a review of the denial. You will also receive information about how to file a complaint with Montrose HHS or with the Colorado State and/or U.S. Department of Health and Human Services, Office for Civil Rights.

How to File a Complaint or Report a Problem

You may contact any of the people listed below if you want to file a complaint or to report a problem with how Montrose HHS has used or disclosed information about you. Your benefits will not be affected by any complaints you make. Montrose HHS cannot retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe to be unlawful.

Montrose County HIPAA Privacy Officer
Stephen Tullos
1845 S. Townsend
Montrose, CO 81401
Phone: 970-252-5000 Fax: *970-252-5060* e-mail: stullos@montrosecounty.net

Office of Civil Rights
U.S. Dept of Health & Human Services
1961 Stout St. -room 1426IP
Denver, CO 80294
Phone: 303-844-2024 Fax: 303-844-2025