Information specific to
Long Term Care, **Nursing Home Medicaid**

Please fill out all of the forms included in this packet. (The exception is the Spousal Protection application, which only needs to be filled out if you are married.) Applications cannot be processed until *all* required forms are completed and returned to our office. You can expect processing of a new application to take up to 90 days.

Please include the following with the COLORADO DEPT OF HUMAN SERVICES, APPLICATION FOR ASSISTANCE:

- ☐ A copy of private health insurance card, both sides.
- ☐ Life insurance policy information – for *each* policy we need a letter from the insurance company stating:
  - ☐ the current face and cash value
  - ☐ if dividends are paid to owner
  - ☐ date insurance was purchased
  - ☐ who owns the policy
  - ☐ who is the insured
- ☐ A complete copy of any burial/funeral agreement and plots. If the contract is irrevocable, please *circle or highlight* the word irrevocable.
- ☐ Complete copies of the three most recent bank statements for all bank accounts, CD's etc.
- ☐ Verification of all income showing gross and net amount. (Please note: because gross income is not shown on a bank statement, this is not a valid verification source.)
- ☐ A copy of current property tax statement(s) for all properties you own or are in the process of buying, including your place of residence.
- ☐ A copy of the following items:
  - ☐ Social Security Card
  - ☐ Medicare Card
  - ☐ Birth Certificate (not needed if you are receiving Medicare)
  - ☐ Photo ID
- ☐ A copy of legal Power of Attorney, Guardianship, etc., if applicable.

Depending on your individual circumstances, the State may require more supporting documents. Your technician can guide you through this process.

- ☐ If you are a Veteran, proof that you have applied for VA benefits
- ☐ An Income Trust may be needed. If so, your technician will send you one.

Long Term Care, **Nursing Home Medicaid**

Long Term Care services are very expensive. Most Nursing Home clients must use all of their income to pay toward their costs for care, except for a small allowance set aside for personal needs, dependent care or certain uncovered medical costs. Medicaid pays the difference between the client's payment and the provider's charges.

BENEFITS:

Colorado's Long Term Care (LTC) Program provides medical assistance to aged, blind, or mentally or physically disabled persons who need the same level of care in their home that is delivered in a nursing home.

Long Term Care programs include:

- Nursing Home Care
- Long Term Hospital Care
- Home & Community Based Services (HCBS)

Medicaid may also cover:

- Inpatient and outpatient services
- Laboratory and X-ray services
- Physician Services
- Pharmacy Services
- Medical transportation
- Dental care (limited to surgical procedures)
- Medical supplies and durable medical equipment

If you have specific questions regarding ***functional qualification***, call the Options for Long Term Care (OLTC) intake line at 498-7780 for a functional needs assessment. Leave a brief message and phone number and a case manager will return your call no later than the following business day.

NEED ASSISTANCE COMPLETING YOUR APPLICATION?

When the applicant lives in a Rehab Center or Skilled Nursing Home, please contact the social service department in the nursing home or rehab center for assistance with the following applications:

- Long Term Care Medicaid/Health First Colorado
- Medicare Savings Program
- Old Age Pension (OAP)
- Aid to the Needy Disabled (AND)

The nursing home staff will assist you with the application process and answer any questions about eligibility and documentation requirements.

Larimer County Office on Aging/ADRC Application Assistance, (970) 498-7750 is available to assist applicants who live in the community with the following applications:

- Long Term Care Medicaid/Health First Colorado
- Medicare Savings Program

Home visits are available upon request for homebound individuals.
The Larimer County Office on Aging ***cannot assist*** with applications if the ***person applying lives*** in a ***skilled nursing home or rehab center.***

Catholic Charities Northern, 970-484-5010, is available to assist with the following applications:

- Food Assistance
- Aid to the Needy Disabled (AND)
- Old Age Pension (OAP)
- Low-income Energy Assistance (LEAP) -- Nov 1st -April 30th only)

Home visits are available upon request

Larimer County
Options for Long Term Care

If you are having a difficult time living in your home due to your age or disability, Options for Long Term Care may be able to assist.

To learn more about the program or to apply please contact:

970-498-7780 or OLTC@larimer.org

Mission Statement:
Options for Long Term Care (OLTC) provides access to publicly funded programs, providing support to people with disabling functional conditions and limited finances. These programs are designed to help people continue to live in their own homes or in other community settings, as alternatives to nursing home care.

Who May Qualify:

- An individual who has difficulty completing activities of daily living such as bathing, dressing, toileting, eating, difficulty with walking, or requires supervision due to memory or behavioral concerns.
- An individual who has an income of $2,199 or less or is willing to put any excess in a Medicaid approved income trust.
- An individual who has assets of $2,000 or less not including the home they live in and one automobile. Couples may have up to $121,220 in assets, not including their home or automobile for one of them to qualify for services.

Potential Services Available:

- Personal Care or Homemaking
- Consumer Directed Services
- Adult Day Services
- Assisted Living
- Electronic Monitoring Devices
- Home Modifications
- Non-Medical Transportation
- Respite

Services dependent on individual need and waiver restrictions

Medicaid Waivers served by OLTC:

- Elderly Blind and Disabled Waiver (EBD)
- Community Mental Health Supports Waiver (CMHS)
- Brain Injury Waiver (BI)
- Children with Life Limiting Illness Waiver (CLLI)

Visit our website at:
www.larimer.org/humanservices/adultservices/oltc.htm

Program Managers:

Angela Korthaus: 970-498-6877
akorthaus@larimer.org

Matt Bohanan: 970-498-6820
bohanam@larimer.org

LARIMER COUNTY

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 in to 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

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. Would you prefer?

☐ Paper notices ☐ An e-mail with a link to view my notices sent to: _____@_____

Instructions: List **EVERYONE LIVING IN YOUR HOME**, Even if You Are Not Applying for Them. Use More Paper if Necessary.
If you are a non-citizen who has a SPONSOR, list the Sponsor's information here, including their SSN.

Relation to You	Legal Name (First, Middle, Last)	Birth Date (MM/DD/YY) and Birth State	*Male/ Female (M/F)	Does This Person Want Benefits?	*Married, Single, Divorced, Separated, Widowed	Optional for People Not Applying. This is voluntary for food assistance and health coverage. Race information is optional, will not affect eligibility, and is to ensure that benefits are provided regardless of race/color/national origin.		
						Social Security Number (SSN)**	Race***	US Citizen or US National
Self	My Name is on Page 1	My Birth Date is on Page 1 *State:		❑Yes ❑No		My SSN is on Page 1		❑Yes ❑No
Person 2		/ / *State:		❑Yes ❑No		- -		❑Yes ❑No
Person 3		/ / *State:		❑Yes ❑No		- -		❑Yes ❑No
Person 4		/ / *State:		❑Yes ❑No		- -		❑Yes ❑No
Person 5		/ / *State:		❑Yes ❑No		- -		❑Yes ❑No

*Optional for Food Assistance
**For programs other than Food Assistance and health coverage, you must give your SSN if you are applying. You don't have to give it if you are not applying but if you do, 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.
*** *Race options include: Asian –A; Hispanic/Latino – H; American Indian/Alaskan Native - AI; White – W; Native Hawaiian/Pacific Islander- NH; Black/African American. – B; Other – O.*

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	Other Information You Can Provide

Including Yourself, How Many People in Your Home Do You Buy and Prepare Food for?		Do You Pay Any Heating or Cooling Costs? ❑Yes $_____/month ❑No	Did You Receive LEAP Last Year at Your Current Address? ❑ Yes ❑ No
Total Money My Household Expects to Get This Month (Before Deductions).	$	Do You Pay for Electricity? ❑Yes $_____/month ❑No	Do You Pay for Phone Service? ❑Yes $_____/month ❑No
If You Are Supposed to Pay Rent or Mortgage, Write the Amount.	$	Do You Pay for Water? ❑Yes $_____/month ❑No	Do You Pay for Sewer? ❑Yes $_____/month ❑No
Total Cash on Hand and Money in Your Checking/Savings Accounts.	$	Do You Pay for Garbage Service? ❑Yes $_____/month ❑No	Other Utility Expenses. Type: Amount: $_____/month
Is Anyone in the Home a Migrant or Seasonal Farm Worker?	❑Yes No❑	Home Insurance/Property Taxes/HOA Fees $	
Did Anyone in the Home Get Benefits in Another State in the Last 30 Days?	❑Yes No❑	*You may receive food assistance within 7 days 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; OR 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 and in the bank.*	

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❑
Does 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 Who is Applying for Benefits 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 the non-citizen's 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 ❑

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 the non-citizen's 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?	

INCOME Use More Paper if There is Not Enough Room for Your Answers on This Application.

Is Anyone Working?	☐Yes ☐No	*If yes, please include one full month of income (before taxes and deductions) or proof of employment. If you did not provide your Social Security number, please include proof of your employment.*

INCLUDE *Sponsor's income even if the Sponsor lives out of the home.*

CURRENT JOB 1: Name of Person Who is Working:

Employer Name and Phone number			
Monthly Wages/Tips (Before Taxes):		*Average Hours Worked Each Week*	
How Often is This Person Paid? ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly			
Is This Job Considered Temporary and Expected to Last Less than 3 Months? ☐Yes No☐			

CURRENT JOB 2: Name of Person Who is Working:

Employer Name and Phone number			
Monthly Wages/Tips (Before Taxes):		*Average Hours Worked Each Week*	
How Often is This Person Paid? ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly			
Is This Job Considered Temporary and Expected to Last Less than 3 Months? ☐Yes No☐			

CURRENT JOB 3: Name of Person Who is Working:

Employer Name and Phone number			
Monthly Wages/Tips (Before Taxes):		*Average Hours Worked Each Week*	
How Often is This Person Paid? ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly			
Is This Job Considered Temporary and Expected to Last Less than 3 Months? ☐Yes No☐			

Complete if Anyone in the Home Is Starting a New Job:

Name of Person who is going to receive income:
Employer Name and Phone number
Date this person will start new job:
Monthly wages/tips (before taxes):
How often will this person be paid? ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly
Is This Job Considered Temporary and Expected to Last Less than 3 Months? ☐Yes No☐

Complete this box if:

- Anyone has a **Home Business;** or
- Anyone sells things online on websites such as **eBay or craigslist;** or
- Anyone is **Self-Employed;** or if anyone earns money by **babysitting, donating plasma,** or **selling goods such as make-up or kitchenware.**

Who is Self-Employed?	
Name of Business	
Is Business a Corporation orLLC?	☐Yes☐ No
Last Month's Gross Income	$
Utilities Paid for Business	$
Business Taxes Paid	$
Interest Paid on Business Loans	$
Gross Business Labor Costs	$
Cost of Merchandise for Business	$
Other Business Costs: Please describe below:	$
	$
	$
	$
	$
	$
	$
Total Income (Net Income)	$
Signature of Person Who Has This Income.	

For Any Other Income, Use More Paper if There is Not Enough Room for Your Answers on This Application.

Has Anyone in the Home Quit or Lost a Job in the Past 30 days?	☐Yes No☐	*If yes, please complete below.*
Name of Person Who Quit or Lost a Job:	*Employer Name and Phone number:*	
Start and End Date of Job:		
Monthly Wages/Tips (Before Taxes):		
Date and Amount of Your Last Paycheck:		
How Often Was This Person Paid? ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly		

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

☐ *Unemployment Benefits* ☐ *SSI* ☐ *Veteran Widow* ☐ *Workers' 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☐

If you are only applying for Food Assistance, 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

Affidavit of Lawful Presence

If You Are Applying for Colorado Works Everyone in Your House Over 18 Needs to Complete and Sign. If You Are Applying for Aid to the Needy Disabled, (AND-CS or AND-SO), Old Age Pension, or Home Care Allowance You Need to Complete and Sign.

Are You a Citizen of the United States ❑Yes No❑ If No, Are You a Legal Permanent Resident of the United States? ❑Yes No❑

I Am Lawfully Present in the United States Pursuant to Federal Law ❑Yes No❑

I understand this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further admit that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Signature Date

Affidavit of Lawful Presence

If You Are Applying for Colorado Works Everyone in Your House Over 18 Needs to Complete and Sign. If You Are Applying for Aid to the Needy Disabled (AND-CS or AND-SO), Old Age Pension, or Home Care Allowance You Need to Complete and Sign.

Are You a Citizen of the United States ❑Yes No❑ If No, Are You a Legal Permanent Resident of the United States? ❑Yes No❑

I Am Lawfully Present in the United States Pursuant to Federal Law ❑Yes No❑

I understand this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further admit that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Signature Date

Does Anyone Have Any of the Following: ❑Yes No ❑ *List everything below.*

- *Cash*
- *Checking and Saving Accounts*
- *Certificates of Deposits (CD)*
- *Annuities*
- *College Funds*
- *Mutual Funds*
- *Inheritance*
- *PASS Accounts*
- *Individual Development Accounts*
- *Retirement Accounts*
- *Stocks*
- *Bonds*
- *Trusts*
- *Promissory Notes*
- *Education Accounts*
- *Property (Land, Homes)*
- *401(K)*
- *Proceeds from Sale of Home(s)*
- *Other resources*

Person Who Has It	What Do They Have	Amount	Person Who Has It	What Do They Have	Amount
		$			$
		$			$
		$			$
		$			$

Does Anyone Own a Car, Truck, Van, Boat, Motorcycle, RV, or Trailer? ❑Yes No ❑ *List them below.*

Person Who Owns It	Make/Model and Year	Value	Person Who Owns It	Make/Model and Year	Value
		$			$
		$			$

Has Anyone Given Away Anything of Value or Sold Anything for Less than Fair Market Value in the Last Five Years? ❑Yes No ❑ *List what was sold or given away below.*

Person Who Gave It Away or Sold It	What was Given Away or Sold and When	Value	Person Who Gave It Away or Sold It	What was Given Away or Sold and When	Value
		$			$

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☐

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❑

Instructions: Please complete for yourself, your spouse/partner, and children who live with you and/or anyone on your 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. If yes, answer questions 1-3 ❑No. If no, answer question 3	*You can still apply for Medicaid, CHP+, or health insurance even if you do not file a federal income tax return.*

1. Will you file jointly with a spouse?	❑Yes No ❑	If **yes**, please list full legal name of spouse	
2. Will you claim any dependents on your tax return?	❑Yes No ❑	If **yes**, list full legal name of dependents	
3. Will you be claimed as a dependent on someone's tax return?	❑Yes No ❑	If **yes**, list full legal name of the tax filer	
		How are you related to the tax filer?	

Does Anyone Else in the Home Plan to File a Federal Income Tax Return NEXT YEAR?	❑Yes. If yes, answer questions 1-3 ❑No. If no, answer question 3	*You can still apply for Medicaid, CHP+, or health insurance even if you do not file a federal income tax return.*

Name			
1. Will they file jointly with a spouse?	❑Yes No ❑	If **yes**, please list full legal name of spouse	
2. Will they claim any dependents on their tax return?	❑Yes No ❑	If **yes**, list full legal name of dependents	
3. Will they be claimed as a dependent on someone's tax return?	❑Yes No ❑	If **yes**, list full legal name of the tax filer	
		How are they related to the tax filer?	

Does Anyone Else in the Home Plan to File a Federal Income Tax Return NEXT YEAR?	❑Yes. If yes, answer questions 1-3 ❑No. If no, answer question 3	*You can still apply for Medicaid, CHP+, or health insurance even if you do not file a federal income tax return.*

Name			
1. Will they file jointly with a spouse?	❑Yes No ❑	If **yes**, please list full legal name of spouse	
2. Will they claim any dependents on their tax return?	❑Yes No ❑	If **yes**, list full legal name of dependents	
3. Will they be claimed as a dependent on someone's tax return?	❑Yes No ❑	If **yes**, list full legal name of the tax filer	
		How are they related to the tax filer?	

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.

15. 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.

16. Colorado Works is Colorado's TANF (Temporary Assistance for Needy Families) program. It is not an entitlement program and benefits are not guaranteed. Each county has the authority to determine eligibility requirements and benefit levels. 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.

17. As an applicant for Colorado Works, I am required to assign all rights to child support that may be received on my behalf or for those in my household that I am applying for. This assignment starts when I am determined eligible and will continue until my Colorado Works benefits end. If I do not do this or refuse to cooperate with Child Support Enforcement 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.

18. If I am an adult between the ages of 18 and 49, with no children under the age of 18 in my food assistance house, I will only be able to get food assistance benefits for three months during the next three years unless: I work in a job 80 hours each month and report that information to Employment First; or I work my assigned hours at my Employment First office, including *Workfare* or the Employment First work program; or I am determined to be physically or mentally unable to work; or the food assistance office tells me that I am exempt. As long as I do one of these activities each month, I will be able to receive food assistance benefits if I am otherwise eligible.

19. I understand and agree that to receive food assistance, 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 food assistance office schedules you for an appointment. B) Comply with the instructions the Employment First (work program) gives you including reporting for all scheduled appointments and following through on the written agreements you sign. C) Provide information to the food assistance office or the Employment First (work program) about any jobs you get while you are on food assistance. D) Tell the food assistance office or the Employment First (work program) if you are not able to work – you will be asked to provide verification; work any workfare hours you are assigned; go to job interviews arranged for you. Anyone who does not follow the work requirements may be disqualified from receiving food assistance.

20. 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 house will not be eligible for food assistance if I refuse to cooperate with any review of my case, including a quality control review.

21. I cannot use food assistance benefits to buy nonfood items, such as alcohol or cigarettes. I can be disqualified for using food assistance to pay for items purchased on credit. **A person found guilty of using food assistance benefits to illegally purchase or receive controlled substances 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 food assistance upon the first occasion of such violation.**

22. Trafficking food assistance means knowingly transferring benefits to another person who does not use or does not intend to use them for the benefit of the household to whom the benefits were issued. The buying, selling, or transferring of food assistance benefits or Electronic Benefit Transfer Card for cash or consideration other than eligible food or the intent to commit such acts shall be considered trafficking. A person who traffics in food assistance benefits shall include any person who knowingly acquires, accepts, uses, or transfers to another for consideration, food assistance benefits not issued to him or her or to a household of which he or she is a member or for which he or she is an authorized representative. An individual convicted by a Federal, State, or local court of having trafficked benefits for an aggregate amount of $500 or more shall be permanently ineligible to receive food assistance upon the first occasion of such violation.

23. If I do not report and provide proof of rent, 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 food assistance benefit amount.

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

25. 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.

26. 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 will affect your food assistance eligibility and benefit level.

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 ndvh.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 real address for use with state and local government agencies. I can find out more about ACP at acp.colorado.gov. If I need or receive either of these services, I should tell my department worker because it will allow him or her to provide better service and assistance to me.

Our non-discrimination policy. This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion and political beliefs. The U.S Department of Agriculture also prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination with USDA, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800)221-5689, which is also in Spanish or call the State Information/Hotline Numbers; found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm. To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY). USDA and HHS are equal opportunity providers and employers.

SPOUSAL PROTECTION APPLICATION

☑ DEFINITIONS:

- **Institutionalized Spouse** is the person who will be living in an assisted living facility or in a nursing home.
- **Community Spouse** is the spouse who remains at home and is not applying for or receiving Medicaid.

☑ VERIFICATION CHECKLIST:

- Check stub or award letter verifying GROSS income & deductions from all sources (Social Security, private pension, annuities, etc.) for both spouses.
- Billing statements verifying the following household expenses, as applicable:
  - Property Taxes
  - Mortgage/rent
  - Home/renters insurance
  - HOA fees
  - Annual *required* maintenance for property
  - Utilities (gas, electric, water/sewer, home phone *or* cell phone)
- Receipts verifying the following medical expenses for only the COMMUNITY SPOUSE (12 month period unless otherwise noted):
  - Medical Doctor visits (including chiropractor and specialists)
  - Prescriptions (obtain a printout from your pharmacy)
  - Eye Doctor visit/supplies
  - Hospital bills, including scheduled payments
  - Private Health Insurance (monthly premium)
  - Medicare Premiums

LARIMER COUNTY
COMMITTED TO EXCELLENCE

DEPARTMENT OF HUMAN SERVICES

Benefits & Community Support
Fort Collins • Loveland • Estes Park
970-498-6300 Fax 970-498-6304
benefits@larimer.org

Yearly Residential Expenses:
(include copy of receipts for each expense)

Property Taxes	$
Home Insurance	$
Renter's Insurance	$
HOA Fees	$
Maintenance	$
TOTAL	$

Monthly Residential Expenses:
(include copy of receipts for each expense)

Mortgage	$
Rent	$
Heating (gas)	$
Electric	$
Water / Sewer / Trash	$
Home Phone *or* Cell phone	$
TOTAL	$

Yearly Medical Expenses for Community Spouse
(include copy of receipts for each expense)

Medical Doctor	$
Chiropractor/Specialists	$
Prescriptions	$
Eye Care	$
Hospital Bills	$
Medicare Supplemental Insurance	$
Medicare Premiums	$
TOTAL	$

INSTITUTIONALIZED SPOUSE INCOME INFORMATION

Name: _____ Date of Birth: _____

Social Security Number: _____

Income Source		Monthly Gross Amount
1.		
2.		
3.		
4.		
5.		

COMMUNITY SPOUSE INCOME INFORMATION

Name: _____ Date of Birth: _____

Social Security Number: _____

Income Source		Monthly Gross Amount
1.		
2.		
3.		
4.		
5.		

Anyone making false statements or misrepresentation of material facts for use in determining the spousal protection allowance will face, if convicted, a fine and/or jail time.

Signature Of Community Spouse: Date:

Witnesses are required *only if this statement has been signed above by a mark (X).* If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full name and full address.

Witness #1 Printed Legal Name

Address (Number and street, city, state, zip) of Witness #1

Signature of Witness #1 Date

Witness #2 Printed Legal Name

Address (Number and street, city, state, zip) of Witness #2

Signature of Witness #2 Date

LCHS 5336 (11/16)

DEPARTMENT OF HUMAN SERVICES
Benefits & Community Support
Fort Collins • Loveland • Estes Park
970-498-6300 Fax 970-498-6304
benefits@larimer.org

AUTHORIZATION

For the Use and Disclosure of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 states that your protected health information cannot be shared without your permission, except in certain situations. For example, your protected health information can be shared without your permission if it is used to facilitate your health care treatment, payment, or for health plan operations. If you sign this form, you are giving us permission to receive the protected health information you indicate below.

This authorization will only last until the date you specify, and must expire on a specific date or upon the occurrence of a specific event. If you decide later that you do not want us to receive your protected health information any more, you may cancel your authorization at any time by signing the REVOCATION SECTION at the end of this form. Any revocation can only apply to future disclosures or actions regarding your protected health information and cannot cancel actions taken or disclosures made while the authorization was in effect.

Date: _____

Person or group authorized to receive and use my protected health information:

LARIMER COUNTY DEPARTMENT OF HUMAN SERVICES

I, _____ (print your name) **authorize the Larimer County Department of Human Services to receive the protected health information checked below.**

- ☐ Information related to my medical conditions and treatments for the following time period (specify dates):

From: _____ To: _____

Name of health care provider: _____

Name of health care provider: _____

Name of health care provider: _____

Name of health care provider: _____

Name of health care provider: _____

- ☐ Other (specify): _____

Purpose of request for information:

To be used in order to assess my eligibility for Temporary Assistance for Needy Families when I am requesting a medical exemption from participating in the Works program, and/or the Food Assistance program.

Expiration of authorization: (You must specify a date or event) Not to exceed one year from the date of signature.

Date / event of expiration: _____

I understand that the Larimer County Department of Human Services (LCDHS), as a Business Associate of the Colorado Department of Health Care Policy and Financing, may condition payment, enrollment or eligibility for benefits on provision of this authorization because the authorization sought is for the determination of my eligibility or enrollment in this program. I understand that I may refuse to sign this authorization, but if I should refuse, LCDHS may be unable to determine my eligibility for the Temporary Assistance for Needy Families program or Food Assistance.

State ID number: _____ Signature: _____

Date of birth: _____ Social Security # : _____

Name of Designated Personal Representative: _____
*** Legal documentation must be included to show authority to receive information ***

Signature of Designated Personal Representative: _____

Relationship of Designated Personal Representative: _____

I am entitled to receive a copy of this Authorization. Please mail to the following address:

Street address: _____

City, State, Zip: _____

REVOCATION SECTION

I understand that I have the right to revoke this authorization at any time by notifying my case manager. I understand that the revocation is only effective after it is received. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

I no longer want my protected health information used or disclosed.

Signature: _____ Date: _____

COLORADO
Department of Health Care Policy & Financing
Benefits Coordination, Legal Division
1570 Grant Street
Denver, CO 80203

MEDICAID ESTATE RECOVERY PROGRAM
NOTIFICATION OF MEMBER REAL ESTATE OWNERSHIP

Property owned by an applicant for Medicaid benefits is to be identified at the time of Medicaid application. If the applicant is applying for or receiving benefits from the Medicaid Program, this document must be completed. Property to be reported on this notification should include:

- The principal residence owned solely or jointly by the Medicaid applicant.
- Any subsequent properties in the State of Colorado owned solely or jointly by the Medicaid applicant.
- Any out-of-state property owned solely or jointly by the Medicaid applicant.
- Property previously owned solely or jointly where an applicant's interest has been transferred in any way (including the addition of any names to the title) within the last five (5) years.

The _____ County Department of Social Services has been informed that

_____ (Members Name), _____ (Members State ID#) **owns solely, jointly, or has transferred his/her ownership interest on the following properties. These properties may be subject to the TEFRA lien and estate recovery provisions defined in the Colorado Revised Statute 25.5-4-302.**

Primary Property Owner(s) : _____, _____
(as defined on Title)

Joint Ownership Yes ☐ or No ☐ Date of Transfer or change in Title _____

Primary Address: _____

Secondary Property Owner(s): _____, _____
(as defined on Title)

Joint Ownership Yes ☐ or No ☐ Date of Transfer or change in Title _____

Secondary Address: _____

Please use additional forms to indicate additional properties owned by the applicant/client.

_____ Signature or mark of Applicant/Member or their Representative

_____ Date

This information will be reported to the Colorado Estate Recovery Program. Refusal to sign by the applicant, member, or his/her representative does not negate the Department's ability to pursue an Estate Recovery claim.

COLORADO
Department of Health Care Policy & Financing

Benefits Coordination, Legal Division
1570 Grant Street
Denver, CO 80203

MEDICAL ASSISTANCE ESTATE RECOVERY PROGRAM

A. What is estate recovery?

Estate recovery is a program to help pay the costs of providing services to people on Medicaid. Estate recovery is required by federal law. The Colorado Department of Health Care Policy and Financing (the Department) is responsible for administering estate recovery.

B. Who will be affected by estate recovery?

1) The Department may recover payments made for all medical assistance paid on behalf of an individual who was institutionalized at the time he/she received medical assistance; OR,
2) For persons age 55 and older at the time they received medical assistance, the Department may recover the costs of medical assistance provided for nursing facility care, home and community based services, and related hospital and prescription drug services.

Any Medicaid recipient with the circumstances listed above may be affected. Estate recovery applies to all Medicaid recipients, regardless of program type or category of eligibility (e.g. MAGI clients may be affected).

C. What costs will be recovered by the estate recovery program?

For institutionalized recipients, all payments made by Medicaid will be recovered. Payments include, but are not limited to, payments made to providers and capitation fees paid on behalf of the client.

For recipients age 55 and older at the time they received medical assistance, recovered costs are limited to nursing facility services, home and community-based services, and related hospital and prescription drug services.

D. How does estate recovery work?

The Department will file a claim against the estate of a deceased Medicaid recipient. The estate of the recipient will include all of the property (personal and real) that is left when the recipient passes away. Proceeds from the sale of the property in the estate will be used to reimburse the Department for medical assistance provided on behalf of the recipient.

E. Will any estates be exempt from recovery?

The Department will not recover from a deceased recipient's estate if:

1) The deceased Medicaid recipient is survived by a spouse, child under age 21, or a blind or disabled dependent; OR,
2) There is a brother or sister who lived in the home for at least one year before the recipient went into a nursing facility, and who lived in the home continuously since the date of entry into the nursing facility; OR,
3) There is a son or daughter who lived in the home for at least two years before the recipient entered a nursing facility, whose care allowed the recipient to delay nursing facility placement, and who has lived in the home continuously since the date of entry into the nursing facility.

F. What if estate recovery would cause a hardship?

The heirs of a Medicaid recipient may submit a request to waive or compromise recovery from the estate on the basis of hardship. Determination of hardship is at the discretion of the Department.

G. Can the recipient's heirs keep the property in the estate and pay the Department the amount owed instead?

Yes. If the heirs wish to retain the property that is in the estate they may do so as long as they agree to pay the amount that the Department would have otherwise recovered.

H. Does the program require a Medicaid recipient to sell a home while they are still alive?

No. The program does not require a recipient to sell a home. However, the Department may place a lien on the property while the recipient is alive. A lien represents a debt that must be satisfied when the property is sold. A lien secures the Department's interest by ensuring the Department can recover medical costs when the property is sold. A lien does not change the ownership of the property. Liens will be used when ALL five of the following conditions are met:

1) The recipient resides in a nursing facility or other medical institution.
2) The recipient owns a home or other real property.
3) The Department determines that the recipient is not likely to return home to the property.
4) The recipient does not have a spouse, child under age 21, or a blind or disabled dependent living in the home; and,
5) The recipient does not have a brother or a sister who is part owner of the home and who has lived in the home continuously since at least one year prior to the recipient entering the nursing facility.

If a nursing facility resident is discharged from the facility and returns home to live, the Department will remove any lien it has placed on the recipient's home or other property.

Questions or concerns should be directed to Health Management Systems ("HMS") at 303-837-8293.

1570 Grant Street, Denver, CO 80203-1818 P 303.866.2993 F 303.866.4411
www.colorado.gov/hcpf

RESPONSIBILITIES OF RECIPIENTS

As a recipient of Human Services funds, I am aware that I MUST report in writing to Larimer County Department of Human Services within 10 days any change in my circumstances. This includes (but is not limited to) reporting:

(1) Any employment or change in employment.

(2) Receiving any help in paying bills - such as contributions from relatives.

(3) Receiving money from any source - some of the more common sources are:

- VA or Military Benefits
- Sale of Property
- Rental Income
- Sales commissions
- Insurance claims
- Employment income
- Child Support
- Other Pensions
- SSI
- Social Security monthly benefits and/or lump sums
- Railroad Retirement Benefits
- Unemployment Compensation
- Aid to Needy Disabled-Welfare
- Workmen's Compensation
- Bank interest or dividends
- Trust and Annuity payments

(4) Any change in address _____

I have received a copy of the foregoing requirements, which I fully understand and agree to comply with. I UNDERSTAND THAT FAILURE TO NOTIFY THE COUNTY DEPARTMENT WILL MAKE ME LIABLE TO A LEGAL ACTION, EITHER CIVIL OR CRIMINAL.

I ALSO UNDERSTAND THAT IF I FRAUDULENTLY REPRESENT OR MISREPRESENT MY POSITION TO THE DEPARTMENT OF HUMAN SERVICES, I MAY BE FOUND GUILTY OF A FELONY PUNISHABLE "BY UP TO 10 YEARS IN THE PENITENTIARY".

I have read this and/or have had it read to me by _____

this _____ day of _____.
Month Year

Recipient Signature Date	Witness Signature Date
Recipient Printed Name	Title

White: Case file
Yellow: Client

LCHS 5012 (04/03)

LARIMER COUNTY
COMMITTED TO EXCELLENCE

DEPARTMENT OF HUMAN SERVICES
Benefits Planning Division
Fort Collins • Loveland • Estes Park
970-498-6300 Fax 970-498-6304
benefits@larimer.org

CLIENT RESPONSIBILITIES FORM

The following information is to notify the applicant and or his representative of his duties as an applicant and an on-going recipient of assistance in a nursing home.

Please read this form carefully and retain a copy for future reference.

1. The nursing home must be notified immediately that an applicant has applied for Medicaid/Health Care Colorado.
2. An applicant must establish residency in a nursing home or hospital by remaining there for at least 30 days. These 30 days may be covered under Medicaid/Health First Colorado if otherwise eligible. The applicant must be assessed by Options for Long Term Care. Call 970-498-7780 for an assessment.
3. A client may retain up to the Personal Needs Allowance (PNA) as determined each year with Social Security Administration's Cost of Living Adjustment. This amount may or may not increase each year. All other *gross* income must be paid to the nursing home towards his/her care.
4. Any change in a client's income, regardless of the amount, must be reported to the nursing home and/or County Department of Human Services. The receipt of any resources not reported on the application or any change in existing resources, which may affect the client's eligibility, must be immediately reported to the County Department of Human Services.
5. **Any changes must be reported in writing within 10 days.**

At any time that you have a question concerning any of the above items, please call or write your technician.

For individuals only (not spousal protection cases), the individual is eligible on the day after the department determines the resources to be $2,000.00 or below.

Received by: _____ _____
Eligibility Technician

Date: _____

LCHS 5311 (08/16)

LARIMER COUNTY
COMMITTED TO EXCELLENCE

DEPARTMENT OF HUMAN SERVICES

Benefits Planning Division
Fort Collins • Loveland • Estes Park
970-498-6300 Fax 970-498-7987
benefits@larimer.org

VOLUNTARY AUTHORIZATION TO RELEASE INFORMATION AND AGENCY REFERRAL

Name of Referring Agency:_____ **DOB**_____

Name of Consenting Participant:_____ **SSN:**____-___-____

This release is a **voluntary consent** to allow the above named referring agency to enter into ongoing discussion(s) with any of the departments/agencies initialed below. The purpose of the discussion(s) are to allow the providing and/or sharing of information necessary to provide ongoing services for the benefit of the undersigned. Shared information will be only on a need to know basis and only from the department(s) specified below. The shared information may be VERBAL and/or WRITTEN.

The following are the departments and other agencies that have been identified to be used with this individual. I authorize that information may be released and requested on a need to know basis from the departments and agencies indicated below. **(Initial applicable box(es)).**

____ **ALTERNATIVES TO VIOLENCE**
____ **CARE HOUSING**
____ **CATHOLIC CHARITIES NORTHERN**
____ **COLORADO CHILD CARE ASSISTANCE PROGRAM (CCCAP)**
____ **CENTER FOR COMMUNITY PARTICIPATION**
____ **CITY OF FORT COLLINS NEIGHBORHOOD RESOURCES**
____ **COLORADO RURAL LEGAL SERVICES**
____ **CROSSROADS SAFEHOUSE**
____ **CSU COOPERATIVE EXTENSION**
____ **DISABLED RESOURCE SERVICES**
____ **DIVISION OF VOCATIONAL REHABILITATION**
____ **EDUCATION LIFE TRAINING CENTER (ELTC)**
____ **EVEN START**
____ **THE FAMILY CENTER**
____ **FORT COLLINS HOUSING AUTHORITY**
____ **FRONT RANGE COMMUNITY COLLEGE**
____ **HOUSE OF NEIGHBORLY SERVICES**
____ **OTHER AGENCY/DEPARTMENT:**

LARIMER COUNTY WORKFORCE CENTER
____ Larimer County Works Program
____ Welfare to Work
____ Larimer County Adult WIA
____ Larimer County Youth WIA
____ Job Corps
____ Department of Veteran Affairs

LARIMER COUNTY DEPT. OF HUMAN SERVICES (DHS)
____ DHS – Case Service Plans
DHS – Child Support Enforcement
____ **LOVELAND HOUSING AUTHORITY**
____ **MERCY HOUSING**
____ **NEIGHBOR TO NEIGHBOR**
____ **PROJECT SELF-SUFFICIENCY**
____ **VOCATIONAL REHABILITATION**
____ **THE WOMEN'S CENTER**
____ DHS Financial or Food Assistance & Medicaid/ Health First Colorado

Participant Notice

I understand that State and Federal Law mandate that applicants for public assistance must furnish necessary information to assist the department of Social Services to verify statements and/or conditions, and prevent misrepresentation and fraud. I further understand the State of Colorado has authority for solicitation of this information under Title 26, Colorado Revised Statutes, Article 2, Section 107; Title 45, Code of Federal Regulations, Part 233, Section 10(A) (II) (B); and Income Maintenance Manual, Volume 3, Section 3.110.

I am aware and have been advised of the provisions of existing State and Federal Statutes, and Regulations and that the information may be confidential and protected from disclosure.
( ) Participant's initials.

I understand that the information obtained will be shared and used for assessing, planning and facilitating the delivery of services for my benefit. My signature below indicates that I consent to any or ALL department/agencies initialed above discussing records and summaries of information. I further understand that this voluntary consent provides for ongoing discussions and the sharing of information necessary to provide continued services.

I hereby release and hold harmless all of the departments/agencies designated herein from any and all liability and claims of any kind related to this release and the sharing of information as described in the foregoing, provided by any/all of the departments and or agencies. I further acknowledge receiving a copy of this authorization to release.

This release will expire one year from the date of signing unless revoked earlier by the participant.

Participant/Parent/Guardian Signature Date

Employment Coach/Agency Rep. Signature Date

In the event the participant is under the age of 18 years and not emancipated, the participant's parent or legal guardian must sign this release. Verification of the parent or guardian status must be obtained prior to signing.

A properly completed photocopy of this release is as valid as the original

AUTORIZACIÓN VOLUNTARIA PARA DAR INFORMACIÓN Y REMISIÓN A UNA AGENCIA

Nombre de la agencia que lo remite:_____ **DOB**_____

Nombre del participante que autoriza dar la información:_____ **SSN:**____-__-_____

Este comunicado es un **permiso voluntario** para permitir que la agencia nombrada arriba discuta con cualquiera de los departamentos/agencias marcadas abajo. El propósito de la discusión(es) es permitir proveer y/o compartir la información necesaria para seguir otorgando la continuidad de servicios para el beneficio del participante. Solamente en caso de necesitar conocer las bases se compartirá la información y esta será sólo del departamento(s) especificado. La información compartida puede ser VERBAL y/o ESCRITA.

Los siguientes son departamentos y otras agencias que han sido identificadas para usarse con esta persona. Doy mi autorización para que la información pueda ser mostrada y requerida en caso de necesitar conocer las bases desde el departamento y agencia indicada abajo. **(Marque con sus iniciales los departamentos o agencias que sean aplicables.**

____ **ALTERNATIVES TO VIOLENCE**
____ **CARE HOUSING**
____ **CATHOLIC CHARITIES NORTHERN**
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____ **VOCATIONAL REHABILITATION**
____ **THE WOMEN'S CENTER**
____ DHS Financial or Food Assistance & Medicaid/ Health First Colorado

Aviso al participante

Yo entiendo que el State and Federal Law (La ley federal y estatal) requieren que los solicitantes para asistencia pública deben proveer la información necesaria para asistir al departamento de Servicios sociales para verificar las declaraciones y/o condiciones, y prevenir mal representaciones y fraude. Además entiendo que el Estado de Colorado tiene autoridad para solicitar esta información bajo el Title 26, Colorado Revised Statutes, Article 2, Section 107; Title 45, Code of Federal Regulations, Part 233, Section 10(A) (II) (B); e Income Maintenance Manual, Volume 3, Section 3.110.

Estoy consciente y he sido aconsejado de las provisiones existentes por los Estatutos y regulaciones Federales y estatales y que la información puede ser confidencial y protegida de ser divulgada.
( ) Iniciales del participante.

Yo entiendo que la información obtenida será compartida y usada para asistir, planear y facilitar la obtención de servicios para mi beneficio. Mi firma abajo indica que doy permiso a cualquiera o a TODOS los departamentos/agencias marcadas arriba para que discutan los registros y hagan un resumen de la información. Además entiendo que este permiso voluntario servirá para otras discusiones y para compartir la información necesaria para proveer la continuidad de los servicios.

Por este medio libero de toda responsabilidad y demandas de cualquier tipo y afirmo no tomar represalias para ninguno de los departamentos/agencias mencionadas aquí con relación a divulgar y compartir la información como se describe anteriormente y que se haya dado a conocer por cualquier/todos los departamentos o agencias. Además es de mi conocimiento que recibí una copia de esta autorización para dar a conocer información.

Esta autorización terminará en un año a partir de la fecha de la firma al menos que sea revocada antes por el participante.

Firma del participante/padre/encargado Fecha

Firma del trabajador que lo asiste/agencia representante Fecha

En el caso de que el participante se menor de 18 años y no sea independiente, los padres del participantes, representantes legales deben firmar esta forma de divulgación. La verificación de la condición de los padres o encargados debe de ser obtenida antes de la firma..

Una copia propiamente completada de esta permiso para la obtención de información es tan valido como el original

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 a resident of the state of Colorado for at least 22 days before the election at 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 the election at 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)

Formulario de Elegir Registración de Votante

Para uso de la oficina solamente

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: _____

Instrucciones

Por favor, lea la siguiente información y complete y firme el formulario abajo. Esta agencia mantendrá el formulario por su registro.

Aviso Importante

Usted puede presentar una queja con el Secretario de Estado de Colorado si usted cree que alguién ha interferido con su derecho a :

- registrarse o declinar la registración para votar,
- privacidad en la decisión de registrarse o en aplicar para registrarse para votar, o
- elegir su propio partido político y otras preferencias políticas.

Enviar quejas a:

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

Usted puede aplicar para registrarse para votar o actualizar su registro hoy

- Si usted no está registrado para votar en el lugar donde reside ahora, usted puede registrarse para votar aquí hoy.
- Si usted quisiera ayuda para llenar el formulario de registración de votante, le ayudaremos. Usted decide si desea o no buscar o aceptar ayuda. Usted puede llenar el formulario de registración en privado.

¿Afecta los servicios que estoy solicitando el hecho de que llene o no llene el formulario de registración?

No. Aplicar para registrarse o declinar la registración para votar no afectará la cantidad de ayuda que esta agencia le proporcionará.

¿Qué tan privado es este proceso?

El nombre y lugar de la agencia u oficina pública donde recibió la aplicación de registración de votante no aparecerá en sus expedientes. Si decide no usar esta aplicación para registrarse para votar, esto también es confidencial.

Complete y firme abajo

Si usted no está registrado para votar en el lugar donde reside ahora, ¿desea aplicar para registrarse para votar aquí hoy?

Por favor, sólo marque una de las casillas a continuación y firme abajo. Si no marca ninguna casilla, se considerará que ha decidido no registrarse para votar por el momento.

☐ Sí, deseo aplicar para registrarme para votar hoy. (Por favor llene el Formulario de Registración de Votante)

Usted es elegible para votar si:

- Es ciudadano de los Estados Unidos.
- Es un residente del estado de Colorado durante por lo menos 22 días antes de la elección en la que usted se propone votar,
- Tiene por lo menos 16 años de edad, pero usted debe tener 18 años de edad o mayor en la fecha de la elección en la que usted se propone votar.
- NO está cumpliendo una condena (inclusive libertad condicional) debido a una condena por delito.

☐ No, no deseo aplicar para registrarme para votar hoy.

_____
Su nombre completo (letra de imprenta)

_____
Firma

_____
Fecha de hoy (MM/DD/AA)

Long Term Care, **Nursing Home Medicaid**

ELIGIBILITY:

LTC applicant must meet specific requirements for Long Term Care Nursing Home Medicaid Services, including:

1. Currently living in a medical care facility for at least 30 days ***or*** requiring nursing home placement.
2. Having income and resources below the limits set for current year. Resources include, but *are not limited to*: cash, monies in checking and savings accounts, annuities, CD's, burial funds, stocks, bonds, some insurance policies and property you own other than your home.
3. Be a citizen or Legal Permanent Resident
4. Be a resident of Colorado
5. If under age 65, must meet federal disability requirements.

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	2. State of Colorado Application for Assistance	615-82-13-0029
	3. BIC flyer	
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Brochure	8. Medical Assistance Estate Recovery	615-82-92-2011
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NOTICE

Failure to report or verify any expenses such as rent, utilities, mortgage, taxes, insurance, daycare or medical costs will be seen as a statement by your household that you do not want to receive a deduction for that expense.

LARIMER COUNTY

DEPARTMENT OF HUMAN SERVICES

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