COLORADO
Department of Health Care Policy & Financing

PATIENT APPLICATION
Hospitals and Hospital Based Clinics

Section I: PATIENT/APPLICANT

Today's Date:

Homeless: _____

Emergency Application: _____

Last Name | **First Name** | **Middle Initial**

Address | **City** | **Zip Code** | **County** | **Phone Number**

List Household Members	Relationship to Patient	Date of Birth	Health First CO Number	Selected Program for Household Member (Hospital Discounted Care, Charity Care, Hospital Discounted Care & Charity Care, HH Size Only)
1.	PATIENT/APPLICANT			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

Section II: Calculating Income

Income Source	Monthly Income	
1. Gross Employment Income	$	$
2. Unearned Income	$	$
3. Self-Employment Income	$	$

4. Total Income (Lines 1 + 2 + 3)	$ _____	$ _____
5. Allowable Deductions **(See Worksheet 3)**	$ _____	
6. Grand Total Annual Income	$ _____	

FPG Percentage: _____ Household Size: _____

HDC Facility Monthly Max: _____ **HDC Physician Monthly Max:** _____

PENALTY CLAUSE,CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the provider to use any information contained in the application to verify my eligibility for assistance under Hospital Discounted Care, and to obtain records pertaining to eligibility from a bank or other financial institution as defined in section 15-15-201(4), C.R.S., or from any insurance company.

YOU HAVE 30 CALENDAR DAYS TO APPEAL YOUR ELIGIBILITY DETERMINATION FOR HOSPITAL DISCOUNTED CARE
(Ask your eligibility technician for more information on the appeal process)

_____ _____
Print Patient/Applicant Name Applicant Signature and Date

Patient was contacted by ☐ phone ☐ email ☐ other: _____ and documentation of contact is attached in lieu of signature.

_____ _____
Print Eligibility Technician Name Eligibility Technician Signature and Date

_____ _____
Print Facility Name Facility Phone Number

Application Notes:

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Worksheet 1 - Earned and Unearned Income

Payment Sources	Monthly Income	Annualized Income	Documented	Self-Declared
Earned Income:				
Employment Income	$	$		
Monthly Unearned Income Sources:				
Social Security	$	$	☐	☐
Social Security Disability Income (SSDI)	$	$	☐	☐
Disbursement from Retirement Account	$	$	☐	☐
Pension Payments	$	$	☐	☐
Payments from Trust Funds	$	$	☐	☐
Disbursement from Lottery Winnings	$	$	☐	☐
Annual or One Time Income Sources:				
Bonuses (enter full amount of bonuses included on pay stubs)	$	$		
Short Term Disability (enter full amount of remaining payments from STD)	$	$		
Unemployment Income (weekly amount multiplied by 52 to ensure corrct annual FPG calculation)	$	$		
Tips and Commissions (only if not normal on paystub)	$	$		
Infrequent Overtime	$	$		
Earned Income Total	$	$		
Unearned Income Total	$	$		
Total Income	$	$		

Eligibility Technician Signature Date

Facility Phone

Revised June 2025

This worksheet must be signed and included with all client applications.

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Worksheet 2 - Net Self-Employment Income

Does the client operate their business from their home? _____

Square footage of applicant's home: _____

Square footage used for applicant's home business: _____

Hours per week applicant works out of their home: _____

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

_____	$ _____	$ _____
_____	$ _____	$ _____
_____	$ _____	$ _____
_____	$ _____	$ _____
_____	$ _____	$ _____
_____	$ _____	$ _____
Total Expenses:	$ _____	$ _____
Total Expenses Attributed to Business:	$ _____	$ _____
Net Profit	$ _____	$ _____ (use this figure on line 3, Section II of the Application)

Eligibility Technician Signature Date

Facility Date

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This worksheet only needs to be signed and included if the applicant owns their own business.

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Worksheet 3 - Allowable Deductions

Type of Deduction	Amount	Frequency	Annualized Amount
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$

Household declares they have no deductions ☐ **Grand Total** $

Eligibility Technician Signature Date

Facility Phone

Revised June 2025

If your facility includes deductions, this worksheet must be signed and included with all client applications.