**PATIENT APPLICATION**
**Hospitals and Hospital Based Clinics**

**Section I: PATIENT/APPLICANT**

Homeless: ________________

Today's Date:

Emergency Application: ________________

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

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

| **List Househould 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 b☐ phon☐ 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:**

## Worksheet 1 - Earned and Unearned Income

| Payment Sources | Monthly Income | Annualized Income | | |
|---|---|---|---|---|
| Earned Income: | | | | |
| Employment Income | $ | $ | | |
| **Monthly Unearned Income Sources:** | | | Documented | Self-Declared |
| 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) |

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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.**