Community Access and Referral Enrollment System Application

Some dental, mental health, and primary care medical providers in La Plata County have agreed to provide discounts for patients without private or governmental insurance. If you and/or members of your household wish to apply for the **CARES** program, you must fill out and sign this form. All information you give is confidential, and this is a voluntary program. The **CARES** ID card must be taken with you to the provider's office in order in order to qualify for a discounted fee.

Your Full Name _____

Address: Street_____City_____Zip Code_____

Phone Numbers: Home_____ Work_____ Cell_____

Email address: _____ Number of persons living in the household _____

Ethnicity *(optional)*: Caucasian Hispanic Native American Other

LIST BELOW <u>ONLY</u> THOSE PERSONS IN YOUR HOUSEHOLD APPLYING FOR CARES *(include yourself if you are applying):*

Last Name	First Name	Gender	Last 4 Digits of Social Security # *(leave blank if undocumented)*	Birth Date	How is this person related to the Applicant?	Is this person a U.S. Citizen? (Yes/No)	CARES ID Number ***(office use only)***
		M F					
		M F					
		M F					
		M F					
		M F					
		M F					

Gross household monthly income *(before taxes):* _____

Note: include income from <u>all</u> persons in household and income from all sources, including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self employment, alimony, child support, military, unemployment, public aid, and other.

Have those applying for CARES been covered by health insurance at any time <u>in the past 2 years</u>? Yes____ No_____

(IF YES) Please check the type of insurance coverage you/your family had <u>in the past 2 years</u> *(CHECK ALL THAT APPLY):*

Medicaid_____ CHP+_____ Private Insurance_____ *(through employment)* Private insurance_____ *(self-paid)* Other_____

I certify that the information shown above is correct and the members of my household applying for this program do not have health insurance. The Financial Counselor has explained the **CARES** program to me. I understand I must be a resident of La Plata County to participate in the Program and that the amount of discount provided, if any, will be determined by each provider independently. I agree to remit payment at time of service unless specified otherwise by the provider. I understand that Information on this form and from other agencies may be used for reporting purposes. My individual personal information will not be disclosed and will remain confidential. My eligibility for the Program must be determined in one year; current documentation must be provided at that time.

Applicant Signature_____ Date_____

Financial Counselor Signature_____ Date_____ Agency_____

***<u>FOR OFFICE USE ONLY</u>**: Approved: _____ Denied _____ Reason for Denial_____*

***CARES** eligibility code: L1 (< 100% FPL) _____ L2 (101-133%) _____ L3 (134-200%) _____ L4 (201-250%) _____ L5 (251-400%) _____*

Card Issued: ____/____/____ By: _____ Entered into Computer: ____/_____/_____ By:_____Renewal date:_____