summit community
CARE CLINIC

The Care Card is a Sliding Fee Scale program based on your income and family size, according to the current Federal Poverty Guidelines.

The current 2023 Federal Poverty Guidelines are as follows:

Family Size Including Applicant	1 Person	2 People	3 People	4 People	5 People	6 People	7 People	8 People
Yearly Gross Income Limit	$45,180	$61,320	$77,460	$93,600	$109,740	$125,880	$142,020	$158,160

REQUIREMENTS FOR CARE CARD APPLICATION

1. Completed Care Card Application Form (In paper or online)

2. Proof of identification for ALL dependents living in the SAME household. Photo ID for adults is preferred. Adult children over 18 in higher education MUST provide student ID or school enrollment.

   - **Identification, examples:**
     - Driver License
     - Passport
     - Birth Certificate
     - School Identification
     - SSN Card, etc.

3. Proof of income (Please bring ONE(1) of the following for every employed family member):

   - **Earned Income, examples:**
     - Last calendar month of pay stubs (2 consecutive biweekly or 4 consecutive weekly paystubs)
     - Typed income verification letter from your employer or SCCC Income Verification form (**gross** income, estimated tips, if applicable, dated within the last 30 days, on company letterhead to include address, phone number, and contact for employer)
     - Taxes from prior year, W2, Form 4506-T
     - Self-Declaration of income
   - **Self Employed, examples:**
     - Taxes 1040 or 1099 from prior year
     - Profit and Loss Statement
     - One month of gross bank business deposits or ledger
     - Summit Community Care Clinic Self-Employment worksheet and business bank statement
   - **Unearned Income, examples:**
     - Unemployment or Worker's Compensation
     - Social Security or Supplemental Security Income (SSI)
     - Public assistance
     - Veterans' benefits
     - Survivor benefits
     - Disability benefits
     - Pension or retirement income
     - Interest or dividends
     - Rents, royalties, estates, and trusts
     - Alimony
     - Child support
     - Self-declaration of income

Please Drop Off Application with all required documents at the Medical Office Front Desk (Suite 100) or via web through the link: https://intakeq.com/new/qrouon/asknei or QR Code. If you have any questions regarding documentation required, or would like to speak with an Eligibility Coordinator, please call (970)668-4040 or email frontdesk@summitclinic.org.

summit community CARE CLINIC

CARE CARD APPLICATION FORM

Please complete all sections, mark NA if not applicable

First Name and Last name of applicant	Social Security #	Date of Birth Month _____ Day _____ Year_____
Physical Address	City, State, Zip Code	Phone #
Mailing Address or PO Box #	Name of the PO Box Holder if different than applicant:	City, State, Zip Code

Are you pregnant?	Y / N	Do you have private medical Insurance?	Y / N	Do you have private dental insurance (that is not through a Medicare Advantage Plan)?	Y / N

Please list spouse and dependents under 18 years old who live with you, even if not requesting benefits, and select "Y" or "N" if they have insurance and "Y" or "N" if they need the discounts as well.

(Adult students MUST provide student ID or school enrollment from current year/ Seniors dependents over 60 years old only):

FULL NAME Partner/ Spouse and Dependents	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP WITH APPLICANT	PATIENT HAS INSURANCE	APPLYING FOR DISCOUNT
				Y N	Y N
				Y N	Y N
				Y N	Y N
				Y N	Y N
				Y N	Y N
				Y N	Y N
				Y N	Y N

DECLARATION OF INCOME:

INCOME SOURCE	SELF	SPOUSE	OTHER	TOTAL
Earned, Unearned, Self Employed Income for the Household				

APPLICATION FOR MEDICAID/CHP+

I grant permission to Summit Community Care Clinic to apply for Medicaid/CHP+ on behalf of myself and/or family members as noted above. Yes No

CERTIFICATION

I certify that the family size and income information above is correct.

Applicant Signature _____ Completion Date _____

V: 03/01/24

CARE CARD APPLICATION CHECK LIST

For Internal Use Only

summit community CARE CLINIC

Applicant Name _____

Employee Initials	Date Received	
		Received Application complete and Sign with items provided marked and completed

Please make copies of the following:

Employee Initials	Date Received	
		ALL FAMILY MEMBERS IDENTIFICATION:

*Examples of approved identification: Colorado Driver~~'s~~ License, Colorado Issued ID, Passport, Other state ID,

ID from your country, ID from your employer, Green card, School ID

Employee Initials	Date Received	
		PROOF OF INCOME:

Examples of approved income:

*Last 30 days of consecutive pay stubs
*Income Verification letter from your employer (gross income, estimated tips, if applicable, dated within the last
*30 days, on company letterhead to include address, phone number, and contact for employer)
*Taxes from prior year, or W2's
*Self-Declaration of income

If Self Employed, one of the following will be required:
*Unemployment
*Workers Compensation
*Social security or Supplemental
*Public Assistance
*Veteran's Benefits
*Survivor Benefits

DO NOT RECEIVE APPLICATIONS WITH LACK OF INFORMATION, PLEASE RETURN TO THE PATIENT UNTIL THEY PROVIDE ALL THE REQUIREMENTS