Elevated Community Health

# CARE CARD APPLICATION

The Elevated Care Card is an income-based program and is determined using a Sliding Fee Scale. The Sliding Fee Scale is based off your gross income and family size in accordance with the current Federal Poverty Guidelines.

**The current 2026 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 | $31,920 | $43,280 | $54,640 | $66,000 | $77,360 | $88,720 | $100,080 | $111,440 |

## Required documents needed to apply:

1. **Completed Elevated Care Card Application.**
2. **Proof of identification for each family member living in the same household**. Provide proof of identification for each member of the household. Accepted documents include a driver's license, birth certificate, passport, etc. A photo ID is preferred for adults. Household members include:
   - Husband, wife, common-law spouse, or civil union partners.
   - Children, stepchildren, foster children under the age of 18 years old, or unborn.
   - Adult children (over 18) with disabilities or adult children who are still in high school or higher education and living full-time in the household. (must provide proof of current enrollment/disabilities)
   - Dependent parents.
3. **Proof of Patient and/or Family Income.** All income from spouses, significant others, and other family members. Provide documentation of income for **the last full calendar month** or taxes for previous year. Acceptable documents include:
   - Paycheck stubs from the **last full calendar month**
   - Current income tax forms 1040 or W-2s.
   - Income verification letter from the patient's employer,
     *If employment income is paid in cash, an employer's income verification is required.*
     For the employer's income verification letter, it should:
     - Be typed and on company letterhead and dated within the last 30 days.
     - Include the employer's address, phone number, and contact person.
     - Specify the employee's gross income and, if applicable, estimated tips.
   - Self-Declaration of income can be used on a temporary basis. Completed form is required.

   **If the patient is self-employed**, they must provide one of the following:
   - Taxes, 1040 OR 1099.
   - Profit and Loss worksheet.
   - One month of gross business bank deposits or a ledger.

   **If the income is derived from unearned sources,** it may include:
   - Unemployment benefits or Worker's Compensation.
   - Social Security or Supplemental Security Income (SSI).
   - Pension or retirement income.
   - Public assistance. (e.g., SNAP, TANF)
   - Veterans' benefits or Survivor benefits.
   - Disability benefits. (SSDI)
   - Income from interest, dividends, rents, royalties, estates, or trusts.
   - Alimony.
   - Child support.
4. **Insurance cards for all family members (Front and Back of cards)**
   **(Private insurance, Medicare, Medicare Advantage, Medicaid or CHP+)**
5. Proof of Colorado Residency for seniors over the age of 60 (Senior Dental Grant Program)

If you are interested in applying for Medicaid/CHP+ please call (970) 372 - 4908 or scan the QR code below for the link to the application.

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# CARE CARD APPLICATION

| CONTACT INFORMATION | | | |
|---|---|---|---|
| **Home Address:** | X<br>**Address** **City** **Zip** **County** | | |
| **Mailing Address:** | X<br>**Address** **City** **Zip** **County** | | |
| **Email Address:** | | **Phone Number** | |
| **How would you like to receive information about the benefits:** | | | ☐ Text<br>☐ Email |

## APPLICANT/DEPENDENT INFORMATION

| FULL NAME<br>Include the Applicant/Partner/Spouse/Dependents | Date of Birth<br>(Month/Day/Year) | Relationship | Employed | Does the patient have insurance? | Requesting a discount? |
|---|---|---|---|---|---|
| | | | ☐YES ☐NO | ☐YES ☐NO | ☐YES ☐NO |
| | | | ☐YES ☐ NO | ☐YES ☐NO | ☐YES ☐NO |
| | | | ☐YES ☐NO | ☐YES ☐NO | ☐YES ☐NO |
| | | | ☐YES ☐ NO | ☐YES ☐NO | ☐YES ☐NO |
| | | | ☐YES ☐ NO | ☐YES ☐NO | ☐YES ☐NO |
| | | | ☐YES ☐NO | ☐YES ☐NO | ☐YES ☐NO |
| | | | ☐YES ☐NO | ☐YES ☐NO | ☐YES ☐NO |
| | | | ☐YES ☐NO | ☐YES ☐NO | ☐YES ☐NO |

Is anyone in your household pregnant ☐ YES ☐ NO If yes, who: _____

## DECLARATION OF MONTHLY GROSS INCOME: (Income Before taxes or deductions)

**INCOME SOURCE**

Earned, Unearned, Self-Employed Income.

| APPLICANT: | PARTNER/SPOUSE: | OTHER: | TOTAL: |
|---|---|---|---|
| Monthly Gross $_____ | Monthly Gross $_____ | Monthly Gross $_____ | Monthly Gross $_____ |

## DECLARATION

I acknowledge that this is an income-based program and understand that I am required to submit the necessary documentation listed above. I hereby certify that the family size and income information above is accurate. Any discrepancies found in the disclosed information may result in the withdrawal of the Sliding Fee Discounts and the imposition of the full fee.

Applicant Signature: _____ Completion Date:_____

Please allow us two weeks to process your application. For any questions regarding required documentation or if you'd like to speak with an Eligibility Coordinator, Please call (970) 668-4040 Option #5 or email eligibility@elevatedch.org .