



Affidavit
for the Colorado Department of Human Services
and the Department of Health Care Policy and Financing
as Proof of Lawful Presence in the United States

I, _____, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check one);

_____ I am a United States citizen, or

_____ I am a legal Permanent Resident of the United States, or

_____ I am lawfully present in the United States pursuant to federal law.

I understand that this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall construe a separate criminal offense each time a public benefit is fraudulently received.

Name

Date

**AUTHORIZATION FOR REIMBURSEMENT OF INTERIM ASSISTANCE
INITIAL CLAIMS PAYMENT OR POST-ELIGIBILITY CASE PAYMENT**

Name _____ Social Security Number _____

Address _____ City/Town/Zip Code _____

The term State means the State of Colorado.

What actions am I authorizing when I sign this authorization and I check the "Initial Claim Only" block?

X Initial Claim Payment Only

You are authorizing the Commissioner of the Social Security Administration (SSA) to reimburse the State for some or all of the money the State gives you. This money helps you while SSA decides if you are eligible to receive SSI benefits. If you become eligible, SSA pays the State from the retroactive SSI benefits due you. The reimbursement covers the time from the first month you are eligible to receive SSI benefits through the first month your monthly SSI benefits resume.

If the State cannot stop the last payment made to you, SSA can reimburse the State for this additional payment amount.

What actions am I authorizing when I sign this authorization and I check the "Post-eligibility Case Payment Only?"

□ Post-eligibility Case Payment Only

You are authorizing the Commissioner of the Social Security Administration (SSA) to reimburse the State for some or all of the money the State gives you. This money helps you while SSA decides if your SSI benefits can be reinstated after being terminated or suspended. If your SSI benefits resume, SSA pays the State from the retroactive SSI benefits due you. The reimbursement covers the time from the day of the month the reinstatement is effective through the first month your monthly SSI benefits resume.

If the State cannot stop the last payment made to you, SSA can reimburse the State for this additional payment amount.

How can the State use this form when boxes for initial claims and post-eligibility cases are part of the form?

The State can use this form for one case situation at a time, either an initial claim or a post-eligibility case. If both payment blocks are checked the form is not valid. You and the State must sign and date a new form with only one block checked.

What kind of State payment qualifies for reimbursement by SSA?

SSA can reimburse a State payment that is paid only from State or local funds. The State cannot be reimbursed for payments made wholly or partially from Federal funds.

How does SSA determine how much of my SSI money to pay the State?

SSA decides the amount of payment based on two considerations. First, SSA looks at the amount of money claimed by the State, and second, SSA looks at the amount of your retroactive SSI money available to pay the State. SSA can reimburse the State for a payment made in a month only when you receive a State payment and a SSI payment in the same month. SSA will not pay the State more money than you have for the SSI retroactive period.

How long is this authorization effective for the State and me if I checked the Initial Claims Block?

This authorization is in effect for you and the State for twelve (12) months. The 12 months begin with the date the State notifies SSA through an electronic system that the State has received the authorization and ends 12 months later. You and a State representative must sign and date the authorization for the authorization to be valid.

Exceptions apply to this rule. The State must send SSA the authorization within a certain time limit. For a State using an electronic system, SSA must receive the authorization information within 30 calendar days of the State matching your SSI record with your State record. If the information is late, SSA will not accept the information sent by the State. SSA will not pay any of your retroactive SSI benefits to the State. SSA will send you any SSI money that may be due you, based on SSA's regular payment rules.

Can the authorization stay effective longer than the 12-month period? Can the authorization end before or after the 12-month period ends?

The authorization can stay effective longer than the 12-month period, if you

- apply for SSI benefits before the State has the authorization form, or
- apply within the 12-month period the authorization is effective, or
- file a valid appeal of SSA's decision on your initial claim.

The period of the authorization can end before the 12-month period ends, or end after the 12-month period ends when any of these actions take place:

- SSA makes the initial SSI payment on your initial claim; or
- SSA makes a final decision on your claim; or
- The State and you agree to terminate this authorization.

The authorization period will end with the day of the month any of these actions take place.

How long is this authorization effective for the State and me if I check the Post-eligibility Case block?

This authorization is in effect for you and the State for twelve (12) months. The 12 months begin with the date the State notifies SSA through an electronic system that the State has received the authorization and ends 12 months later.

Exceptions apply to this rule. The State must send SSA the authorization within a certain time limit. For a State using an electronic system, SSA must receive the authorization information within 30 calendar days of the State matching your SSI record with your State record. If the information is late, SSA will not accept the information sent by the State. SSA will not pay any of your retroactive SSI benefits to the State. SSA will send you any SSI money that may be due you, based on SSA's regular payment rules.

Can the authorization stay effective longer than the 12-month period? Can the authorization end before or after the 12-month period ends?

The authorization can stay in effect longer than the 12-month period if you file a valid appeal. You must file your appeal within the time frame SSA requires.

The period of the authorization can end before the 12-month period ends, or can end after the 12-month period ends when any of these actions take place:

- SSA makes the first SSI payment on your post-eligibility case after a period of suspension or termination; or
- SSA makes a final decision on your appeal; or
- The State and you agree to terminate this authorization.

The authorization period will end with the day of the month any of these actions take place.

Can SSA use this authorization form to protect my filing date for SSI benefits?

SSA can use this form to protect your filing date if you checked the Initial Claims block. When you sign this form, you are saying that you have the intention of filing for SSI benefits if you have not already applied for benefits.

You have sixty (60) days from the date the State receives this form to file for SSI benefits. Your eligibility to receive SSI benefits can be as early as the date you sign this authorization if you file within the 60-day time period. If you file for SSI benefits after the 60-day time period, this form will not protect your filing date. Your filing date will be later than the date you sign this form.

How do I appeal a State's decision if I do not agree with the decision?

You can disagree with a decision the State made during the reimbursement process. You will receive a State notice telling you how to appeal the decision. You cannot appeal to SSA if you disagree with any State decision.

Within 10 working days after the State receives the reimbursement money from SSA, the State must send you a notice. The notice will tell you three things. The State will tell you the amount of the payment SSA sent to the State and your right to a hearing with the State, including how to request the hearing. Also, the notice will tell you that SSA will send you a letter explaining how SSA will pay the remaining SSI money (if any) due you.

Date _____
Signature of Individual Receiving Interim Assistance

Date _____
Signature of State Representative

AGREEMENT NOT TO SPONSOR

NAME OF APPLICANT/CLIENT:

STATE I.D. NUMBER:

HOUSEHOLD/CBMS NUMBER:

I am applying for or currently receiving financial or medical assistance from the State of Colorado. As a condition of my eligibility for this assistance, I agree that, during the time I am receiving such assistance, I will not sign an Affidavit of Support to sponsor a noncitizen who is seeking permission to enter or remain in the United States. I understand that my eligibility of assistance is not affected by any Affidavit of Support I signed before July 1, 1997.

SIGNATURE

DATE



County Department Fax Information: 303-441-1523/ imaging@bouldercounty.org Med-9 Due Date: _____

Med-9 Instructions for the Client	
Important Information	What We Are Asking You To Do?
<p>You need a medical examination to determine your ongoing eligibility for Aid to the Needy Disabled (AND).</p> <p>You need to get the attached Med-9 form completed by a medical provider* and then return it to your county office by the due date specified at the top of this form.</p>	<ol style="list-style-type: none"> 1. Make an appointment with a medical provider* 2. Ask the medical provider* to: <ol style="list-style-type: none"> a. Read the instructions below; and b. Complete all of gray sections on the Med-9 form 3. Return the completed Med-9 form to your county office by the due date. You can return the form in person, through email, by fax, by mail, or online through your PEAK account.
Med-9 Instructions for the Medical Provider* (Please Read)	
Important Information	What Are We Asking the Medical Provider* To Do?
<p>This individual has applied for Aid to the Needy Disabled (AND). AND provides a monthly payment to individuals that cannot maintain gainful employment due to a disability.</p> <p>In order to qualify for AND, a medical provider* must certify the applicant's disability by filling out the attached Med-9 form based on an assessment of the applicant's medical condition.</p> <p>The words "total disability" on the Med-9 form are derived from regulations. They are not intended to reflect medical prognosis terminology. The county department of human/social services and State Department of Human Services will consider your medical opinion expressed on the form.</p>	<ol style="list-style-type: none"> 1. Evaluate the applicant's disability 2. Complete <i>all</i> of the gray Sections on the Med-9 form <ol style="list-style-type: none"> a. Check only <i>one</i> disability level box b. Your signature, provider type, name, address, phone number, license number, the state issuing your license and date of exam 3. Return the completed form to the applicant. You may also send a copy to the county department to assist the process. Please be aware of the fax number and due date above.

**Acceptable Medical Providers are: Colorado licensed physician (general practitioner or specialist), licensed psychologist, physician's assistant, advanced practice nurse, registered nurse, licensed professional counselor, or licensed clinical social worker. Medical certification for blindness shall be completed only by an ophthalmologist licensed in Colorado.*

The Aid to the Needy Disabled (AND) Program provides financial benefits to Colorado residents who are disabled. This form is used by County Departments of Human/Social Services to determine medical eligibility for the AND Program.

Name	SSN	DOB
Address	Phone	Zip Code
City	County	Effective Date

The rest of this form must be completed by one of the following medical professionals licensed in Colorado.

<p>Please select the option that corresponds to your license/certification:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <input type="radio"/> Physician* <input type="radio"/> Licensed Psychologist* <input type="radio"/> Registered Nurse* <input type="radio"/> Licensed Professional Counselor* </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <input type="radio"/> Physician's Assistant* <input type="radio"/> Advanced Practice Nurse* <input type="radio"/> Licensed Clinical Social Worker* <p>*If Specialized, list your specialty: _____</p> </td> </tr> </table>			<ul style="list-style-type: none"> <input type="radio"/> Physician* <input type="radio"/> Licensed Psychologist* <input type="radio"/> Registered Nurse* <input type="radio"/> Licensed Professional Counselor* 	<ul style="list-style-type: none"> <input type="radio"/> Physician's Assistant* <input type="radio"/> Advanced Practice Nurse* <input type="radio"/> Licensed Clinical Social Worker* <p>*If Specialized, list your specialty: _____</p>
<ul style="list-style-type: none"> <input type="radio"/> Physician* <input type="radio"/> Licensed Psychologist* <input type="radio"/> Registered Nurse* <input type="radio"/> Licensed Professional Counselor* 	<ul style="list-style-type: none"> <input type="radio"/> Physician's Assistant* <input type="radio"/> Advanced Practice Nurse* <input type="radio"/> Licensed Clinical Social Worker* <p>*If Specialized, list your specialty: _____</p>			
Medical Professional Signature		Printed Name		
License Number	State	Date of Exam		
Provider Address		Provider Phone		

Please select the individual's diagnosis(es):

<ul style="list-style-type: none"> <input type="radio"/> Respiratory disorders <input type="radio"/> Cardiovascular disorders <input type="radio"/> Digestive disorders <input type="radio"/> Genitourinary disorders <input type="radio"/> Hematological disorders <input type="radio"/> Congenital disorders <input type="radio"/> Neurological disorders <input type="radio"/> Cancer 	<ul style="list-style-type: none"> <input type="radio"/> Immune System disorders <input type="radio"/> Vision, Hearing, or Speech disorders <input type="radio"/> Musculoskeletal disorders <input type="radio"/> Mental or Cognitive disorders <input type="radio"/> Other (please define): 	<p>Use this space to write any specific diagnoses or relevant factors to the disorder type/diagnoses selected on the left:</p>
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Select Only One of the four disability level options below:

<input type="radio"/>	This individual has a total disability to the extent the person is unable to work full time at any job due to the disability/diagnosis(es) listed above which is expected to last 12 months or longer.			
<input type="radio"/>	The individual has a physical/mental disability/diagnosis(es) listed above that is expected to last 6 to 12 months and which, in combination with other factors such as age, training, experience, and social setting substantially precludes the individual from having any employment that exists in the community for which they have competence.	Please enter duration, from 6 to 12 months. This condition is expected to last ____ months.	Please identify the social factors preventing the individual from employment: <ul style="list-style-type: none"> <input type="radio"/> Age <input type="radio"/> Training <input type="radio"/> Experience <input type="radio"/> Social Setting <input type="radio"/> Other/Additional: _____ 	
<input type="radio"/>	This individual does not have a total physical or mental disability/diagnosis(es) that is expected to last 6 months.			
<input type="radio"/>	This individual has a primary diagnosis of alcoholism or controlled substance addiction. Selecting this option means there are no other disability(ies) that prevent this person from working other than their alcohol or controlled substance addiction . (When selected, this individual will be offered treatment through the Office of Behavioral Health and will be expected to work once treatment is complete.)			