BRIDGES TO EMPLOYMENT WEBINAR SERIES

PART 2: THE APPLICATION PROCESS FOR BUY-IN

Today’s Presenters
Brenda Mosby, CCDC Board Co-Chair & Board Secretary
Donna Sablan, CCDC Director of Medicaid Appeals and Eligibility

Assisted by
Dawn Howard, Director of Community Organizing
Angela Nevin, Director of Training
**SOME HOUSEKEEPING**

- Please leave your video off to maximize the overall bandwidth.
- Please put all questions in the chat.
  - If you have a question of clarification, the moderator will ensure it is answered.
  - All other questions will be answered as possible however, all will be in a Q & A that you will receive via email after the presentation.
- We are recording the presentation. It will be posted on our website when available.
- You will get a copy of the slides emailed to you later this week.
INTRODUCTIONS OF YOUR PRESENTERS

Brenda Mosby  
CCDC Board Co-Chair &  
Owner of Mosby Professional Services

Donna Sablan  
CCDC Director of Medicaid Appeals & Eligibility
WHAT IS BUY-IN?

- An option for qualifying adults with disabilities to “buy-into” Colorado’s Medicaid Program
- For those who work and earn too much money to qualify for Medicaid or long-term care
  - You pay a monthly premium based on your income (with certain rules)
  - There is no asset test
  - You must have a qualifying disability
THE APPLICATION PROCESS INVOLVES NUMEROUS FORMS

We will look at these today:

- Medicaid Buy-In Application
- Disability Determination Application
- Non-Attorney Authorization Form
- 3rd Party Release of Information Form:
  - Multiple Medical Release Forms determined by your application
- Medical Records supporting your disability claim and proof of work
CALCULATING YOUR PREMIUM

We have gotten many questions about how to calculate your premiums. Here is the simple version:

<table>
<thead>
<tr>
<th>Income</th>
<th>Formula</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earned Income (from a job BEFORE Taxes)</td>
<td>$965</td>
<td>- $65</td>
</tr>
<tr>
<td>Subtract</td>
<td>2</td>
<td>[ \frac{900}{2} ]</td>
</tr>
<tr>
<td>Subtotal</td>
<td></td>
<td>$450</td>
</tr>
<tr>
<td>Unearned Income (NOT from a job)</td>
<td>$220</td>
<td>- $20</td>
</tr>
<tr>
<td>Add both adjusted amounts together for the total monthly income.</td>
<td>$450 + $200 = $650</td>
<td></td>
</tr>
</tbody>
</table>

Income Chart and Premium Guide for Buy-In

<table>
<thead>
<tr>
<th>Family Size = 1</th>
<th>$0-$426</th>
<th>$427-$1,415</th>
<th>$1,416-$2,127</th>
<th>$2,128-$3,190</th>
<th>$3,191-$4,785</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Poverty Level (FPL)</td>
<td>0-40%</td>
<td>41%-133%</td>
<td>134%-200%</td>
<td>201%-300%</td>
<td>301%-450%</td>
</tr>
<tr>
<td>Monthly Premium</td>
<td>$0</td>
<td>$25</td>
<td>$90</td>
<td>$130</td>
<td>$200</td>
</tr>
</tbody>
</table>
BUY-IN APPLICATION:
APPLICATION FOR HEALTH COVERAGE & HELP PAYING COSTS

The Buy-In application is the same application you use for other health coverage needs. Because of this you will only be completing the information relevant to the Buy-in program.

You are completing the application only for the person needing buy-in. Each person applying has their own application.
**STEP 1**

Tell us about yourself.

We need one adult in the family to be the contact person for your application. Please print clearly.

<table>
<thead>
<tr>
<th>1. Legal First name, Middle name, Last name, &amp; Suffix</th>
<th>2. Home address (Leave blank if you do not have one.)</th>
<th>3. Apartment or suite number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angela Renée Nevin</td>
<td>Arkansas Place</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lakewood</td>
<td>CO</td>
<td>80232</td>
<td>Jefferson</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Mailing address (if different from home address)</th>
<th>9. Apartment or suite number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14. Phone number</th>
<th>15. Other phone number</th>
<th>Ext.</th>
<th>Ext.</th>
<th>Phone Type:</th>
<th>Ext.</th>
<th>Phone Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(720) 837-4229</td>
<td></td>
<td></td>
<td></td>
<td>Cell ☐ Home ☐ Work ☐</td>
<td></td>
<td>Cell ☐ Home ☐ Work ☐</td>
</tr>
</tbody>
</table>

| 16. Preferred spoken language: ☑️ English ☐ Spanish |
| Other: ☐ English ☐ Spanish |

| 17. Preferred written language: ☑️ English ☐ Spanish |

| 18. I can get information about this application by (select all that apply): ☑️ Email ☑️ In the mail |

Email address: angenevin@gmail.com
**STEP 2: PERSON 1** *(Start with yourself)*

Complete Step 2 for **yourself**. See page 1 for more information about who to include later in the application. If you do not file a tax return, remember to still add family members who live with you.

1. Legal First name, Middle name, Last name, & Suffix  
   Angela Renée Nevin

2. Relationship to you?  
   SELF

3. Date of birth (mm/dd/yyyy)  
   00/00/00000

4. Sex  
   □ Male  □ Female

5. Social Security number (SSN)  
   XXX-XX-XXXX

   If no Social Security Number, why?  
   □ Has applied for SSN  □ Illness  □ Legally Present Non-citizen  □ Religion  □ Newborn

   **We need this if you want health coverage and have an SSN.** Even if you do not want health coverage, providing your SSN can be helpful as it may speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit [socialsecurity.gov](http://socialsecurity.gov). TTY users should call 1-800-325-0778.

6. Do you plan to file a federal income tax return for the COVERAGE YEAR(i)?  
   *(You can still apply for Medicaid, CHP+, or health insurance even if you do not file a federal income tax return. However, you must plan to file taxes for the coverage year to see if you could be eligible for tax credits and reduced out of pocket costs available through the Marketplace.)*

   - **☑ YES. If Yes, answer questions a–c.  □ NO. If No, SKIP to question c.**

   a. Will you file jointly with a spouse?  
      □ Yes  □ No

      If Yes, legal name of spouse:  Better Half Nevin

   b. Will you claim any dependents on your tax return?  
      □ Yes  ☑ No

      If Yes, list legal name(s) of dependents:

   c. Will you be claimed as a dependent on someone’s tax return?  
      □ Yes  □ No

      If Yes, list the name of the tax filer:

   How are you related to the tax filer?
BUY-IN APPLICATION:
PAGE 2 STEP 2

7. Do you have an individual shared responsibility exemption(s)? □ Yes □ No
   If Yes, Exemption Certificate Number:

8. Do you need health coverage?
   □ YES, If Yes, answer all of the following questions. □ NO, If No, SKIP to question 18.
   The answers to the next three questions cannot be used to determine the availability or cost of any health insurance purchased through Connect for Health Colorado.

9. Are you pregnant? □ Yes □ No
   a. If Yes, how many babies are expected during this pregnancy? Due Date (mm/dd/yyyy)?

10. Do you have a medical or developmental condition that has lasted, or is expected to last, more than 12 months? □ Yes □ No

11. Do you need help with some or all of your self-care activities (such as bathing, dressing, eating, or using the bathroom)? Or are you in, or have been in, a medical facility (such as a nursing home, hospital, mental health institution, or a group home) within the last 90 days? □ Yes □ No
   If you have answered ‘yes’ to either of the above questions, please also fill out Worksheet D: Additional Information Required.

12. Are you a U.S. citizen or U.S. national? □ Yes □ No

13. If you are not a U.S. citizen or U.S. national, do you have eligible immigration status?
   □ Yes. Fill in your document type, ID number, and alien registration number below. □ No.
   a. Immigration document type: 
   b. Document ID number:
   c. Alien registration number:
   d. If document type is a passport: Country of origin: Expiration date (mm/dd/yyyy):
   e. Have you lived in the U.S. since 1996? □ Yes □ No
   f. Are you, or your spouse or parent an honorably discharged veteran or an active-duty member of the U.S. military?
      □ Yes □ No If Yes, name(s):

14. Do you want help paying for medical bills from the last 3 months? □ Yes □ No

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? □ Yes □ No

16. Are you a full-time student? □ Yes □ No

17. Were you in foster care at age 18 or older? □ Yes □ No
A key requirement for Buy-In is in the name: Health First Colorado Buy-In Program for Working Adults with Disabilities.

**STEP 2: PERSON 1 (Continue with yourself)**

18. Within the past 6 months, have you used tobacco products regularly (4 or more times per week on average)?  Yes ☑ No  
Answering this question will not affect your ability to get Medicaid or CHP+ or help with costs; however, if you do not answer this question and are determined eligible for help with private insurance costs, Connect for Health Colorado will need to follow up with you before you can be enrolled in a Qualified Health Plan.

19. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
- [ ] Mexican  
- [ ] Mexican American  
- [ ] Chicano/a  
- [ ] Puerto Rican  
- [ ] Cuban  
- [ ] Other

20. Race (OPTIONAL—check all that apply.)
- [ ] White or Caucasian  
- [ ] Black or African American  
- [ ] Asian Indian  
- [ ] American Indian or Alaska Native (Complete and Include Worksheet B)  
- [ ] Filipino  
- [ ] Japanese  
- [ ] Korean  
- [ ] Chinese  
- [ ] Vietnamese  
- [ ] Other Asian  
- [ ] Native Hawaiian  
- [ ] Guamanian or Chamorro  
- [ ] Samoan  
- [ ] Other Pacific Islander  
- [ ] Other  

Answering the next two questions will not affect your ability to get Medicaid or CHP+ or help with costs.

21. Were you uninsured in the last six months?  Yes ☑ No

22. Do you have a general doctor who you go to who treats a variety of illnesses? (OPTIONAL)  Yes ☑ No  
For example, a doctor (or pediatrician) in general practice, family medicine, or internal medicine. If Yes, can you provide the doctor’s name? (OPTIONAL)  
Dr. Jacob Lewis  
(Please do not include a doctor who treated you when you were hospitalized overnight or in hospital emergency rooms.)

**Current Job & Income Information**

<table>
<thead>
<tr>
<th>Employed</th>
<th>Not employed</th>
<th>Self-employed or have other income</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>☑</td>
<td>☑</td>
</tr>
</tbody>
</table>

**Current Job 1:**

23. Employer name and address
Colorado Cross-Disability Coalition
24. Employer phone number
(303) 839-1775

25. Wages/tips (before taxes)
- [ ] Hourly
- [ ] Weekly
- [ ] Every 2 weeks
- [ ] Twice a month
- [ ] Monthly
- [ ] Yearly

26. Average hours worked each WEEK
45
**CURRENT JOB 2:** (If you have more jobs and need more space, attach another sheet of paper.)

27. Employer name and address

28. Employer phone number

29. Wages/tips (before taxes)
   - Hourly
   - Weekly
   - Every 2 weeks
   - Twice a month
   - Monthly
   - Yearly

30. Average hours worked each WEEK

31. **In the past year, did you:**
   - [ ] Change jobs
   - [ ] Stop working
   - [ ] Start working different hours
   - [ ] Have a death in the family
   - [ ] Get married, legally separated, or divorced
   - [x] Receive a wage or salary change
   - [ ] None of these

32. Are you a seasonal worker? [ ] Yes [x] No

33. **If self-employed, answer the following questions:**
   - a. Type of work
   - b. How much gross income (profits before taxes, deductions, or expenses are paid) will you receive from this self-employment this month?

34. **Monthly self-employment expenses:**

<table>
<thead>
<tr>
<th>Expense Type</th>
<th>Expense Amount</th>
<th>Expense Type</th>
<th>Expense Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business rent/mortgage</td>
<td></td>
<td>Interest paid for business</td>
<td></td>
</tr>
<tr>
<td>Gross business labor cost</td>
<td></td>
<td>Utilities paid for business</td>
<td></td>
</tr>
<tr>
<td>Cost of merchandise for business</td>
<td></td>
<td>Business equipment costs</td>
<td></td>
</tr>
<tr>
<td>Business taxes paid</td>
<td></td>
<td>Other business costs</td>
<td></td>
</tr>
<tr>
<td>Income Type/How often?</td>
<td>Amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>--------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One time only</td>
<td>Weekly</td>
<td>Every 2 weeks</td>
<td>Twice a month</td>
</tr>
<tr>
<td>Social Security</td>
<td>One time only</td>
<td>Weekly</td>
<td>Every 2 weeks</td>
</tr>
<tr>
<td>Retirement/pension</td>
<td>One time only</td>
<td>Weekly</td>
<td>Every 2 weeks</td>
</tr>
<tr>
<td>Spousal maintenance received()</td>
<td>One time only</td>
<td>Weekly</td>
<td>Every 2 weeks</td>
</tr>
<tr>
<td>Net Capital Gains</td>
<td>One time only</td>
<td>Weekly</td>
<td>Every 2 weeks</td>
</tr>
<tr>
<td>Dividends/Interest</td>
<td>One time only</td>
<td>Weekly</td>
<td>Every 2 weeks</td>
</tr>
<tr>
<td>Net Farming/Fishing</td>
<td>One time only</td>
<td>Weekly</td>
<td>Every 2 weeks</td>
</tr>
<tr>
<td>Net Rental/Royalty</td>
<td>One time only</td>
<td>Weekly</td>
<td>Every 2 weeks</td>
</tr>
</tbody>
</table>

36. DEDUCTIONS: Check all that apply, and give the amount and how often you pay it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of your health coverage a little lower. Some of these deductions are taken directly from your paycheck.

**NOTE:** You should not include a cost that you already considered in your answer to self-employment expenses (question 34) or net rental income.

<table>
<thead>
<tr>
<th>Deduction Type/How Often?</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spousal maintenance paid()</td>
<td></td>
</tr>
<tr>
<td>One time only</td>
<td>Weekly</td>
</tr>
<tr>
<td>Student loan interest</td>
<td>One time only</td>
</tr>
<tr>
<td>Other deductions()</td>
<td>One time only</td>
</tr>
</tbody>
</table>

37. YEARLY INCOME

| Your total income this year | Your total income next year (if you think it will be different) |

THANKS! This is all we need to know about you.
BUY-IN APPLICATION:
SKIP PAGES 5, 6, 7, AND THE TOP OF 8

If you are a member of a Federally recognized American Indian or Alaskan Native Tribe, there are additional benefits you may be eligible for.
## STEP 4 Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in or eligible for health coverage now from the following?  
   - Yes. If Yes, check the type of coverage and write the person(s)' name(s) next to the coverage.  
   - No.

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Name:</th>
<th>Enrolled</th>
<th>Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Health Plan Plus (CHP+)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRICARE (Do not check if you have direct care or Line of Duty)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VA Health Care Programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peace Corps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Name: Angela Nevin</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Name of health plan and/or policy type: Kaiser through the Exchange</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Start date of coverage or date the coverage could start (mm/dd/yyyy): 05/18/2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Policy number: 0000-00-00-00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Continue with your information.
## STEP 4 (Continue with Health Coverage)

2. Will anyone be **eligible** or **enrolled** in health coverage from the following in the coverage year(s)?
   - [ ] Yes. If Yes, check the type of coverage and write the person(s)' name(s) next to the coverage.  
   - [ ] No.

<table>
<thead>
<tr>
<th>Other State or Federal Health Benefit Program</th>
<th>Name:</th>
<th>Type:</th>
<th>Name of program:</th>
<th>Enrolled □ Eligible □</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Medicare</td>
<td>Name:</td>
<td>Medicare claim number:</td>
<td>Enrolled □ Eligible □</td>
<td></td>
</tr>
<tr>
<td>Check for: □ Part A □ Part B □ Part D</td>
<td></td>
<td>Please include a copy of the front and back of the Medicare card with application if it is available.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ TRICARE (Do not check if you have direct care or Line of Duty)</td>
<td>Name:</td>
<td>Enrolled □ Eligible □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ VA Health Care Programs</td>
<td>Name:</td>
<td>Enrolled □ Eligible □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Peace Corps</td>
<td>Name:</td>
<td>Enrolled □ Eligible □</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- [ ] Employer Insurance (Check even if the coverage is from someone else's job, such as a parent or spouse.)
  - [ ] Yes □ No
  - If Yes, complete and include Worksheet A.
  - Enrolled in COBRA(i) coverage? □ Yes □ No
  - Enrolled in a retiree health plan? □ Yes □ No
  - If Yes, complete and include Worksheet A.
  - If also eligible for Medicaid, do any members of this household have access to group health insurance and want help paying the monthly premium? □ Yes □ No
  - Enrolled □ Eligible □
BUY-IN APPLICATION: PAGE 11  STEP 5

1st Signature is on page 11

This is not the only place you will need to sign. There is more coming up!

I understand that my answers, together with any supplements or additional pages, are the basis for the health insurance policy that is issued. I agree that no insurance or financial assistance program will be effective until the date specified by the insurance company or organization providing the certificate, policy, or notice. I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible copy signature shall have the same force and effect as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

To make it easier to determine my eligibility for help paying for health coverage in future years if I am enrolled in a Qualified Health Plan, I agree to allow Connect for Health Colorado to use income data, including information from tax returns for the next coverage year. Connect for Health Colorado will send me a notice, let me make changes, and I can opt out at any time. I can visit the Connect for Health Colorado website at ConnectforHealthCO.com for more information.

I understand that if I am eligible for the Advance Premium Tax Credit (APTC) and/or Reduced Co-pays and Deductibles these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or Reduced Co-pays and Deductibles may impact my coverage year(s) tax liability. I will be given the option to apply all, some, or none of any APTC amount I may be eligible for to my monthly premium.

I confirm that no one should be made to lose their health insurance because of this application. If not, I am incarcerated.

(Name of Person)

Is this person(s) pending disposition? □ Yes □ No

To appeal means to tell someone at Medicaid/CHIP or Connect for Health Colorado that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting Medicaid at 1-800-221-3943, or I can contact the Marketplace at 1-855-PLANS-4YOU or by visiting their website at ConnectforHealthCO.com. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

By checking this box, I agree to allow my information to be used and collected from data sources for this application. I have consent for all people I list on the application allowing collection of information about them from data sources for this application. (See page ii for full Privacy Statement.)

Sign this application. The person who filled out STEP 1 should sign this application. In case you are eligible for help with costs, we also need EACH tax filer in your household to sign this application. If you are an authorized representative, you may sign here as long as you have provided the information required in Worksheet C.

PERSON 1 Signature or Authorized Representative

Angela Renee Nevin

Date (mm/dd/yyyy)

02/04/2021

Tax Filer Signature (if different than above)

Date (mm/dd/yyyy)

02/04/2021

Note: If there are more tax filers in the home, please attach an additional sheet of paper with signatures.
**WORKSHEET D**

**Additional Information Required continued**

<table>
<thead>
<tr>
<th>Disability Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Has anyone who is disabled applied for SSI? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>If Yes, Name of person ___________________________ Date of application? (mm/dd/yyyy) ___________________________</td>
</tr>
<tr>
<td>What is the status of the application (pending, approved, denied)? ___________________________</td>
</tr>
<tr>
<td>10. Does this person receive SSI or SSDI? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>If No, has this adult ever received SSI/SSDI? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>If Yes, when did SSI/SSDI end? (mm/dd/yyyy) ___________________________ Reason SSI/SSDI Ended: ___________________________</td>
</tr>
</tbody>
</table>

| 11. If you or anyone in your household is eligible for the Medicaid Buy-in Programs, which may require a monthly premium to be paid, do you agree to be enrolled? (Check all that apply.) |
| ☐ Person 1 ☐ Person 2 ☐ Person 3 ☐ Person 4 ☐ None |

**SIGNATURE AND CERTIFICATION:**

By signing this form I am giving my permission to the State of Colorado and its designers to make contacts to verify the information given within this form. Under penalty of perjury I certify all information I have given is true and correct.

*I MUST ALSO SIGN PAGE 10 OF THIS APPLICATION.*

---

**Angela Reneé Nevin**

Print First name, Middle name, Last name, & Suffix ___________________________ Signature ___________________________ Date (mm/dd/yyyy) 02/04/2021

**Angela Reneé Nevin**

Authorized Representative, Conservator, Guardian, or other Contact:

Print First name, Middle name, Last name, & Suffix ___________________________ Signature ___________________________
Before we go on to the disability determination form, what questions are there about the Buy-in application?
**MEDICAID DISABILITY APPLICATION**

**Section 1 – Information About The Disabled Person(s)**

**A. Name (First, Middle Initial, Last)**
Angela R. Nevin

**B. Social Security Number**
XXX-XX-XXXX

**C. Mailing Address (Street, City, State, and Zip Code)**

Arkansas Place, Lakewood, CO 80232

**D. Daytime Telephone Number (if you have no phone where you can be reached, give us a daytime number where we can leave a message for you.)**

(720) 837-4229

This is Ø Your number Ø Message Ø None

**E. Give the name of a friend or relative that we can contact (other than your doctor) who knows about your conditions and can help you with your application.**

**Name:** Better H Nevin

**Relationship:** Spouse

**Mailing Address:**

Arkansas Place, Lakewood, CO 80232

(Number, Street, Apt. No. [if any], P.O. Box, or Rural Route)

City: Lakewood

State: CO

Zip: 80232

Phone: (720) ___ ___ ___

**F. What is your height without shoes?**

5 Feet 5 Inches

**G. What is your weight without shoes?**

XXX# (not telling!)

**H. What is your Date of Birth?**

??

**Age:** ??

**Sex:** F

01/2007 - HCPF
### DISABILITY DETERMINATION

Continue with section 1 about you.

### PAGE 3: SECTION 2

Continue with section 2 about your health conditions.

---

## Section 2 – Your Conditions and How They Affect You

**A. What are your disabling conditions?**

- Major Depressive Disorder, Recurrent Episode
- Anxiety
- Hypersomnia, Idiopathic
- Common Migraine, Hearing Loss with Hearing Aids
- Insomnia

**B. How do your conditions limit your ability to work?**

Need to sleep during work hours, need tech compatible with hearing aids, unexpected things trigger my anxiety including projects or demands made unexpectedly, depression impacts making deadlines and ability to deliver on-time, anxiety is extreme in crowded situations/rooms/groups.

**C. Do your conditions cause you pain or other symptoms?**

- Yes

**D. When did your conditions first bother you?**

- Month: 06
- Day: 02
- Year: 2010

**E. When did you become unable to work because of your conditions?**

- Month: 04
- Day: 03
- Year: 2010

**F. Have you ever worked?**

- Yes

(If "No," go to Section 4.)
Continue with section 2 about your health conditions.

STOP!

You want to complete the state disability determination first before applying for any SSI/SSDI

PAGE 4  SECTION 3

Section 3 is about the work you do.

I. Are you working now? ☑ Yes ☐ No
   
   If "No," when did you stop working?

J. Why did you stop working?

K. Have you ever applied for Social Security Disability Income (SSDI) or Supplemental Security Income (SSI)? ☑ Yes ☐ No
   
   If "Yes," on what date did you file the most recent application? __________
   
   Was your Social Security claim: ☑ Allowed ☐ Denied ☐ Still pending
   
   What was the date of your most recent decision?
   
   If you appealed, on what date did you file the appeal?

Please include copies of all letters and notices from SSA

Section 3 – Information About Your Work

A. List the kinds of jobs that you had during the last 15 years that you worked.

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Type of Business</th>
<th>Dates Worked (month/year)</th>
<th>Hours Per Day</th>
<th>Days Per Week</th>
<th>Rate of Pay (Per hour, day, week, month, or year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cook</td>
<td>Restaurant</td>
<td>9/99 - 10/02</td>
<td>8</td>
<td>5</td>
<td>$ 7.00 per hour</td>
</tr>
<tr>
<td>Video designer</td>
<td>Online training</td>
<td>11/14 - 4/2015</td>
<td>10</td>
<td>5</td>
<td>$ 96,000 per year</td>
</tr>
<tr>
<td>Home Health Aid</td>
<td>CDASS</td>
<td>current - current</td>
<td>varies</td>
<td>varies</td>
<td>$ 16 per hour</td>
</tr>
<tr>
<td>Care Partner</td>
<td>Memory Care Residence</td>
<td>8/2015 - 10/2015</td>
<td>12</td>
<td>4</td>
<td>$ 18 per hour</td>
</tr>
<tr>
<td>Director Training</td>
<td>Non-profit</td>
<td>12/2016 - current</td>
<td>8.5</td>
<td>5</td>
<td>??? per year</td>
</tr>
</tbody>
</table>
DISABILITY DETERMINATION NOTICE

April 1, 2021
Angela Nevin
7650 West Arkansas Place
Lakewood, CO 80232

**** PLEASE KEEP THIS DOCUMENT FOR YOUR RECORDS ****
***** IMPORTANT DATES ARE INCLUDED *****
We received your medical disability application. We reviewed your application and the medical records we received from your providers, and made this disability decision:

☐ You have a disability. You will receive a different letter that will tell you if you qualify for Health First Colorado benefits.

Listing(s) of Impairment: Meets 12.06; 12.15; Equals 11.14; 3.03

☐ You meet Colorado’s standards for limited disability, but you do not meet the Social Security Administration’s full disability standards.

Listing(s) of Impairment:

☐ The Social Security Administration has decided you do not have a disability and you do not meet Colorado’s disability standards.

Reason: Individual does not meet the definition of disability for longer than 12 months.

☐ The Social Security Administration has already approved your disability application. Colorado accepts that you have a disability.

☐ The Social Security Administration (SSA) has already decided you do not have a disability.

- If you disagree with that decision, you can appeal that decision with Social Security.
- If you have new critical and/or disabling conditions, you can submit a new disability application to your local COUNTY Department of Human or Social Services OR Medical Assistance SITE OFFICE.

For a listing of County Department of Human or Social Services OR Medical Assistance Site locations, please see https://apps.colorado.gov/apps/maps/hcpf.map

If you have any questions about this letter, please contact the State Disability Contractor at 877-265-1864

If you disagree with your disability determination, you have the right to appeal. Please see the Appeal Information section of this letter for more information.
B. Which job did you do the longest?  Director of Training for Non-profit

C. Describe this job. What did you do all day?
(If you need more space, write in the “Remarks” in Section B.)
Create training materials, provide staff support and training, teach advocacy classes

D. In this job, did you:
- Use machines, tools, or equipment?  Yes  No
- Use technical knowledge or skills?  Yes  No
- Do any writing, complete reports, or perform duties like this?  Yes  No

E. In this job, how many total hours each day did you do each of the following:
- Walk 0  Kneel (bend legs to rest on knees)
- Stand 0  Crouch (bend legs and back down and forward)
- Sit 3.5  Handle, grab, or grasp big objects
- Climb  Crawl (move on hands and knees)
- Stoop (bend down and forward at waist)  Reach overhead

F. Lifting and carrying
(Explain what you lifted, how far you carried it, and how often you did this.)

G. Check the heaviest weight lifted:
- Less than 10 pounds  10 pounds  20 pounds
- 50 pounds  100 pounds or more  Other

H. Check the weight frequently lifted:
(Frequently means from 1/3 to 2/3 of the workday.)
- Less than 10 pounds  10 pounds  20 pounds
- 50 pounds  100 pounds or more  Other

I. Did you supervise other people in this job?  Yes  No
If “No,” go to Section 4; If “Yes,” complete the following.
How many people did you supervise?  1
What part of your time was spent supervising people?  1 hours
Did you hire and fire employees?  Yes  No
Section 4 is about your medical records.

Section 4 – Information About Your Medical Records

A. Have you been seen by a doctor/hospital/clinic or anyone else for the conditions that limit your ability to work?  ☐ Yes  ☐ No

B. Have you been seen by a doctor/hospital/clinic or anyone else for emotional or mental problems that limit your ability to work?  ☐ Yes  ☐ No

If you answered "No" to both of these questions, go to Section 5.

C. List other names you have used on your medical records, including your maiden or married names.

Angela Renee Nevin

Tell us who may have medical records or other information about your conditions.

D. List each doctor/clinic/therapist/medical professional you have used. Use an extra sheet, if needed. Please include date last seen and date of your next appointment.

<table>
<thead>
<tr>
<th>Name</th>
<th>Dr. Ed Smith</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>Kaiser 8363 W Alameda Ave,</td>
</tr>
<tr>
<td>City</td>
<td>Lakewood</td>
</tr>
<tr>
<td>State</td>
<td>CO</td>
</tr>
<tr>
<td>Zip</td>
<td>80226</td>
</tr>
<tr>
<td>Phone</td>
<td>(303) 338-4545</td>
</tr>
<tr>
<td>Reason(s) for Visits</td>
<td>Adjustment in medication for major depressive disorder</td>
</tr>
<tr>
<td>What treatment was received?</td>
<td>Increase/ addition of new meds</td>
</tr>
<tr>
<td>Date First Seen</td>
<td>5/4/2016</td>
</tr>
<tr>
<td>Date Last Seen</td>
<td>11/20/2020</td>
</tr>
<tr>
<td>Date Next Appointment</td>
<td>NA</td>
</tr>
</tbody>
</table>
Continue section 4 about your medical records and conditions.

**Name**
Dr. Sarah Smith

**Street Address**
2955 S. Broadway

**City**
Englewood

**State**
CO

**Zip**
70113

**Date First Seen**
NA

**Date Last Seen**
02/19/2020

**Phone**
(303) 661-3382

**Next Appointment**
NA

**Reason(s) for Visits**
Meds not effective in maintaining awareness during the day for my idiopathic hypersomnia

**What treatment was received?**
Change of medication

---

**Name**
Leo Walter, IV X, AUD

**Street Address**
1375 E 20th Avenue

**City**
Denver

**State**
CO

**Zip**
80205

**Date First Seen**
4/19/19

**Date Last Seen**
4/19/19

**Phone**
(303) 338-4545

**Next Appointment**
NA

**Reason(s) for Visits**
Hearing Test

**What treatment was received?**
Hearing Aids recommended

If you need more space, use “Remarks” in Section 8.
Add any relevant hospital information.

### E. List each hospital you have used. Include dates and type of visit.

<table>
<thead>
<tr>
<th>Name</th>
<th>Street Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Type of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date In</td>
</tr>
</tbody>
</table>

- [ ] Inpatient Stays (stayed at least overnight)

- [ ] Outpatient Visits (sent home same day)

- [ ] Emergency Room Visits

<table>
<thead>
<tr>
<th>Date of First Visit</th>
<th>Date of Last Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** If you need more space, use “Remarks” in Section 8.
**DISABILITY DETERMINATION**  
**PAGE 9 SECTION 5**

Complete information about tests related to your disability.

**Section 5 – Tests**

Have you had any medical tests for your conditions?  
- Yes
- No

(If “Yes,” complete the information below.)

<table>
<thead>
<tr>
<th>Kind of Test</th>
<th>When was test done? (month/day/year)</th>
<th>Where was test done? (Name of facility)</th>
<th>Who sent you for this test?</th>
</tr>
</thead>
<tbody>
<tr>
<td>EKG (heart test)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treadmill (exercise test)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biopsy – Name of body part</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Test</td>
<td>4/19/194</td>
<td>KP Audiology</td>
<td>Smith</td>
</tr>
<tr>
<td>Vision Test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IQ Test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EEG (brain wave test)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Test (not HIV)</td>
<td>12/20/20</td>
<td>KP</td>
<td>Smith</td>
</tr>
<tr>
<td>Breathing Test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-Ray – Name of body part</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI/CT Scan – Name of body part</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other – Name of test and on what body part</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have had other tests, list them in “Remarks” in Section 8.
Section 6 is about the mediation you take for your disability.

Section 7 is about your education.

Section 6 – Medications

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>Name and Phone Number of Doctor</th>
<th>Reason for Medicine</th>
<th>Side effects from the Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>250 mg</td>
<td>Sarah Smith, MD</td>
<td>OCIPATHIC HYPERsomia</td>
<td></td>
</tr>
<tr>
<td>20 mg</td>
<td>Sarah Smith, MD</td>
<td>OCIPATHIC HYPERsomia</td>
<td>Agitation, dental complications</td>
</tr>
<tr>
<td>15 mg</td>
<td>Jacob Smith, DO</td>
<td>Anxiety/Depression</td>
<td></td>
</tr>
<tr>
<td>XL 150 mg</td>
<td>Jacob Smith, DO</td>
<td>Anxiety/Depression</td>
<td></td>
</tr>
<tr>
<td>XR 75 mg</td>
<td>Jacob Smith, DO</td>
<td>Anxiety/Depression</td>
<td></td>
</tr>
</tbody>
</table>

Section 7 – Education/Training Information

A. Check the highest grade of school completed.

Grade school: 0 1 2 3 4 5 6 7 8 9 10 11 12 GED

College: 1 2 3 4 or more

Approximate date completed: 8/1/90

B. Did you attend special education classes?  Yes No

If “Yes,” complete the following information:

Name of School

Address

(Number, Street, Apt. No. [if any], P.O. Box, or Rural Route)

City to State Zip

Date Attended

Type of Program
Section 8 is for additional information about how your disability affects your ability to work and daily living activities.

When writing about your disability, describe what it is like for you on your worst day. For example, if you have difficulty sleeping at night or wake up often, you “are unable to sleep through the night”.

Use this section for any additional information you did not share in an earlier part of this form. When you have completed this section (or if you don’t have anything to add), go to the next page and complete the signature block. Since COVID we have been working from home and my anxiety is less, my distractions are less. I no longer have to share an office which caused increased distraction. I am able to take naps as needed, not having to drive to work reduces the risk of an accident due to excessive sleepiness. I am incapable of being anywhere that there may be excessive crowds or a large gathering of people.
Section 8 continued.

This is the only signature needed unless you choose a personal representative (on page 14).

Signature
is on page 12

***THIS APPLICATION MUST BE SIGNED***

By signing this application, I affirm that everything is true to the best of my knowledge. I understand that I am giving the Department of Health Care Policy and Financing and its designees the authority to make the necessary contacts to verify any statements made on this application and to request all records/information necessary to determine medical disability eligibility. I understand that this application does not guarantee any benefits will be paid to me or on my behalf.

Signature of claimant or person filing on claimant’s behalf (parent, guardian)

Angela Renée Nevin

Date (Month, day, year)

02/04/2021

Witnesses are required ONLY if this statement has been signed by an (X) mark above. If signed by an (X) mark, two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

<table>
<thead>
<tr>
<th>1. Signature of Witness</th>
<th>2. Signature of Witness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (number and street, city, state, and zip code)</td>
<td>Address (number and street, city, state, and zip code)</td>
</tr>
</tbody>
</table>
This page is for you to authorize someone who knows you and your situation to answer questions or provide information if you are not available.
DISABILITY DETERMINATION APPLICATION:
PAGE 15 MEDICAL RELEASE FORM CALCULATIONS

HOW TO COMPLETE MEDICAL RELEASE FORMS

- Only your signature is needed. Sign your full name in the space marked “INDIVIDUAL authorizing disclosure.”
- Sign each release form.
- Leave all other areas blank. Do not date the release forms.
- You need to sign one (1) release for every doctor or hospital you have listed on this form. You also need to sign three (3) additional release forms for any new or discovered medical sources.
- If you do not have enough release forms, please contact your county technician to get more.

REQUEST ENOUGH RELEASE FORMS

Count the number of doctors, hospitals, and medical sources you listed in the application and write that number on this line.

The number of extra release forms you need is 3

TOTAL: A + B = C. Add the number you listed in A and the number listed in B. That tells you the total number of release forms you need.

If the number of release forms listed in “C” is more than you have in the application packet, call your county worker and ask them to send you more.
BREAK TIME – LET’S RELAX FOR A MOMENT BEFORE WE GET ALL FULL UP!
This form allows an advocate, in this case CCDC, to speak on your behalf. That means all information regarding your case will go through that advocate and not directly to you.

Complete the information about you.

Fill this section with CCDC’s information (just like this)
My information may only be shared, disclosed, or used to further and assist in my appeal. This Authorization will expire at the conclusion of the appeal process.

Signature: Angela Renée Nevin Date: 01/21/2021

Parent/Legal guardian may sign on behalf of minor child

Date of birth: 07/04/________ Medicaid ID Number: NA

Name of E Personal Representative: ________

Legal documentation must be included to show authority to sign on behalf of client or applicant; if client/applicant is not signing on his/her own.

Signature of Designated Personal Representative: ____________

Relationship of Designated Personal Representative: ________________

I, Angela R. Nevin, request Department of Health Care Policy & Financing (HCPF) and its contractors to use unsecured emails from n and to Colorado Cross-Disability Coalition (CCDC) to use (n@cccolinonline.org) emails for communicating about benefits.

I am aware that is an unsecured email (initial) AN

CCDC communicates with different local, county, and state agencies including, but not limited to, Health Care Policy & Financing and the Colorado Department of Human Services in order to resolve issues for our clients. As an organization, we do not use encrypted email to communicate with these agencies. As your representative, we are making you aware there is always some level of risk of being "hacked" by an unauthorized third party. We have multiple layers of security and our Information Technology Manager works hard to ensure your information is protected. By signing this release you are stating you are aware your Personal Health information is being sent in unencrypted email. Additionally, you are agreeing you will not hold any local, county, or state agency liable for any unauthorized "hacking" of your Personal Health Information.
The number you calculated on page 15 of the Disability Determination Application is how many copies you need of this form.

How to complete medical release forms

- Only your signature is needed. Sign your full name in the space marked "INDIVIDUAL authorizing disclosure."
- Sign each release form.
- Leave all other areas blank. Do not date the release forms.
- You need to sign one (1) release for every doctor or hospital you have listed on this form. You also need to sign three (3) additional release forms for any new or discovered medical sources.
- If you do not have enough release forms, please contact your county technician to get more.

Request enough release forms

Count the number of doctors, hospitals, and medical sources you listed in the application and write that number on this line.

The number of extra release forms you need is 3

The number of release forms listed in "C" is more than you have in the application packet, call your county worker and ask them to send you more.

3rd party release of information form page 1

Complete this section.

WHOSE Records to be Disclosed
NAME (First, Middle, Last Initial)
Angela Renee Nevin
SSN XXX-XX-XXXX
Birthday (mm/dd/yy) 07/04/??

Authorization to disclose information to
ARBOR E & T, LLC dba ACTION REVIEW GROUP (ARG)

** Please read the entire form, both pages, before signing below **

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

- All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:
- All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
  - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
  - Drug abuse, alcoholism, or other substance abuse
  - Sickle cell anemia
  - Records which may indicate the presence of a communicable or non communicable disease; and tests for or records of HIV/AIDS
  - Gene-related impairments (including genetic test results)
- Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
- Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
- Information created within 12 months after the date this authorization is signed, as well as past information.

From whom

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by ARG
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

This box to be completed by ARG (as needed): Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed.
Complete and sign this section.

Leave this blank.

Signature is on page 1
Once complete, you need to make the number of calculated copies – for our example this is 6.
To help with your disability claim, you want to provide supporting documents.

The determination process includes asking for additional documents as needed, however, by providing initial support, you may be decreasing the time it takes for a determination ruling.

Documents should support your claim by speaking directly to the condition you are reporting on your determination form.

After visit reports, test results, and medical notes are all documents that can support your claim.

If you have an online medical portal, there is a good chance this information is easily available to you.
Let’s look at our example’s specific claims and supporting documents:

From the Disability Determination Application form, on page 3, section 2, our example has related the following disability conditions:

- Episodic Major Depressive Disorder
- Anxiety
- Idiopathic Hypersomnia
- Common Migraine
- Hearing Loss with Hearing Aids
- Insomnia
EPISODIC MAJOR DEPRESSIVE DISORDER

This after visit report shows:

The individual

A date documenting a recent visit

A statement showing the doctor you saw and what conditions were addressed during the visit.

You saw Jacob J. DO on Tuesday November 10, 2020. The following issue was addressed: MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE.
IDIOPATHIC HYPERSOMNIA, INSOMNIA

This after visit report shows:

The individual

Angé Nevin

A date documenting a recent visit

2/19/2020 3:10 PM

A statement showing the doctor you saw and what conditions were addressed during the visit.

You saw Sarah MD on Wednesday February 19, 2020. The following issues were addressed:
- HYPEROSOMNIA, IDIOPATHIC
- INSOMNIA

Today's Visit

Blood Pressure: 136/98
Temperature: 98.8°F
Pulse: 98
Oxygen Saturation: 97%
HEARING LOSS WITH HEARING AIDS
This test result shows:

Test results supporting your claim.

A date documenting a recent visit and the person completing the test.
WRAP UP

We know this is a lot of information!

- Medicaid Buy-In Application
- Disability Determination Application
- Non-Attorney Authorization Form
- HCPF 3rd Party Release of Information Form: Multiple Medical Release Forms determined by your application
- Medical Records supporting your disability claim

We know it is overwhelming and can seem too much!

Often when you find you need to apply for Medicaid Buy-In you are under stress, emotional, and even in a bad place.

But that is exactly when you need to contact an advocate like us.

But that is exactly when you need to contact an advocate like us.

But that is exactly when you need to contact an advocate like us.

Now it is calming and seem too much!
QUESTIONS?

ANYTHING WE CAN’T ANSWER HERE, YOU WILL GET IN A Q & A DOCUMENT LATER THIS WEEK.
PLEASE JOIN US FOR OUR NEXT WEBINAR IN THIS SERIES

Bridges to Employment Webinar Series
Part 3: AWIC Area Work Incentives Coordinators

Monday, March 22 · 10:00am – 11:00am

Registration is already open.

Go to Bridges to Employment Part 3 Registration and sign up now.
Thank you for joining us today. If you valued our presentation, please go to our website (www.ccdconline.org) and become a free member of CCDC.