CGS
Building Leadership in Aging

INSTRUCTIONS TO APPLY FOR A SENIOR ANSWERS AND SERVICES VISION GRANT

PLEASE READ BEFORE FILLING OUT THE ENCLOSED FORM.

Call 303-333-3482 if you have questions.

Older adults age 60 and over who live in Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Gilpin, and Jefferson County may apply for a grant for partial assistance with eyeglasses, frames and an exam. Priority is given to older adults who are in the greatest economic and social need.

HOW TO APPLY FOR A GRANT:

1. Complete the attached Intake Form.
2. Select an eye doctor. (You may select an eye doctor from the attached list or you may use your own eye doctor, but your eye doctor must be willing to accept the grant. Some eye doctors may charge more money than the amount approved by the Grant).
3. Contact the eye doctor and ask if they will accept you as a patient on the Senior Answers and Services Vision Program.
4. Submit the completed Intake Form to the Senior Answers and Services Vision Program, 1330 Leyden St #148, Denver CO 80220 (be sure to sign the Intake Form, the Required Acknowledgments Form and the HIPPA - Disclosure Form). INCOMPLETE FORMS WILL BE RETURNED.
5. You will be placed on the waiting list.

WHEN YOU ARE SELECTED TO RECEIVE A GRANT:

1. When funding is available, you will receive an Initial Grant Award Letter to make an appointment for an exam.
2. After your exam, a treatment plan will be submitted for a grant to cover eyeglasses.
3. When you receive a Final Grant Award Letter, make another appointment to be fitted for your eyeglasses.
4. After you receive your glasses, the eye doctor will request payment from Senior Answers.
5. ANY CHARGES OVER THE AMOUNT APPROVED ARE THE PATIENT'S RESPONSIBILILITY.

THINGS TO KNOW:

1. The Senior Answers program is NOT insurance.
2. Any work that is started prior to the grant award will not be covered by the grant.
3. Grants are for a limited time. All work must be completed in a timely fashion.
4. There is no guarantee of a grant, as grants are dependent on funding availability.

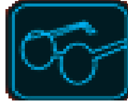
APPEAL RIGHTS:

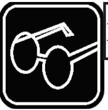
You will receive a letter indicating that your Form has been received and that you have been placed on the waiting list within six weeks. You may appeal your place on the waiting list if you believe we have inaccurate or incomplete information on the Form.

PLEASE KEEP THIS LETTER AND THE ATTACHED COMPLAINTS PROCEDURES FOR YOUR RECORDS

Funding is made possible through grants from the Older Americans Act through the
Denver Regional Council of Governments, Area Agency on Aging, other foundation grants and private donations.

Colorado Gerontological Society
1330 Leyden St, #148, Denver, CO 80220 · 303-333-3482 · 303-333-9112 · www.senioranwers.org

 This page left intentionally blank.



Date Received by CGS:

2018 Basic Consumer Intake Form

Updated March 1, 2018

Basic Client Information:		**Date of Assessment:** / /
*Last Name:	*First Name:	Middle Initial:
*Gender: ☐Male ☐Female ☐ Other	*Date of Birth: / /	*Age
Residential Address:		
*Address Line 1:	*Address Line 2:	
*City:	*State:	*Zip:
*County:	Phone (Home):	
Phone (Mobile):	Phone (Work):	
Location Comments (Directions):		
Email Address:	Are you receiving Medicaid? ☐Yes ☐No	
What is your marital status ? ☐Married/Domestic Partner ☐Single ☐ Widowed	Are you a veteran? ☐Yes ☐No	
*Lives : ☐Alone ☐ With others	What is your primary language?	
*What is your race?	*Ethnicity? ☐Hispanic/Latino ☐ Not Hispanic/Latino	
*Are you visually impaired (cannot be corrected with glasses)? ☐Yes ☐No		
How many people live in your household?		
What is your monthly income?	What is your monthly household income?	
*If you live alone, is your individual monthly income below $1,012? ☐Yes ☐No	*If you have a spouse or partner, is your monthly household income below $1,372? ☐Yes ☐No	
Mailing Address, if different from physical Address:		
Address Line 1:	Address Line 2 (Apt #, Unit #, Floor #):	
City:	State:	Zip:
Are you interested in receiving nutrition counseling? ☐Yes ☐No		
How did you hear about our services? ☐AAA Brochure ☐AAA Newsletter ☐Channel 9 Senior Source (TV) ☐Congregate Meal Site ☐From a Current Client ☐From a Friend/Relative ☐Senior Fair ☐Walk-In ☐Web Site ☐Other ________		
Do you want to hear about other services? ☐ Yes ☐ No	If yes, how can we contact you? ☐ Email ☐ Mail ☐ Phone	
When is the best time to contact you?	Please tell us what services you would like to receive:	
Do you use any assistive devices? ☐Yes ☐No	If so, which ones? ________	
Emergency contact name	Relationship:	Phone Number:

I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so.

(If filled out by assessor or via phone, please have assessor check here and sign below ☐).

Signature________________________ Date____________

Office use only: Information filled out by ______________ Date____________

Activities of Daily Living

	Yes	No
1. I can eat without help.		
2. I can dress without help		
3. I can bathe myself without help.		
4. I can use the toilet without help.		
5. I can get in and out of bed/chairs without help.		
6. I can get around inside my home without help.		
7. Are you currently receiving assistance with any of the above tasks from anyone else		

From whom are your receiving assistance? Phone ________________________________

Instrumental Activities of Daily Living

	Yes	No
1. I can manage money without help.		
2. I can take care of shopping without help.		
3. I can take my medications without help.		
4. I can prepare meals without help.		
5. I can do ordinary housework without help.		
6. I can get use the telephone without help.		
7. I can use transportation without help.		

From whom are you receiving assistance? Phone ________________________________

Your Name: ____________________

Vision Addendum

Language Ability *(Please Check All That Apply)*

- ☐ I have difficulty reading English, and require help to do so.
- ☐ I have difficulty writing English
- ☐ I do not speak enough English to talk to someone who only speaks English and have them understand.
- ☐ I do not understand English to speak to an English speaking person without the aid of an interpreter.

Race and/or Ethnicity *(Please Check All That Apply)*

☐ American Indian	☐ Alaska Native	☐ Black / African-American	☐ Native Hawaiian / Other Pacific Islander	☐ White / (Not Hispanic)	☐ Hispanic/ Latino	☐ Asian	☐ Other

Coordination of Benefits *(Please Check All Benefits You Currently Receive)*

- ☐ Supplemental Security Income (SSI)
- ☐ Colorado Old Age Pension (OAP)
- ☐ Supplemental Nutrition Assistance Program (SNAP / Food Stamps)
- ☐ Low Income Energy Assistance Program (LEAP)
- ☐ Rent Subsidy (Section 8 or HUD housing)
- ☐ Colorado Property Tax/Rent/Heat Rebate (PTC 104)
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Options for Long Term Care (Colorado Access)
- ☐ Health Maintenance Organization (HMO), Private Fee for Service (PFFS) or Special Needs Plan (SNP) *(Please Indicate Below)*:

  ____

- ☐ Medicaid
- ☐ Medicare Savings Programs (MSP)
  - ☐ Qualified Medicare Benefit (QMB)
  - ☐ Qualifying Individual 1 (QI-1)
  - ☐ Special Low-Income Medicare Benefit (SLIM-B)
- ☐ Home and Community Based Services (HCBS)
- ☐ Veterans Administration Benefits (VA Benefits)
- ☐ Vision Insurance (*Please Indicate Below*):

  ____

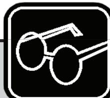
- ☐ Other Vision Benefit/Grant (*Please Indicate Below*):

  ____

Voluntary Contributions

This program is made possible through a grant from the Older Americans Act, through the Denver Regional Council of Governments, Area Agency on Aging, other grants and private donations.Any person receiving services shall have the opportunity to contribute towards the cost of the service. No eligible person shall be denied a service because of their inability and/or choice not to contribute. Individuals are not charged a set fee by the Colorado Gerontological Society for any service provided. Individuals are welcome to make a voluntary donation to help other seniors receive assistance. Donations for grants or other projects may be sent to Colorado Gerontological Society, 1330 Leyden St #148, Denver CO 80220.

Your Name:



Vision Needs Addendum

☐ 1. I have had headaches because of my vision problems.

☐ 2. My eyes are frequently sore or strained.

☐ 3. I cannot see well enough to read my mail.

☐ 4. I cannot see well enough to read the newspaper.

☐ 5. My vision problems prevent me from driving and limit my ability to use public transportation.

☐ 6. My vision has become significantly worse in the last year.

☐ 7. I am currently experiencing blurriness or lack of focus because my current level of correction is not enough.

☐ 8. I do not have glasses, or the pair I have is more than three years old.

Please Only Select the Options Below That Apply to Your Vision

I am far sighted (hyperopic) and:

☐ 9. I have difficulty seeing things less than an arm's length away from me.

☐ 10. I need rooms to be very bright so that I can see things clearly.

I am near sighted (myopic) and:

☐ 11. I have difficulty seeing things more than an arm's length away from me.

☐ 12. I cannot easily see objects further than 10 feet away from me.

Choose An Eyeglasses Dispenser

1. *Choose a eyeglasses dispenser from the attached list (or ask your personal provider if he/she will accept a grant from our program).*
2. *Call the eyeglasses dispenser to ask if they will take you as a client with the Senior Answers and Services Vision Program.*

Provider's Name:

Clinic/Office Name

Address:

City, ZIP Code

Phone: Fax:

Name ____

HIPPA - Authorization to Disclose

I voluntarily authorize and request disclosure to the Colorado Gerontological Society (Senior Answers and Services Division) of such medical information as may be needed to provide the necessary care for me (including through written, spoken and electronic communication).

WHAT INFORMATION WILL BE DISCLOSED?

- All records and other information regarding vision assessments, recommended treatments, vision work performed as well as not performed or declined, referrals to other vision providers and complicating medical conditions or other impairments.
- Information about how my impairments will affect my ability to complete the authorized treatment plan.

WHO MAY DISCLOSE INFORMATION ABOUT ME?

- All vision and medical sources, optometrists, ophthalmologists, eye glasses dispensers, hospitals, clinics, labs, physicians, psychologists, and so forth including mental health, correctional, addiction treatment, and VA health care facilities.
- Social workers, case managements, case workers, rehabilitation counselors and others associated with my care.
- Consulting Vision providers
- Employers
- Others who may know about my condition (someone helping me fill out this form, family, interpreters, friends, neighbors, and public officials).

TO WHOM MAY INFORMATION BE DISCLOSED?

- To the Colorado Gerontological Society, the Denver Regional Council of Governments, and other agencies or organizations that fund or finance this program, or which help to administer this vision program, program auditors, optometrists, ophthalmologists, eye glasses dispensers, and other medical professionals.

THE PURPOSE OF THIS AUTHORIZATION IS

- To determine the specific services for which this project will make a grant, and to monitor the provision of services leading to successful completion of the authorized treatment plan, or termination of treatments and the grant.

GENERAL PROVISIONS

- This authorization is good for five years from the date signed (next to my signature below).
- I authorize the use of a photocopy, faxed copy, or other electronic copy of this form for the disclosure of the information described above.
- I may write to the Colorado Gerontological Society to revoke this authorization at any time.
- The Colorado Gerontological Society will give me a copy of this authorization if I request it by phone or in writing.
- I have read this form and the Colorado Gerontological Society's privacy policy or had them explained it to me and agreed to the disclosures.

Complete and sign below if you agree to the above statements so we can share the information needed to serve you.

Name			**Birth Date:** / /
Address	**City**	**Zip**	**Phone**
I have carefully read, understand and agree to the above disclosures. **SIGNATURE**			**DATE**

Your Name:

Request for Additional Services

- I understand the Colorado Gerontological Society attempts to assess clients for eligibility for other and related benefit programs.
- I want help to apply for other benefits, and will cooperate in completing assessments and in providing documentation.
- I wish to receive the newsletter, STA-Well NEWS from the Colorado Gerontological Society.

I have carefully read, understand and agree to the above optional acknowledgements and consents.

SIGNATURE **DATE**

Required Acknowledgements and Consents

- I understand that if approved for a vision grant through this program, I must pay any amounts not covered by the grant directly to my optometrist, ophthalmologists, or eye glasses dispenser, and I agree to do so (do not send your payment to CGS). The provider has agreed to accept this grant as full or partial payment towards the eye glasses and other approved services. CGS does not accept any responsibility for costs above the grant award.
- I understand that the grant payment from CGS will be made directly to my optometrist, ophthalmologists, or eye glasses dispenser. No payment will be made to me and CGS will not reimburse me for work initiated before the final grant.
- I understand the program and grant will not cover any work performed prior to my receipt of official letters of grant award.
- I have received a coy of and have read the Colorado Gerontological Society's HIPPA–Authorization to Disclose Information. I authorize my optometrist, ophthalmologists, or eye glasses dispenser to share with CGS and with others who are part of this program, information about me and my hearing condition.
- I understand that CGS has a "coordination of benefits" policy. I agree to use vision coverage and benefits through Medicaid, Medicare, health maintenance organizations, private insurance, and any other vision benefit or program which I currently receive.
- I certify that all information in this assessment is complete, true and correct and that I have not left out or omitted information that might inaccurately represent myself or my economic and social need for assistance. In understand that priority is given tot hose in the most economic and social need.
- I agree to defend, indemnify and hold the Colorado Gerontological Society harmless from any and all claims, disputes, liabilities, or causes of action arising out of the agreement to provide a grant or assistance, or arising out of services and goods sold or provided to recipients of a grant or assistance through the Colorado Gerontological Society.

I have carefully read, understand and agree to the above required acknowledgements and consents.

SIGNATURE: **DATE**

RETURN ASSESSMENT FORM

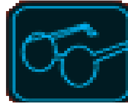
BY MAIL: Colorado Gerontological Society, 1330 Leyden St, #148, Denver CO 80220

BY FAX: 303-333-9112 · **BY E-MAIL:** cogs@senioranswers.org

QUESTIONS/COMMENTS: 303-333-3482

Colorado Gerontological Society
Vision Providers

	A	B	C	D	E	F	G
1	Clinic Name	First Name	Last Name	Address	City	Zip	Work Phone
2	Complete Eye Care	Linda	Carlson, OD	11480 Sheridan Blvd, Ste 100	Westminster	80020	(303) 404-2020
3	Complete Eye Care	Katherine	Johns, OD	11480 Sheridan Blvd, Ste 100	Westminster	80020	(303) 404-2020
4	Eye to Eye Care	James	Kani, OD	9225 S Broadway	Highlands Ranch	80129	(303) 683-4466
5	Eye to Eye Care	Michelle	Koh, OD	9225 S Broadway	Highlands Ranch	80129	(303) 683-4466
6	Eye to Eye Care	Mansur	Nurdel, OD	9225 S Broadway	Highlands Ranch	80129	(303) 683-4466
7	Eye to Eye Care	Richard	Zavoda, OD	9225 S Broadway	Highlands Ranch	80129	(303) 683-4466
8	Golden Eye Optical	Cuong	Bui, OD	1068 S Federal Blvd	Denver	80219	(303) 922-2311
9	Look Optical	Lynn	Durfee, OD	5790 W 44th Ave	Denver	80212	(303) 421-4422
10	Look Optical	James	Kani, OD	5790 W 44th Ave	Denver	80212	(303) 421-4422
11	Look Optical	Thu	Cao, OD	5790 W 44th Ave	Denver	80212	(303) 421-4422
12	Look Optical	Mansur	Nurdel, OD	5790 W 44th Ave	Denver	80212	(303) 421-4422
13	Mark's Optical	Mark	Drake	345 S Colorado Blvd	Denver	80246	(303) 333-1632
14	Mayfair Vision Clinic	Janice	Jarrett, OD	1336 Leyden St	Denver	80220	(303) 333-9898
15	One Hour Optical	JoAnne	Takara, OD	1113 S. Abilene St Suite 100	Aurora	80012	(303) 755-9447
16	One Hour Optical	Elizabeth	Thomas, OD	1113 S. Abilene St Suite 100	Aurora	80012	(303) 755-9447
17	One Hour Optical	Garrett	Moen, OD	1113 S. Abilene St Suite 100	Aurora	80012	(303) 755-9447
18	One Hour Optical	Aaron	LaHoud, OD	1113 S. Abilene St Suite 100	Aurora	80012	(303) 755-9447
19	One Hour Optical	Jeff	Sider, OD	1113 S. Abilene St Suite 100	Aurora	80012	(303) 755-9447
20	One Hour Optical	Aaron	LaHoud, OD	1685 S. Colorado Blvd, Unit O	Denver	80222	(303) 757-6747
21	One Hour Optical	Carol	Lipton, OD	1685 S. Colorado Blvd, Unit O	Denver	80222	(303) 757-6747
22	One Hour Optical	Stacy	Hieb, OD	3867 E. 120th Ave	Thornton	80233	(303) 450-0200
23	One Hour Optical	Timothy	Whitmire, OD	3867 E. 120th Ave	Thornton	80233	(303) 450-0200
24	One Hour Optical	JoAnne	Takara, OD	8547 E. Arapahoe Rd, Unit H	Englewood	80112	(303) 741-0446
25	One Hour Optical	Emily	Lemburg, OD	8547 E. Arapahoe Rd, Unit H	Englewood	80112	(303) 741-0446
26	Replace a Lens	Richard	French, OD	7800 E Iliff Ave, Unit I	Denver	80231	(303) 752-1234

This page left intentionally blank.

Colorado Gerontological Society
Senior Answers and Services Material Aid Division
Client Notification of Complaint Procedure

Senior Answers and Services is committed to serving our clients to the best of our ability. Should you be dissatisfied with the Hearing or Vision Services you have received, the procedure for filing a complaint with the Colorado Gerontological Society is listed below.

In accordance with the Older Americans Act (OAA) Sec, 307(5), Vol 10.910.1, and ASU Memorandum 04-27 consumer complaints may initially be verbal or written.

1. A complaint, in the context of Volume 10.900 rule, is an expression of dissatisfaction by:
   a. An older individual receiving services under the Older Americans Act (OAA) or State Funded Programs for Seniors (SFPS), or his/her representative or caregiver;
   b. An applicant is an older adult who has applied for services under the OAA or SFPS, or his/her representative or caregiver.
2. Older individuals receiving services, applicants for services, or their representatives or caregivers may file a complaint related to the following:
   a. Any action or failure to act which impacts the older individual's experience with programs and services funded by the OAA or SFPS;
   b. Dissatisfaction with services including issues related to quality and quantity of services;
   c. Dissatisfaction with service providers (applicants select their own service providers who are not employees or agents of Senior Answers and Services); or,
   d. Other issues related to OAA or SFPS programs raised by the older individual or his/her representative or caregiver
3. Applicant complaints must be filed within 30 calendar days of the unsatisfactory experience to Colorado Gerontological Society.
4. If a verbal complaint is made in person, the agency staff or volunteer receiving the complaint shall assist the older individual in recording the complaint on the agency form.
   a. The narrative of the complaint shall be read back to the older individual to ensure that the individual's complaint is accurately documented and the older individual shall be asked to sign the complaint. The staff member shall sign and date the document to verify this step.
   b. The older individual shall not be required to sign the complaint if he/she refuses or is unable to sign.
   c. Senior Answers and Services will accept and act on anonymous complaints at the sole discretion of the Executive Director.
5. Complaints received by phone, in person or in writing, shall be investigated and documented on the agency form by the agency staff.
6. Complaints shall be forwarded to the executive director for follow-up and disposition. Written notice of the resolution shall be sent to the complainant within 15 working days. This notice shall include:
   a. A summary of the concern or issue
   b. The results of the investigation into the complaint and the service provider's resolution or attempted resolution of the concern, and

c. Notification to the complainant of his/her right to appeal the service provider's decision if he/she is dissatisfied with the resolution, and instructions for filing such an appeals.

7. Complaints that cannot be resolved by the executive director may be appealed to the Material Aid Advisory Committee for review and disposition. Upon request, the older individual and/or the individual filing the complaint on behalf of the older individual, will be given an opportunity to have an in-person hearing with the Material Aid Advisory Committee.
8. Appeals that cannot be resolved by the Materials Aid Advisory Committee may be referred to the Colorado Gerontological Society Board of Directors for review and disposition. Upon request, the older individual and/or the individual filing the complaint on behalf of the older individual, will be given an opportunity to have an in-person hearing with the Colorado Gerontological Society Board of Directors.
9. Appeals that cannot be resolved by the Colorado Gerontological Society Board of Directors may be referred to the Denver Regional Council of Governments (DRCOG). Appeals that are referred to DRCOG will comply with the DRCOG Client Grievance Procedure.
   a. Colorado Gerontological Society is a contractor of the Denver Regional Council of Governments Area Agency on Aging (AAA). If the complainant has a grievance with Colorado Gerontological Society, a written complaint may be submitted within 30 days from the time the problem occurred to the Area Agency on Aging Director, 1001 17th St #700, Denver CO 80202. 303-455-1000 (Main line).
   b. The AAA Director shall investigate the complaint and respond in writing within fifteen (15) business days of receiving the complaint.
   c. The written response from the AAA director shall include:
      - A summary of the complainants concerns or issues.
      - The results of the investigation into the complaint and
      - If applicable, Senior Answers and Services resolution/response to the complainant's concerns.
10. If the complainant is dissatisfied with the complaint resolution by the Denver Regional Council of Governments, a written appeal may be filed with the State Unit on Aging Director within 10 calendar days of receipt of the decision. Appeals that cannot be resolved by the Denver Regional Council of Governments may be appealed to the State Unit on Aging for review and disposition. Appeals can be sent to Office of Community Access and Independence, Aging and Adult Services, 155 Sherman St, 10th Floor, Denver CO 80203 303-866-2800 (Main line); 303-866-2696 (fax); and 888-866-4243 (toll free).
    a. Appeals that are referred to the State Unit on Aging shall comply with Vol.10.910.2.
    b. The State Unit on Aging Director or designee shall complete a review of the complaint and resolution to that complaint, including all pertinent documentation or new information that may be available.
    c. The State Unit on Aging Director will provide a written response to the complainant within 30 business days of receipt of the appeal.
    d. This written response by the State Unit on Aging shall include notification of the complainant's rights to an Administrative Law Judge hearing as described at Section 10.960, if he/she is dissatisfied with the resolution of the appeal, and instructions for requesting such a hearing.

Get **MONEY BACK** (up to $892.00)

for property taxes, rent, or heat you paid. Apply for the

COLORADO PROPERTY/ RENT / HEAT CREDIT ("PTC") REBATE

If you:

- Resided in Colorado for the **ENTIRE YEAR**
- Are NOT claimed as a dependent on someone's tax return
- Are lawfully present in the United States
- Have income equal to or less than:

2016	**2017**
Single: $13,234.00	Single: $13,608.00
Married: $17,839.00	Married: $18,343.00

- **AND**
  - Are **65** years or older **-OR-**
  - Are a surviving spouse and **58** years old by December 31st **-OR-**
  - Were disabled for an entire year

You have **2 YEARS** to apply for the rebate **AFTER** the end of the calendar year.

Application Deadlines:

2016 - **December 31, 2018**

2017 - **December 31, 2019**

Accepted Forms of Identification Include:

A Colorado driver's license or I.D. card.

Other forms of I.D. may be ok if you do not have a Colorado license or I.D.

The address on your PTC application must match the address on your driver's license or Colorado I.D. card. If the addresses do not match, your rebate will be delayed.

To update your address take a "Change of Address" (DR 2285) form to any Colorado Motor Vehicle Division Driver's License Office

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There is **FREE** help applying for the "PTC" Rebate:

- Colorado Gerontological Society – (303) 333-3482
- **Colorado Department of Revenue** - (303) 238-7378
- **Volunteer Income Tax Assistance (VITA)** - (800) 906-9887
- **Dial 2-1-1** (free call) to find a tax site near you.

For the application and more information, see www.TaxColorado.com 'Click' on File and PTC Rebate

Recupere **DINERO** (hasta $892.00)

Por impuestos a la propiedad, renta o calefacción pagada. Solicite el

CRÉDITO ("PTC") REEMBOLSO DE PROPIEDAD EN COLORADO/RENTA/CALEFACCIÓN

Si usted:

- Vivió en Colorado el **AÑO COMPLETO**
- NO fue reclamado como dependiente en la declaración de impuestos de alguien
- Está presente en los Estados Unidos legalmente
- Tiene ingresos igual o Menos de:

2016	**2017**
Soltero (a): $13,234.00	Soltero (a): $13,608.00
Casado (a): $17,839.00	Casado (a): $18,343.00

- **Y**
  - Tiene **65** años o más **-O-**
  - Es cónyuge sobreviviente y cumple **58** años en o antes del 31 de Diciembre **- O -**
  - Estuvo discapacitado por un año completo

Usted tiene **2 AÑOS** para solicitar el reembolso **DESPUES** de finalizar el año vigente.

Fechas Límites Para Aplicar:

2016 - **Diciembre 31, 2018**

2017 – **Diciembre 31, 2019**

Tipos de Identificación Aceptadas Incluyen:

Licencia de Conducir de Colorado o Tarjeta de Identificación.

*Puede que se acepten otros tipos de Identificaciones si usted no tiene Licencia de Conducir de Colorado o Identificación de Colorado

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La dirección en su solicitud de PTC tiene que ser igual que la dirección en su Licencia de Conducir o Identificación de Colorado. Si las direcciones no son iguales, su reembolso se retrasara.

Para actualizar su dirección entregue un formulario de "Cambio de Dirección" (DR2285) a cualquier Oficina de Licencias de Conducir de Motores y Vehículos de Colorado

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Hay ayuda **LIBRE DE COSTO** para solicitar el Reembolso "PTC":

- **Departamento de Impuestos de Colorado** - (303) 238-7378
- **Asistencia Voluntaria de Impuestos Sobre Ingresos (VITA)** - (800) 906-9887
- **Marque 2-1-1** (llamada libre de costo) para conseguir un lugar de impuestos cerca de usted.

Para la solicitud y más información, vea www.TaxColorado.com

Haga 'Clic' al **File and PTC Rebate (Expediente y Reembolso PTC)**

GET YOUR AFFAIRS IN ORDER

Did you know

In Colorado your spouse, children, other family members, or friends cannot make medical decisions for you if you are unable to speak for yourself. Your wishes need to be in writing.

How does having your wishes in writing help you?

- It can help meeting your care needs
- Reduces unwanted health treatments or care
- You can appoint your Health Care Agent
- If you are unable to make decisions for yourself, Advance Directives help guide your Health Care Agent
- It can lessen your loved ones' and your community's stress
- It can help your family and community respect your wishes
- It can lessen conflict about your care

For more information, call Maria Madrid at 1-855-880-4777

COLORADO GERONTOLOGICAL SOCIETY
BUILDING LEADERSHIP IN AGING

MEDICAL DURABLE POWER OF ATTORNEY

LIVING WILL

FINANCIAL DURABLE POWER OF ATTORNEY

LAST WILL AND TESTAMENT

FAMILY OR INDIVIDUAL COUNSELING

COLORADO GERONTOLOGICAL SOCIETY
1330 Leyden St, Suite 148
Denver, CO 80220
303-333-3482
www.senioranswers.org

PONGA SUS ASUNTOS EN ORDEN

Sabía usted que

La ley en Colorado no permite que su esposo(a), hijos, familiares u otros seres queridos hablen por usted en caso que usted no pueda hablar y necesite tratamiento médico. La ley indica que usted necesita tener sus deseos por escrito.

¿Cuáles son los beneficios de tener sus deseos por escrito?

- Le ayuda a que reciba el cuidado que usted quiere
- Reduce que sean utilizados tratamientos médicos o cuidado que usted no desea
- Usted indica quien es su Representate
- Si usted no puede comunicar sus deseos, directivas medicas guían a su Representate para que usted reciba el cuidado médico deseado
- Puede reducir el estrés de sus familiares y su comunidad
- Le ayuda a su familia saber y seguir sus deseos
- Puede reducir conflictos cuando se está decidiendo su tratamiento

Para más información llame a Maria Madrid 1-855-880-4777

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BUILDING LEADERSHIP IN AGING

CARTA PODER MEDICA

TESTAMENTO VITAL

CARTA PODER FINANCIERA

TESTAMENTO

CONSEJERIA FAMILIAR INDIVIDUAL

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