DC HEALTH LINK
Get the facts. Get covered.

Form Approved
OMB No. 0938-1191

Standard Application for Health Coverage & Help Paying Costs

THINGS TO KNOW

Use this application to see what coverage you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)

You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

Apply faster online

Apply faster online at DCHealthLink.com.

What you may need to apply

- Social Security numbers (or document numbers for any eligible immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** See the Privacy Act Statement attached to this application.

What happens next?

Send your complete, signed application to the address on page 7. We'll follow up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit DCHealthLink.com or call **1-855-532-5465**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** DCHealthLink.com
- **Phone:** Call our Customer Service Center at **1-855-532-5465.**
- **In person:** There may be counselors in your area who can help. Visit DCHealthLink.com or call **1-855-532-5465** for more information.
- **En Español:** Llame a nuestro centro de ayuda al cliente gratis al **1-855-532-5465.**

NEED HELP WITH YOUR APPLICATION? Visit DCHealthLink.com or call us at **1-855-532-5465**. Para obtener una copia de este formulario en Español, llame **1-855-532-5465**. If you need help in a language other than English, call **1-855-532-5465** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **711**.

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name	Middle name	Last name	Suffix

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number

4. City	5. State	6. ZIP code	7. Ward (Optional)

8. Mailing address (if different from home address)	9. Apartment or suite number

10. City	11. State	12. ZIP code	13. County

14. Phone number	15. Other phone number
( ) –	( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage.)

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. Include anyone on your tax return or who you live with, even if they do not live with you or are not applying for health coverage. If you don't file a tax return, remember to still add family members who live with you.

1. First name | Middle name | Last name | Suffix

2. Relationship to you?	3. Date of birth (mm/dd/yyyy)	4. Sex
SELF	☐☐ / ☐☐ / ☐☐☐☐	☐ Male ☐ Female

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐

We need this if you want health coverage and have an SSN. Even if you don't want health coverage for yourself, providing your SSN can be helpful since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. For help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ YES. **If yes,** please answer questions a–c. ☐ NO. **If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? ☐

8. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ YES. **If yes**, answer all the questions below. ☐ NO. **If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? *(See instructions.)*
☐ Yes. Fill in your document type and ID number below.

a. Immigration document type: _____

b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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

13. 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

14. Are you a full-time student? ☐ Yes ☐ No

15. Were you in foster care at age 18 or older? ☐ Yes ☐ No

16. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

NEED HELP WITH YOUR APPLICATION? Visit DCHealthLink.com or call us at **1-855-532-5465**. Para obtener una copia de este formulario en Español, llame **1-855-532-5465**. If you need help in a language other than English, call **1-855-532-5465** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **711**.

STEP 2: PERSON 1 (Continue with yourself)

Current job & income information

☐ **Employed:** If you're currently employed, tell us about your income. Start with question 18.

☐ **Not employed:** Skip to question 28.

☐ **Self-employed:** Skip to question 27.

CURRENT JOB 1:

18. Employer name

a. Employer address

b. City	c. State	d. ZIP code	19. Employer phone number
			( ) –

20. Wages/tips (before taxes)				21. Average hours worked each WEEK
$	☐ Hourly	☐ Weekly	☐ Every 2 weeks	
	☐ Twice a month	☐ Monthly	☐ Yearly	

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name

a. Employer address

b. City	c. State	d. ZIP code	23. Employer phone number
			( ) –

24. Wages/tips (before taxes)				25. Average hours worked each WEEK
$	☐ Hourly	☐ Weekly	☐ Every 2 weeks	
	☐ Twice a month	☐ Monthly	☐ Yearly	

26. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

27. **If self-employed, answer the following questions:**

a. Type of work: _____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? *(See instructions.)* $

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it. Check here if none. ☐

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment	$	How often?	☐ Alimony received	$	How often?
☐ Pension	$	How often?	☐ Net farming/fishing	$	How often?
☐ Social Security	$	How often?	☐ Net rental/royalty	$	How often?
☐ Retirement accounts	$	How often?	☐ Other income Type:	$	How often?

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get 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 health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid	$	How often?	☐ Other deductions Type:	$	How often?
☐ Student loan interest	$	How often?			

30. **YEARLY INCOME: Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to the next person.**

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.

NEED HELP WITH YOUR APPLICATION? Visit DCHealthLink.com or call us at **1-855-532-5465**. Para obtener una copia de este formulario en Español, llame **1-855-532-5465**. If you need help in a language other than English, call **1-855-532-5465** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **711**.

STEP 2: PERSON 2

If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

Complete Step 2 for yourself, your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. Include anyone on your tax return or who you live with, even if they do not live with you or are not applying for health coverage. If you don't file a tax return, remember to still add family members who live with you.

1. First name | Middle name | Last name | Suffix

2. Relationship to you? *(See instructions.)*

3. Date of birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐ **We need this if you want health coverage for PERSON 2 and PERSON 2 has an SSN.**

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if PERSON 2 doesn't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? ☐

9. **Does PERSON 2 need health coverage?**
(Even if PERSON 2 has insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below.

☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status? *(See instructions.)*

☐ Yes. Fill in PERSON 2's document type and ID number below.

a. Immigration document type: _____

b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No

d. Is PERSON 2, or PERSON 2's spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 2 live with at least one child under the age of 19, and is PERSON 2 the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is 22 or younger:

16. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. **If yes**, end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 2 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

Now, tell us about any income from PERSON 2 on the back.

STEP 2: PERSON 2

Current job & income information

☐ **Employed:** If PERSON 2 is currently employed, tell us about his or her income. Start with question 20.

☐ **Not employed:** Skip to question 30.

☐ **Self-employed:** Skip to question 29.

CURRENT JOB 1:

20. Employer name

a. Employer address

b. City	c. State	d. ZIP code	21. Employer phone number
			( ) –

22. Wages/tips (before taxes) $

☐ Hourly ☐ Weekly ☐ Every 2 weeks
☐ Twice a month ☐ Monthly ☐ Yearly

23. Average hours worked each WEEK

CURRENT JOB 2: (If PERSON 2 has more jobs, attach another sheet of paper.)

24. Employer name

a. Employer address

b. City	c. State	d. ZIP code	25. Employer phone number
			( ) –

26. Wages/tips (before taxes) $

☐ Hourly ☐ Weekly ☐ Every 2 weeks
☐ Twice a month ☐ Monthly ☐ Yearly

27. Average hours worked each WEEK

28. **In the past year, did PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If PERSON 2 is self-employed, answer the following questions:**

a. Type of work: _____

b. How much net income (profits once business expenses are paid) will PERSON 2 get from this self-employment this month? *(See instructions.)* $

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it. Check here if none. ☐

NOTE: You don't need to tell us about PERSON 2's child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment $ How often? _____
☐ Pension $ How often? _____
☐ Social Security $ How often? _____
☐ Retirement accounts $ How often? _____
☐ Alimony received $ How often? _____
☐ Net farming/fishing $ How often? _____
☐ Net rental/royalty $ How often? _____
☐ Other income Type: _____ $ How often? _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 2 gets it. If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ How often? _____
☐ Student loan interest $ How often? _____
☐ Other deductions Type: _____ $ How often? _____

32. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month. If you don't expect changes to PERSON 2's monthly income, skip to the next person.**

PERSON 2's total income **this year**	PERSON 2's total income **next** year (if you think it will be different)
$	$

THANKS!

This is all we need to know about PERSON 2.

NEED HELP WITH YOUR APPLICATION? Visit DCHealthLink.com or call us at **1-855-532-5465**. Para obtener una copia de este formulario en Español, llame **1-855-532-5465**. If you need help in a language other than English, call **1-855-532-5465** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **711**.

STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. **Are you or is anyone in your family American Indian or Alaska Native?**

☐ **NO. If no,** skip to Step 4.

☐ **YES. If yes,** go to Appendix B.

STEP 4 Your family's health coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in 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 they have. ☐ **NO.**

☐ Medicaid _____

☐ CHIP _____

☐ Medicare _____

☐ TRICARE (Don't check if you have Direct Care or Line of Duty)

_____

☐ VA health care program _____

☐ Peace Corps _____

☐ Employer insurance _____

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?**

Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ **NO. If no, continue to Step 5.**

STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that I must tell DC Health Link if anything changes (and is different than) what I wrote on this application. I can visit DCHealthLink.com or call **1-855-532-5465** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- I know that my information on this form will be used only to determine eligibility for health coverage and will be kept private as required by law.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.

(name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

STEP 5 (Continued)

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow DC Health Link to use income data, including information from tax returns. DC Health Link will send me a notice and let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid

- I'm giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I'll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

What should I do if I think my eligibility results are wrong?

If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household, including how many days you have to request an appeal. Below is important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your eligibility results, log into your "My Account" at DCHealthLink.com or call **1-855-532-5465**. TTY users should call **711**. You can also mail an appeal request form or your own letter requesting an appeal to **Office of Administrative Review & Appeals; 64 New York Ave. NE, 5th floor; Washington DC 20002**. You can appeal eligibility for purchasing health coverage through DC Health Link, enrollment periods, tax credits, cost-sharing reductions, or Medicaid if you were denied these. If you qualify for tax credits or cost-sharing reductions, you can appeal the amount we determined you are eligible for.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here as long as you've provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)
	☐☐ / ☐☐ / ☐☐☐☐

STEP 6 Mail completed application.

Mail your signed application to:

DC Health Link
Department of Human Services
Case Records Management Unit
441 4th Street, NW, Suite 1C-15
Washington DC 20001

If you want to register to vote, you can complete a voter registration form at DCBOEE.org.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

NEED HELP WITH YOUR APPLICATION? Visit DCHealthLink.com or call us at **1-855-532-5465**. Para obtener una copia de este formulario en Español, llame **1-855-532-5465**. If you need help in a language other than English, call **1-855-532-5465** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **711**.

APPENDIX A

Form Approved
OMB No. 0938-1191

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

Employee information

1. Employee name (First, Middle, Last)	2. Employee Social Security number
	☐☐☐ - ☐☐ - ☐☐☐☐

Employer information

3. Employer name	4. Employer Identification Number (EIN)
	☐☐ - ☐☐☐☐☐☐☐
5. Employer address	6. Employer phone number
	(☐☐☐) ☐☐☐ – ☐☐☐☐
7. City	8. State / 9. ZIP code
	☐☐ / ☐☐☐☐☐
10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above)	12. Email address
(☐☐☐) ☐☐☐ – ☐☐☐☐	

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. **If you're in a waiting or probationary period, when can you enroll in coverage?** (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? **$** ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

c. Date of change (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

NEED HELP WITH YOUR APPLICATION? Visit DCHealthLink.com or call us at **1-855-532-5465**. Para obtener una copia de este formulario en Español, llame **1-855-532-5465**. If you need help in a language other than English, call **1-855-532-5465** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **711**.

EMPLOYER COVERAGE TOOL

Form Approved
OMB No. 0938-1191

Use this tool to help answer questions in your DC Health Link application, Appendix A. That part of the application asks about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or a spouse). The information in the numbered boxes below match the boxes in Appendix A. For example, you can use the answer to question 14 on this page to answer question 14 on Appendix A. **Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage that you're eligible for.**

EMPLOYEE information

The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Employee Social Security Number
	☐☐☐ - ☐☐ - ☐☐☐☐

EMPLOYER information

Ask the **employer** for this information.

3. Employer name	4. Employer Identification Number (EIN)
	☐☐ - ☐☐☐☐☐☐☐
5. Employer address (the Marketplace will send notices to this address)	6. Employer phone number
	(☐☐☐) ☐☐☐ – ☐☐☐☐
7. City	8. State / 9. ZIP code
	☐☐ / ☐☐☐☐☐
10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above)	12. Email address
(☐☐☐) ☐☐☐ – ☐☐☐☐	

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Go to question 13a.)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Go to next question)

☐ **No** (STOP and return this form to employee)

Tell us about the **health plan** offered by this **employer**.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return this form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly (Go to next question)

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return this form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan that meets the minimum value standard* and is available to the employee only. (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? **$** ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

c. Date of change (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

NEED HELP WITH YOUR APPLICATION? Visit DCHealthLink.com or call us at **1-855-532-5465**. Para obtener una copia de este formulario en Español, llame **1-855-532-5465**. If you need help in a language other than English, call **1-855-532-5465** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **711**.

APPENDIX B

Form Approved
OMB No. 0938-1191

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name _____ ☐ No	☐ Yes **If yes**, tribe name _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ ☐☐☐☐☐☐ How often? _____	$ ☐☐☐☐☐☐ How often? _____

NEED HELP WITH YOUR APPLICATION? Visit DCHealthLink.com or call us at **1-855-532-5465**. Para obtener una copia de este formulario en Español, llame **1-855-532-5465**. If you need help in a language other than English, call **1-855-532-5465** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **711**.

APPENDIX C

Form Approved
OMB No. 0938-1191

Assistance with completing this application

You can choose an authorized representative.
You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact DC Health Link. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Phone number

( ) –

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

10. Your signature

11. Date (mm/dd/yyyy)

/ /

For certified application counselors, navigators, agents, and brokers only.
Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

/ /

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

CMS Product No. 11708
August 2013

Instructions to Help You Complete the

Application for Health Coverage & Help Paying Costs

Starting October 1, 2013, you can apply for health coverage through DC Health Link. Coverage begins as soon as January 1, 2014. DC Health Link is designed to help you find health coverage that fits your budget and meets your needs.

Through a streamlined application process, you'll find out if you can get savings that you can use right away to help you pay your premium amount for private health coverage. You can also find out if you qualify for free or low-cost coverage through Medicaid or the Children's Health Insurance Program (CHIP).

For your convenience, there are different ways to apply to DC Health link. The fastest way is to apply online at DCHealthLink.com. If you apply online, you'll also get your eligibility results right away.

These instructions include additional help for some, but not all, of the items in the application.

Before you begin, it may help to have this information ready:

- Social Security numbers (SSNs)
- Document numbers for eligible immigrants who want health coverage
- Birth dates
- Paystubs, W-2 forms, or other information about your family's income
- Policy/member numbers for any current health coverage
- Information about any health coverage from a job that's available to you or your family

DC HEALTH LINK

Get the facts. Get covered.

There are 6 steps in this application.

Use blue or black ink to complete the application.

STEP 1 Tell us about yourself.

(Page 1)

An adult (18 or older) must complete the contact information. We need this information so we can follow up with you if we have questions about your application and so we can let you know what plans or programs you qualify for.

STEP 2 Tell us about your family.

(Page 1)

You need to provide information about everyone on your federal income tax return and all family members who live with you, even if they're not applying for health coverage. **Start with yourself.**

Your household size and income help determine what programs you qualify for. Read the information at the bottom of page 1 ("Who do you need to include on this application?") carefully to figure out which people to add in Step 2. The application has space for up to 2 people.

If you have more than 2 people in your household, make copies of pages 4–5 and complete them for each additional person.

(Page 2)

PERSON 1 (Start with yourself)

Need health coverage?
Complete the whole page.

Don't need health coverage?
Complete items 1–8.

Item 6

You can still apply for coverage even if you don't plan to file a federal income tax return:

- If you're married and interested in getting a premium tax credit, you'll need to file your federal income tax return jointly with your spouse to get the tax credit.
- If you're claimed as a dependent on someone else's tax return, list the names of the tax filer(s).
- If you're claimed as a dependent, include how you're related to the tax filer.
  For example, if you're the child of the tax filer, list "child."

(Page 2)

PERSON 1 (Continued)

Item 9

If you have a physical, mental, or emotional health condition that limits activities like bathing, dressing, or daily chores, or if you live in a medical facility or nursing home, answering "yes" won't increase your health care costs. If you have a disability, you may qualify for free or low-cost coverage.

Item 11

If you're not a U.S. citizen but have eligible immigration status, you may still get coverage through DC Health Link. Check "yes" and provide your document type and document ID number(s) (see pages 7–9). If you have more than one of these documents, list all of them.

Items 16–17

Ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS) better understand and improve the health and health care for all Americans. Providing this information won't impact your eligibility for health coverage, your health plan options, or your costs in any way.

(Page 3)

PERSON 1: Current job & income information

We ask about your current income to see whether you qualify for help paying for coverage and how much help you can get. Include how much you make in wages and tips before taxes are deducted. You don't have to include amounts taken out of your check by your employer for child care, health insurance, or retirement plans that are "not taxable" (sometimes called "pre-tax deductions").

If you're self-employed: Fill in the type of work you do and how much net income you'll get this month. Net income means the amount left over after you've taken out business expenses. The amount can be positive or negative. See the table of self-employment income deductions on page 9 of these instructions to find out what you can subtract from your gross income.

Item 29

Deductions: List any of the deductions you're able to claim on the front page of your 1040 federal income tax return.

STEP 2 Tell us about your family. (Continued)

(Page 4)

PERSON 2

Does PERSON 2 need health coverage?
Complete the whole page.

PERSON 2 doesn't need health coverage?
Complete items 1–9.

Item 2

Use these relationships to describe how PERSON 2 is related to you:

- Husband/wife
- Domestic partner
- Parent
- Stepparent
- Parent's domestic partner
- Son/daughter
- Stepson/stepdaughter
- Child of domestic partner
- Sibling
- Uncle/aunt
- Nephew/niece
- First cousin
- Grandparent
- Grandchild
- Other relative
- Other unrelated

Item 7

You can still apply for coverage even if PERSON 2 doesn't plan to file a federal income tax return:

- If PERSON 2 is married and interested in getting premium tax credits, PERSON 2 will need to file jointly with his or her spouse to get the tax credit.
- If PERSON 2 is claimed as a dependent on someone else's tax return, list the names of the tax filer(s).
- If PERSON 2 is claimed as a dependent, include how he or she is related to the tax filer(s). **For example**, if PERSON 2 is the child of the tax filer, list "child."

Item 10

If PERSON 2 has a physical, mental, or emotional health condition that limits activities like bathing, dressing, or daily chores, or if PERSON 2 lives in a medical facility or nursing home, answering "yes" won't increase their health care costs. If PERSON 2 has a disability, they may qualify for free or low-cost coverage.

Item 12

If PERSON 2 isn't a U.S. citizen, but has eligible immigration status, check "yes" and provide their document type and document ID number(s) (see pages 7–9). If PERSON 2 has more than one of these documents, list all of them.

Items 18–19

Ethnicity and race questions are optional. Providing this information won't impact PERSON 2's eligibility for health coverage, health plan options, or costs in any way.

(Page 5)

PERSON 2: Current job & income information

Provide information about PERSON 2's current income to see if they're eligible for help paying for health coverage. Include how much PERSON 2 makes in wages and tips before taxes are deducted. You don't have to include amounts taken out of PERSON 2's check by their employer for child care, health insurance, or retirement plans that are "not taxable" (sometimes called "pre-tax deductions").

If PERSON 2 is self-employed: Fill in the type of work PERSON 2 does and how much net income they'll get this month. Net income means the amount left over after business expenses have been taken out. The amount can be positive or negative. See the table of self-employment income deductions on page 9 of these instructions to find out what can be subtracted from PERSON 2's gross income.

Item 31

Deductions: List any of the deductions PERSON 2 is able to claim on the front page of PERSON 2's 1040 federal income tax return.

STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

(Page 6)

If anyone in your family is American Indian or Alaska Native, check "yes," complete Appendix B: American Indian or Alaska Native Family Member (AI/AN), and submit it with your application. There are special protections available for members of federally recognized tribes.

STEP 4 Your family's health coverage

(Page 6)

Item 1

If any of the people applying for health coverage are currently enrolled in a type of health coverage listed on page 6 of the application, check the type of coverage, write the person's name next to the coverage they have, and include other information as requested.

Item 2

If anyone in your family is offered health coverage from a job (whether it's their own job or another person's job), check "yes," even if they're offered coverage but aren't currently enrolled. If someone in your family is offered coverage, **you must** complete Appendix A: Health Coverage from Jobs, and submit it with your application. If no, skip to Step 5.

STEP 5 Read & sign this application.

(Page 6)

Read the statements on this page, sign your name, and write today's date. By signing, you're agreeing that the information you provided is true and correct. If you or someone applying for health insurance on this application is incarcerated (detained or jailed), write their name on the line provided. If the person is pending disposition, write "pending" beside their name.

If an authorized representative helped you fill out this application, they can sign the form for you, but they'll need to complete Appendix C: Assistance with Completing this Application, and submit it with your application.

STEP 6 Mail completed application.

(Page 7)

Mail your original, signed application (and appendices, if applicable) to:

DC Health Link
Department of Human Services
Case Records Management Unit
441 4th Street, NW, Suite 1C-15
Washington DC 20001 C

When you mail your application, be sure to use the correct amount of postage. The postage rate will depend on the weight of your application, which will be based on the number of pages you've included.

If you don't have all the information or you can't finish all the items, send in your application anyway. We'll follow up with you within 1–2 weeks.

Next Steps

You'll get information on how to enroll in a plan (if you're eligible) when you get your eligibility results.

Eligible immigration status list:

Use this list to answer questions about eligible immigration status. If you see your status below, check the box that says "yes."

Certain people with an employment authorization document:

- Registry applicants
- Order of supervision
- Applicant for Cancellation of Removal or Suspension of Deportation
- Applicant for Legalization under IRCA
- Applicant for Temporary Protected Status (TPS)
- Legalization under the LIFE Act

Applicant for:

- Special Immigrant Juvenile Status
- Adjustment to LPR Status with an approved visa petition
- Victim of trafficking visa
- Asylum who has either been granted employment authorization, OR is under 14 and has had an application for asylum pending for at least 180 days
- Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) who has either been granted employment authorization, OR is under 14 and has had an application for withholding of deportation or withholding removal under the immigration laws or under the CAT pending for at least 180 days
- Asylee
- Refugee
- Cuban/Haitian entrant
- Paroled into the U.S.
- Conditional entrant granted before 1980
- Battered spouse, child, or parent
- Individual with non-immigrant status (including worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS)
- Lawful permanent resident (LPR/Green Card holder)
- Deferred Action Status (Deferred Action for Childhood Arrivals (DACA) isn't an eligible immigration status for applying for health coverage)
- Lawful temporary resident
- Granted an administrative order stay of removal by the Department of Homeland Security (DHS)
- Member of a federally recognized Indian tribe or American Indian born in Canada
- Resident of American Samoa
- Victim of trafficking and his or her spouse, child, sibling, or parent
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
- Deferred Enforced Departure (DED)

Immigration status and document types:

If you're an eligible non-citizen applying for health coverage, list your immigration document. See the list below for some common document types. If the document you have isn't listed, you can still write its name. If you're not sure, or you have an eligible status but no document, call DC Health Link Customer Service toll-free at **1-855-532-5465** for help.

IF YOU HAVE:	LIST THESE FOR THE DOCUMENT ID:
Permanent Resident Card, "Green Card" (I-551)	• Alien registration number • Card number
Reentry Permit (I-327)	• Alien registration number
Refugee Travel Document (I-571)	• Alien registration number
Employment Authorization Card (I-766)	• Alien registration number • Card number • Expiration date • Category code
Machine Readable Immigrant Visa (with temporary I-551 language)	• Alien registration number • Passport number
Temporary I-551 Stamp (on passport or 1-94/1-94A)	• Alien registration number
Arrival/Departure Record (I-94/I-94A)	• I-94 number
Arrival/Departure Record in foreign passport (I-94)	• I-94 number • Passport number • Expiration date • Country of issuance
Foreign passport	• Passport number • Expiration date • Country of issuance
Certificate of Eligibility for Nonimmigrant Student Status (I-20)	• SEVIS ID
Certificate of Eligibility for Exchange Visitor Status (DS2019)	• SEVIS ID
Notice of Action (I-797)	• Alien registration number **or** an I-94 number
Other	• Alien registration number or an I-94 number • Description of the type or name of the document

For more eligible immigration documents or statuses, continue to the next page.

You can also list these documents or statuses:

- Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada (**Note:** This is considered an eligible immigration status for Medicaid, but not for a Qualified Health Plan (QHP).)
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of Homeland Security (DHS)
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Cuban/Haitian entrant
- Resident of American Samoa

For people who are self-employed:

If you have any of these expenses, you can subtract them from your gross income to get an amount for your net self-employment income:

- Car and truck expenses (for travel during the workday, not commuting)
- Employee wages and fringe benefits
- Interest (including mortgage interest paid to banks, etc.)
- Rent or lease of business property and utilities
- Advertising
- Repairs and maintenance
- Deductible self-employment taxes
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan
- Property, liability, or business interruption insurance
- Depreciation
- Legal and professional services
- Commissions, taxes, licenses, and fees
- Contract labor
- Certain business travel and meals
- Cost of self-employed health insurance

Instructions to Help You Complete the Appendices

APPENDIX A

Health Coverage from Jobs

If anyone in your family has an offer of health coverage from a job, including through a parent or spouse, provide information on the offer of coverage, regardless of whether the person is currently enrolled.

Complete one page for each employer that offers health coverage. This appendix includes an Employer Coverage Tool to be given to the employer to answer questions about the coverage they offer.

APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

If you or a family member are American Indian or Alaska Native, complete Appendix B. You'll be asked about the person's tribe membership, income, and other information.

APPENDIX C

Assistance with Completing this Application

- **Certified application counselors, navigators, in-person assistance counselors, and other assisters:** These are professional individuals or organizations that are trained to help consumers looking for health coverage options through DC Health Link, including help with completing this application. Services are free to consumers. You can ask to see certification showing they're authorized to perform this work. They can help you complete this section. The ID number is the navigator's identification number. This is a unique alphanumeric ID (13 letters and numbers) given to each navigator.
- **Agents and brokers:** Agents and brokers can help you apply for help paying for coverage and enroll in a Qualified Health Plan (QHP) through DC Health Link. They can make specific recommendations about which plan you should enroll in. They're also licensed and regulated by states and typically get payments or commissions from health insurance companies when they enroll consumers. They can help you complete this section.

List both ID numbers for agents and brokers:

- **FFM User ID:** A unique ID that the agent or broker creates when registering with DC Health Link.
- **National Producer Number (NPN):** A unique number (up to 10 digits) that's assigned to each licensed agent or broker. An NPN can be easily located by going to the National Insurance Producer Registry's website at **www.nipr.com**.

Permission for information submitted

By submitting this application, you represent that you have permission from all of the people whose information is on the application to both submit their information to DC Health Link, and receive any communications about their eligibility and enrollment.

Privacy Act Statement

(effective 09/01/2013)

We are authorized to collect the information on this form and any supporting documentation, including social security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act.

We need the information provided about you and the other individuals listed on this form to determine eligibility for: (1) enrollment in a qualified health plan through DC Health Link, (2) insurance affordability programs (such as Medicaid, advanced payment of the premium tax credits, and cost sharing reductions), and (3) certifications of exemption from the individual responsibility requirement. As part of that process, we will verify the information provided on the form, communicate with you or your authorized representative, and eventually provide the information to the health plan you select so that they can enroll any eligible individuals in a qualified health plan or insurance affordability program. We will also use the information provided as part of the ongoing operation of DC Health Link, including activities such as verifying continued eligibility for all programs, processing appeals, reporting on and managing the insurance affordability programs for eligible individuals, performing oversight and quality control activities, combatting fraud, and responding to any concerns about the security or confidentiality of the information.

While providing the requested information (including social security numbers) is voluntary, failing to provide it may delay or prevent your ability to obtain health coverage through DC Health Link, advanced payment of the premium tax credits, cost sharing reductions, or an exemption from the shared responsibility payment. If you don't have an exemption from the shared responsibility payment and you don't maintain qualifying health coverage for three months or longer during the year, you may be subject to a penalty. If you don't provide correct information on this form or knowingly and willfully provide false or fraudulent information, you may be subject to a penalty and other law enforcement action.

Privacy Act statement (continued)

In order to verify and process applications, determine eligibility, and operate, we will need to share selected information that we receive outside of DC Health Link, including to:

1. Federal agencies, (such as the Internal Revenue Service, Social Security Administration and Department of Homeland Security), State agencies (such as Medicaid or CHIP) or local government agencies. We may use the information you provide in computer matching programs with any of these groups to make eligibility determinations, to verify continued eligibility for enrollment in a qualified health plan or Federal benefit programs, or to process appeals of eligibility determinations;
2. Other verification sources including consumer reporting agencies;
3. Employers identified on applications for eligibility determinations;
4. Applicants/enrollees, and authorized representatives of applicants/enrollees;
5. Agents, Brokers, and issuers of Qualified Health Plans, as applicable, who are certified by DC Health Link to assist applicants/enrollees;
6. Contractors engaged to perform a function for DC Health Link; and
7. Anyone else as required by law.

This statement provides the notice required by the Privacy Act of 1974 (5 U.S.C. § 552a(e)(4)).