DC HEALTH LINK
Get the facts. Get covered.

Application for Health Coverage

Form Approved
OMB No. 0938-1191

THINGS TO KNOW

Who can use this application?

Anyone who needs health coverage can use this application.

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 happens next?

Send your complete, signed application to the address on page 4.
If you don't have all the information we ask for, sign and submit your application anyway.

We'll follow up with you within 1–2 weeks to let you know how to join a health plan. 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 costs

You need to use a different application to get help with costs. You could qualify for:

- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost coverage from Medicaid

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). Visit DCHealthLink.com or call **1-855-532-5465** to learn more.

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.**

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 20 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.

Use blue or black ink to complete this application.

STEP 1 Tell us about yourself.

(We'll 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)?

18. Do you need health coverage for yourself?

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

☐ No. **If no**, skip to Step 2 on page 2. (Leave the rest of this page blank)

19. Social Security number - -

We need Social Security numbers (SSNs) for anyone who wants coverage. We use SSNs to verify citizenship. For help getting an SSN, visit **socialsecurity.gov** or call 1-800-772-1213. TTY users should call 1-800-325-0778.

20. Sex ☐ Male ☐ Female

21. Date of birth (mm/dd/yyyy) / /

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

23. **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

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

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

25. **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 who else needs health coverage.

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 Tell us about anyone who needs health coverage.

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

STEP 2: PERSON 2

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

2. Relationship to you?

3. Social Security number ☐☐☐ - ☐☐ - ☐☐☐☐

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

5. Sex ☐ Male ☐ Female

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

If no, list address: _____

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

8. **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 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

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

10. **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 _____

STEP 2: PERSON 3

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

2. Relationship to you?

3. Social Security number ☐☐☐ - ☐☐ - ☐☐☐☐

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

5. Sex ☐ Male ☐ Female

6. Does PERSON 3 live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. Is PERSON 3 a U.S. citizen or U.S. national? ☐ Yes ☐ No

8. **If PERSON 3 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status? *(See instructions.)*

☐ Yes. Fill in PERSON 3's document type and ID number below.

a. Immigration document type: _____

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

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

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

10. **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 _____

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

	AI/AN PERSON 1	AI/AN PERSON 2
2. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
3. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name ☐ No	☐ Yes **If yes**, tribe name ☐ No

STEP 4 Read & sign this application.

- I'm signing this application under penalty of perjury, which means I've provided true answers to all of 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 coverage on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
  (name of person)
- I understand that my information will be used to check eligibility for health coverage. We'll check your answers using information in our electronic databases and databases from Social Security and the Department of Homeland Security. If the information doesn't match, we may ask you to send us proof.

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. 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, you must request an appeal within 90 days of the date of your eligibility notice. To request an appeal, log into your Marketplace 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 and Appeals; 64 New York Avenue NE; Washinton DC 20002**. You can appeal eligibility to purchase health coverage through DC Health Link and enrollment periods.

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)
	☐☐ / ☐☐ / ☐☐☐☐

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 5 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.

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. 11727
August 2013

Instructions to Help You Complete the

Application for Health Coverage

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.

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

Complete this application if you want health coverage for yourself and/or other family members but don't need help paying costs. Filling out this application doesn't mean you have to buy health coverage.

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

DC HEALTH LINK

Get the facts. Get covered.

There are 5 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 how to join a health plan.

Need health coverage?
Complete the whole page.

Don't need health coverage for yourself?
Complete items 1–18.

Item 23

If you're not a U.S. citizen but have eligible immigration status, check "yes," and provide your document type and document ID number(s) (see pages 4–6). If you have more than one of these documents, list all of them.

Items 24–25

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.

STEP 2 Tell us about anyone who needs health coverage.

(Page 2)

Space is included for up to 3 people. If you want to apply for coverage for more than 3 people, make a copy of page 2, and complete the information for each additional person.

Item 8

If the person 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 4–6). If the person has more than one of these documents, list all of them.

Items 9–10

Ethnicity and race questions are optional. This information will help HHS better understand and improve the health and health care for all Americans. Providing this information won't impact the person's eligibility for health coverage, health plan options, or costs in any way.

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

(Page 3)

If you or anyone in your family is American Indian or Alaska Native, check "yes," and complete items 2 and 3. There's special help available for members of federally recognized tribes.

STEP 4 Read & sign this application.

(Page 3)

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 5 Mail completed application.

(Page 4)

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

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.

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.

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 CMS who 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)).