

Application for Exemption

From the Individual Responsibility Requirement for Individuals Who are Unable to Afford Coverage

Use this application to apply for an affordability exemption from the individual responsibility requirement.

- All DC residents and their dependents need to have health coverage or pay a penalty on their DC taxes, unless they qualify for an exemption.
- **This application is for an exemption based on health care being too expensive for you.**
- You must **first** complete an application for financial assistance and provide the eligibility determination notice you received with your application for an affordability exemption. To apply for financial assistance, create an account or login to your account at dchealthlink.com.
- You don't need to apply for an exemption if you, and all of your tax dependents are not required to file a tax return. If you're not sure if you'll file, you may want to apply for an exemption anyway.

Who can use this application?

List everyone on your DC tax return on this application. You can use one application for multiple people in your tax household. If someone in your household file taxes separately, they must also fill out their own application.

Information you need to apply

- Income information for your household and supporting documents.
- Information about any employer-related health coverage available to your family.

Why do we ask for this information?

We ask for this information to determine your eligibility for an exemption. We will keep all the information you provide private and secure, as required by law.

Get help with this application

- Online: at dchealthlink.com
- Phone: (855) 532-5465
- In person: Go to dchealthlink.com or call (855) 532-5465 to get free expert help with this application.
- For help in other languages, call (855) 532-5465. We'll provide help at no cost to you.

Step 1: Tell us about yourself

The person who files a DC tax return in your household should be the contact person for this application, and be listed as "Person 1" throughout this application. If you're applying for an exemption for a child, we need an adult who claims the child on their DC tax return to fill out and sign this application, even if the adult doesn't need the exemption.

FIRST NAME	MIDDLE	LAST NAME	SUFFIX
HOME STREET ADDRESS Leave blank if you don't have one.			APT/SUITE NUMBER
CITY	STATE	ZIP CODE	WARD
PHONE NUMBER () -		OTHER PHONE NUMBER () -	
EMAIL ADDRESS Enter your email address if you want to get information about this application by email.			
What is your preferred spoken language if not English?			
If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply)			
<input type="checkbox"/> Mexican	<input type="checkbox"/> Chicano/a	<input type="checkbox"/> Cuban	
<input type="checkbox"/> Mexican American	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Other _____	
Race (OPTIONAL – check all that apply)			
<input type="checkbox"/> White	<input type="checkbox"/> Japanese	<input type="checkbox"/> Samoan	
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Korean	<input type="checkbox"/> Other Pacific Islander	
<input type="checkbox"/> Indian or Alaskan Native	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Other Asian		
<input type="checkbox"/> Chinese	<input type="checkbox"/> Native Hawaiian		
<input type="checkbox"/> Filipino	<input type="checkbox"/> Guamanian or Chamorro		

Step 2: Tell us about your tax household

Who to include on this application:

- The adult who files a DC tax return for this household should be listed in the table as "Person 1" throughout this application.
- A spouse who is filing jointly with you
- Anyone listed as a dependent on your tax return.

Who not to include on your application:

- Spouses who file separately from you. They need to complete a separate application and include every person they claim on their tax return.
- Anyone who lives with you that won't be listed on your tax return in the year that you want this exemption.

PERSON 1			
FIRST NAME	LAST NAME	DATE OF BIRTH (MM/DD/YYYY) / /	SOCIAL SECURITY NUMBER - -
NEED EXEMPTION? <input type="radio"/> Yes <input type="radio"/> No		RELATIONSHIP TO PERSON 1 Self	
PERSON 2			
FIRST NAME	LAST NAME	DATE OF BIRTH (MM/DD/YYYY) / /	SOCIAL SECURITY NUMBER - -
NEED EXEMPTION? <input type="radio"/> Yes <input type="radio"/> No		RELATIONSHIP TO PERSON 1 <input type="radio"/> Spouse <input type="radio"/> Dependent	
PERSON 3			
FIRST NAME	LAST NAME	DATE OF BIRTH (MM/DD/YYYY) / /	SOCIAL SECURITY NUMBER - -
NEED EXEMPTION? <input type="radio"/> Yes <input type="radio"/> No		RELATIONSHIP TO PERSON 1 <input type="radio"/> Spouse <input type="radio"/> Dependent	
PERSON 4			
FIRST NAME	LAST NAME	DATE OF BIRTH (MM/DD/YYYY) / /	SOCIAL SECURITY NUMBER - -
NEED EXEMPTION? <input type="radio"/> Yes <input type="radio"/> No		RELATIONSHIP TO PERSON 1 <input type="radio"/> Spouse <input type="radio"/> Dependent	
PERSON 5			
FIRST NAME	LAST NAME	DATE OF BIRTH (MM/DD/YYYY) / /	SOCIAL SECURITY NUMBER - -
NEED EXEMPTION? <input type="radio"/> Yes <input type="radio"/> No		RELATIONSHIP TO PERSON 1 <input type="radio"/> Spouse <input type="radio"/> Dependent	
PERSON 6			
FIRST NAME	LAST NAME	DATE OF BIRTH (MM/DD/YYYY) / /	SOCIAL SECURITY NUMBER - -
NEED EXEMPTION? <input type="radio"/> Yes <input type="radio"/> No		RELATIONSHIP TO PERSON 1 <input type="radio"/> Spouse <input type="radio"/> Dependent	
PERSON 7			
FIRST NAME	LAST NAME	DATE OF BIRTH (MM/DD/YYYY) / /	SOCIAL SECURITY NUMBER - -
NEED EXEMPTION? <input type="radio"/> Yes <input type="radio"/> No		RELATIONSHIP TO PERSON 1 <input type="radio"/> Spouse <input type="radio"/> Dependent	

1. For what year and months do you or members of your household need an exemption?

Indicate the year and list the months for each household member who needs an exemption.

FIRST NAME	LAST NAME	YEAR	MONTHS (Jan-Mar, Nov-Dec, all year, etc)

2. Yearly Income

We need to know about any income you or any other member of your tax household have made or expect to make from a job, self-employment, unemployment, retirement, pensions, rental property, fishing/farming, alimony, and social security during the year you want the exemption. If you're submitting this application before the year ends, use an estimate of your income for the year. Submit supporting documents with your application for the income listed below for each person.

INCOME TYPE	DOCUMENTS
All income types	A copy of your tax return -- if it shows what your income will be during the year you want the exemption
Employment	<ul style="list-style-type: none"> One month of pay stubs that show your typical gross income Most recent W-2 Letter from employer (if you do not receive pay stubs; must include gross amount)
Net self-employment	<ul style="list-style-type: none"> Self-employment ledger Schedule C Form 1120S (for S corporations) Other recent tax documents showing self-employment income Copy of a check for the self-employment services
OTHER INCOME	DOCUMENTS
Unemployment	Statements showing total amount received
Retirement (taxable amounts ONLY)	<ul style="list-style-type: none"> 1099 or relevant tax document that lists any withdrawal amounts Documents showing taxable amount from account withdrawals
Pension	<ul style="list-style-type: none"> Pension letter 1099 or relevant tax document

- Rental/royalties (net)
 - Lease agreement for land or property you own with lease amount/frequency
 - Document showing royalty income
 - 1099-MISC (royalty/rental income fields)
- Alimony paid/received
 - Court order or legal document showing the monthly alimony amount and the start and end dates (if applicable)
 - Only submit if agreement was signed before 1/1/2019
- Farming/fishing (net)
 - Schedule C and/or F
 - 1099-G
- Social security (taxable amounts ONLY)
 - Copy of most recent Form 1040 that shows the taxable amount in line 20b. Don't send copies of your benefit or COLA letter UNLESS the taxable amount is listed on it.

FIRST NAME	LAST NAME	TOTAL YEARLY INCOME

Step 3: Tell us about coverage from your jobs

Are you or any other individuals listed on this application offered health coverage from a job?

Select "yes" even if that coverage is from someone else's job, such as a parent or spouse. Also select "yes" if you were offered the coverage but have not signed up for it. If you select yes, you must fill out the Employer Coverage Tool at the end of this application and submit it with your application.

Yes No

If yes, list the people eligible for health coverage from a job:

Step 4: Read, print and sign this application

Review your application for accuracy, print, sign, and date it. By signing, you are agreeing that the information you provided is true and correct. Submitting false information on this form may subject you to civil or criminal penalties under District or federal law.

If an authorized representative helped you fill out this application, they can sign the form for you, but they'll need to complete an Authorized Representative Form included at the end of this application.

SIGNATURE	DATE
	/ /

Step 5: Email or mail your completed application and documents

Email or mail your signed application, proof of income, and the eligibility determination notice you received after submitting your DC Health Link application for financial assistance. Include the Employer Coverage Tool if someone in the household is eligible for health coverage from a job. We cannot process your application without it if someone in your household can get health coverage through a job.

Email Address

info@dchealthlink.com

Mailing Address

DC Health Benefit Exchange Authority
Exemption Processing Unit
1225 Eye Street, NW
Suite 400
Washington, DC 20005

What happens next?

- If you email us your application, we'll send you a confirmation email. If you mail us your application, we won't send a confirmation.
- You'll receive a letter from us if we need more documentation to process your application. If we do not hear from you within 90 days of the date of our request to you, your application will be closed and you'll receive a notice.
- If your application is approved, we'll send an approval letter to you with an exemption certificate number (ECN) for each approved member of your tax household. You will need this ECN when you file your taxes to claim your exemption.
- If you don't qualify for an exemption, you'll receive a letter explaining why.
- If you don't hear from us in 30 days, call (855) 532-5465.

Using an exemption to get a catastrophic plan

- Usually catastrophic health plans are only available to people under 30. If you are determined eligible for either a hardship exemption or an affordability exemption, you're eligible to enroll in a catastrophic health plan, even if you are over 30.
- Catastrophic plans provide low monthly premiums and high annual deductibles and are designed to protect you from worst case situations like a serious illness or an accident. Catastrophic plans provide essential health benefits and count as having coverage for tax purposes. Plans cover at least 3 primary care visits during the plan year and certain preventive services at no cost. You pay all other medical costs until the annual deductible is met. Then the plan pays 100 percent for covered services for the rest of the plan year.
- If you qualify for an exemption, you are not required to buy a catastrophic plan, but if you want to enroll in a plan, call DC Health Link at (855) 532-5465 for assistance.

Using an exemption to get a special enrollment period

- If you're found eligible for a hardship or affordability exemption, the exemption may be for the entire year or only part of the year. If it is for part of the year, once it expires you may be eligible for a special enrollment period. A special enrollment period allows you (and your family) to enroll in insurance through DC Health Link outside the open enrollment period.
- Call DC Health Link at (855) 532-5465 for assistance with enrolling in coverage after an exemption expires.

EMPLOYER COVERAGE TOOL

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 [] [] [] - [] [] - [] [] [] []
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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**.

Authorized Representative Form



Assistance with completing this application

**** NOTE: Items 1 through 9 should list information related to Authorized Representative, not the consumer.**

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 <input type="text"/> <input type="text"/>	6. ZIP code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
7. Phone number (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
8. Organization name		
9. ID number (if applicable) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
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. Consumer Signature		11. Date (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
2. First name, Middle name, Last name, & Suffix		
3. Organization name		
4. ID number (if applicable) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	5. Agents/Brokers only: NPN number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	