# Application for Exemption

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

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**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<br>( ) - | | OTHER PHONE NUMBER<br>( ) - | |
| 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? | | | |

# 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?
◯ Yes ◯ No

RELATIONSHIP TO PERSON 1
Self

**PERSON 2**

| FIRST NAME | LAST NAME | DATE OF BIRTH (MM/DD/YYYY) | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | / / | – – |

NEED EXEMPTION?
◯ Yes ◯ No

RELATIONSHIP TO PERSON 1
◯ Spouse ◯ Dependent

**PERSON 3**

| FIRST NAME | LAST NAME | DATE OF BIRTH (MM/DD/YYYY) | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | / / | – – |

NEED EXEMPTION?
◯ Yes ◯ No

RELATIONSHIP TO PERSON 1
◯ Spouse ◯ Dependent

**PERSON 4**

| FIRST NAME | LAST NAME | DATE OF BIRTH (MM/DD/YYYY) | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | / / | – – |

NEED EXEMPTION?
◯ Yes ◯ No

RELATIONSHIP TO PERSON 1
◯ Spouse ◯ Dependent

**PERSON 5**

| FIRST NAME | LAST NAME | DATE OF BIRTH (MM/DD/YYYY) | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | / / | – – |

NEED EXEMPTION?
◯ Yes ◯ No

RELATIONSHIP TO PERSON 1
◯ Spouse ◯ Dependent

**PERSON 6**

| FIRST NAME | LAST NAME | DATE OF BIRTH (MM/DD/YYYY) | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | / / | – – |

NEED EXEMPTION?
◯ Yes ◯ No

RELATIONSHIP TO PERSON 1
◯ Spouse ◯ Dependent

**PERSON 7**

| FIRST NAME | LAST NAME | DATE OF BIRTH (MM/DD/YYYY) | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | / / | – – |

NEED EXEMPTION?
◯ Yes ◯ No

RELATIONSHIP TO PERSON 1
◯ Spouse ◯ 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) |
|---|---|---|---|
| | | | |
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## 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 | • One month of pay stubs that show your typical gross income<br>• Most recent W-2<br>• Letter from employer (if you do not receive pay stubs; must include gross amount) |
| Net self-employment | • Self-employment ledger<br>• Schedule C<br>• Form 1120S (for S corporations)<br>• Other recent tax documents showing self-employment income<br>• Copy of a check for the self-employment services |

| OTHER INCOME | DOCUMENTS |
|---|---|
| Unemployment | Statements showing total amount received |
| Retirement (taxable amounts (ONLY) | • 1099 or relevant tax document that lists any withdrawal amounts<br>• Documents showing taxable amount from account withdrawals |
| Pension | • Pension letter<br>• 1099 or relevant tax document |

| | |
|---|---|
| Rental/royalties (net) | • Lease agreement for land or property you own with lease amount/frequency<br>• Document showing royalty income<br>• 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)<br>• Only submit if agreement was signed before 1/1/2019 |
| Farming/fishing (net) | • Schedule C and/or F<br>• 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.

# Authorized Representative Form

DC HEALTH LINK
Get the facts. Get covered.

## 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

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. Consumer 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

**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

Use this worksheet to help you gather information about employers that offer traditional health coverage to anyone on your DC Health Link application. **Complete one form for each employer that offers coverage.** You'll need this information to complete the application, even if no one enrolls in coverage through their job (or the job of another person, like a spouse or parent).

Don't use this form if someone works for a business that offers help paying for a health plan or health care expenses through a Health Reimbursement Arrangement (HRA). Visit https://www.dchealthlink.com/hra for details.

Visit https://www.dchealthlink.com/glossary#affordable_coverage for more details if you have (or got an offer for) job-based insurance.

## Employee information

Fill in for the **employee** who's offered job-based health coverage.

| 1. Employee name (First, Middle, Last) | 2. Employee Social Security Number (SSN) |
|---|---|
| | ___ - ___ - ____ |

3. List the first and last names of each person in the employee's household and tell us if they could get health coverage through the employer named in box 4 below, even if they're not currently enrolled. Only list household members who the employee plans to include on their federal income tax return.

| Name | Eligible for health coverage through this employer? |
|---|---|
| | ◯ Yes ◯ No |
| | ◯ Yes ◯ No |
| | ◯ Yes ◯ No |
| | ◯ Yes ◯ No |

## Employer information

You can ask the **employer** to fill out these items.

4. Employer name

5. Person or department we can contact for information about any coverage offered

6. Employer address (the Marketplace may send notices to this address)

| 7. City | 8. State | 9. ZIP code |
|---|---|---|
| | | |

| 10. Employer contact phone number | 11. Employer contact email address | 12. Employer Identification Number (EIN) |
|---|---|---|
| | | |

## Tell us about the health coverage offered by this employer.

13. Do the plans offered by the employer meet the minimum value standard? A health plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the minimum value standard.

◯ **YES** (Go to question 14.) ◯ **NO** (STOP and return this form to employee.)

◯ The employer offers plans that meet the minimum value standard to only the employee.

14. How much would the employee pay for themselves for the lowest-cost plan that meets the minimum value standard? Don't include family plans.

a. Employee would pay this premium: **$**

b. Employee would pay this amount: ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Quarterly ◯ Yearly

15. **If other household members are listed for question 3:** How much would the employee pay for the lowest-cost plan that covers the employee and the household members listed in question 3? If the employer offers wellness programs, enter the premium that the employee would pay if the employee got the maximum discount for any tobacco cessation programs and didn't get any other discounts based on wellness programs.

a. Employee would pay this premium: **$**

b. Employee would pay this amount: ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Quarterly ◯ Yearly

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