Application for Exemption

From the Individual Responsibility Requirement for Individuals Who Experience Hardships

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Use this application to apply for a hardship exemption from the individual responsibility requirement.

- All DC residents and their dependents must have health coverage or pay a penalty on their DC taxes, unless they qualify for an exemption.
- This application is for a category called "hardships" available only through DC Health Link.
- 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 that needs an exemption 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 may need to apply

You may need to provide documents that support your claim of hardship. See the next page for a list of hardships and documents required. Each document must:

- support the reason you're requesting an exemption, **AND**
- include the dates showing when you experienced the hardship.

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.

Types of Hardship and Documentation Requirements

#	TYPE	SUBMIT DOCUMENTS WITH YOUR APPLICATION
1	You were homeless.	None
2	You were evicted in the past 6 months or were facing eviction or foreclosure.	Copy of eviction or foreclosure notice
3	You received a shut-off notice from a utility company.	Copy of shut-off notice from a utility company
4	You recently experienced domestic violence.	None
5	You recently experienced the death of a family member.	Copy of death certificate, copy of notice from newspaper, or copy of other official notice of death
6	You experienced a fire, flood, or other natural human-caused disaster that cause substantial damage to your property.	Copy of police or fire report, insurance claim, or other document from government agency documenting event
7	You filed for bankruptcy in the last 6 months.	Copy of bankruptcy filing
8	You had medical expenses you couldn't pay in the last 24 months.	Copy of medical bills
9	You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.	Copies of receipts related to care
10	You expect to claim a child as a tax dependent who's been denied Medicaid coverage, and another person is required by court order to give medical support to the child.	Copy of medical support order AND copies of eligibly notices for Medicaid and CHIP showing that the child has been denied coverage
11	You successfully appealed an eligibility appeals decision by DC Health Link.	Copy of final appeal decision
13	You were pregnant with a household income below 324 percent of the Federal Poverty Level.	Documentation from a licensed health care provider certifying the period of the pregnancy AND a copy of the federal tax return for the year you are requesting the exemption.

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 is known 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?			

Step 2: Tell us about your tax household

Who to include on this application:

- ✓ You and/or anyone you would list on your DC tax return that needs an 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

TYPE OF HARDSHIP	**TAX YEAR** For which person(s) need exemption	**DATE HARDSHIP STARTED** Note: your hardship can't start in the future mm/dd/yyyy	**DATE HARDSHIP ENDED** Leave blank if still active mm/dd/yyyy	**NAME(S) OF PEOPLE** Who need this exemption
Homelessness		/ /	/ /	
Eviction or foreclosure		/ /	/ /	
Shut off notice from a utility		/ /	/ /	
Domestic violence		/ /	/ /	
Death of a family member		/ /	/ /	
Disaster		/ /	/ /	
Bankruptcy		/ /	/ /	
Medical expenses		/ /	/ /	
Increase in expenses to care for a family member		/ /	/ /	
Medical support court order for child		/ /	/ /	
Appeals decision		/ /	/ /	
Error/misrepresentation/misconduct		/ /	/ /	
Pregnancy		/ /	/ /	

Step 3: 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 4: 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**.