**Application for Health Coverage & Help Paying Costs (Short Form)**

### 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)

#### Who can use this application?

**YOU CAN ONLY USE THIS APPLICATION IF YOU ARE A SINGLE ADULT WHO:**

- Is not offered health coverage from their employer
- Does not have any tax dependents and can’t be claimed as a dependent on someone else’s tax return

**NOTE:** If any of the following apply, you need to use the Standard Form to make sure you get the most benefits possible:

- You're married or have dependent children.
- You were in the foster care system, and you're under age 26.
- You have items that can be deducted from your income. If your only deduction is student loan interest, you can use this form.
- You're American Indian or Alaska Native.

#### Apply faster online

Apply faster online at [DCHealthLink.com](http://DCHealthLink.com).

#### What you may need to apply

- Your Social Security number (or document number if you're an eligible immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)

#### 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 3. 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. Filling out this application doesn’t mean you have to buy health coverage.

#### Get help with this application

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

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**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 15 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.

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**NEED HELP WITH YOUR APPLICATION?** Visit [DCHealthLink.com](http://DCHealthLink.com) or call us at toll-free 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/TDD users should call 711.
Use blue or black ink to complete this application.

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)?

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

19. Sex

Male  Female

20. Social Security number (SSN) – –

We need this if you want health coverage and have an SSN. We use SSNs to check income and other information to see if you're eligible for help with health coverage costs. If you need help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

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

22. 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 a veteran or an active-duty member of the U.S. military?  Yes  No

23. Are you pregnant?  Yes  No  a. If yes, how many babies are expected during this pregnancy?  –

24. 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

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

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

26. Race (OPTIONAL—check all that apply.)

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

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STEP 2 Current job & income information

☐ Employed: If you’re currently employed, tell us about your income. Start with question 1.

☐ Not employed: Skip to question 11.

☐ Self-employed: Skip to question 10.

CURRENT JOB 1:
1. Employer name

   a. Employer address

   b. City ____________________________
   c. State ____________________________
   d. ZIP code ________________________

   2. Employer phone number (___) _______ – ________

   3. Wages/tips (before taxes) $ _______
   a. Hourly
   b. Weekly
   c. Every 2 weeks
   d. Twice a month
   e. Monthly
   f. Yearly

   4. Average hours worked each WEEK

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

   a. Employer address

   b. City ____________________________
   c. State ____________________________
   d. ZIP code ________________________

   6. Employer phone number (___) _______ – ________

   7. Wages/tips (before taxes) $ _______
   a. Hourly
   b. Weekly
   c. Every 2 weeks
   d. Twice a month
   e. Monthly
   f. Yearly

   8. Average hours worked each WEEK

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

10. 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.) $ _______

11. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.

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

   ☐ None
   ☐ Retirement accounts $ _______
   ☐ Alimony received $ _______
   ☐ Unemployment $ _______
   ☐ How often? _______
   ☐ Social Security $ _______
   ☐ How often? _______

   ☐ Pension $ _______
   ☐ How often? _______
   ☐ Other income $ _______
   ☐ How often? _______

   ☐ Net farming/fishing $ _______
   ☐ How often? _______

   12. Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax return?

     ☐ YES. If yes, how much $ _______
     ☐ NO.

13. YEARLY INCOME: Complete only if your income changes from month to month. If you don’t expect changes to your monthly income, skip to Step 3.

   Your total income this year $ _______
   Your total income next year (if you think it will be different) $ _______
STEP 3  Your health coverage

1. Are you enrolled in health coverage now from the following?  
   □ YES. If yes, check which coverage you have.   □ NO.  
   □ Medicaid  □ CHIP  □ Medicare  □ TRICARE (Don’t check if you have Direct Care or Line of Duty)  □ Peace Corps  □ VA health care program  □ Other  
   Name of health insurance: ____________________________  
   Policy number: ____________________________

STEP 4  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 my eligibility.
• 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 I’m not incarcerated (detained or jailed).
• I confirm that next year I expect to file a federal income tax return, won’t claim dependents on that return, and can’t be claimed as a dependent on anyone else’s federal income tax return.
• I confirm that I’m not offered health coverage from an employer.

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.

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 I’m eligible for Medicaid
If I enroll in Medicaid, I’m giving the Medicaid agency my rights to pursue and get any money from other health insurance, legal settlements, or other third parties.

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 5  Mail completed application.

Mail your signed application to:
DC Health Link
Department of Human Services
Case Records Management Unit
P.O. Box 91560
Washington DC 20090

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

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.
# 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)

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<td>2. Address</td>
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<td>4. City</td>
<td>5. State</td>
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<tr>
<td>6. ZIP code</td>
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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

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<td>11. Date (mm/dd/yyyy)</td>
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**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)

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<td>2. First name, Middle name, Last name, &amp; Suffix</td>
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</table>

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

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**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.
Register to Vote

In addition to your application for health insurance, you may REGISTER to vote where you live now or UPDATE your voter registration record to reflect an address, name, or party change.

⚠️ IMPORTANT NOTICE: Applying to register or declining to register to vote will not affect your eligibility or amount of financial assistance you may be provided by DC Health Link.

The NATIONAL VOTER REGISTRATION ACT provides you with the opportunity to register to vote with this application for health insurance. If you would like help filling out a voter registration form, we will help you. The decision whether to seek or accept help is yours.

CONFIDENTIALITY: Whether you decide to register to vote or not, your decision will remain confidential. You may fill out voter registration forms in private and you may send your completed forms separately.

IF YOU BELIEVE SOMEONE HAS INTERFERED with your right to register or to decline to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the D.C. Board of Elections, 441 4th Street, N.W., Suite 250, Washington, D.C. 20001. Phone: (202) 727-2525.

If you are not registered to vote where you live now, would you like to register to vote with this application?

☐ Yes  IF YES ➔ Complete the official Voter Registration Application included on the next page, sign it and submit it to the DC Board of Elections at the address listed at the bottom of the form.

☐ No  IF NO ➔ No Further Action is Necessary.

If you did not fill in either YES or NO above, you will be considered to have decided not to register to vote at this time.
APPLYING TO REGISTER OR DECLINING TO REGISTER TO VOTE WILL NOT AFFECT THE AMOUNT OF
ASSISTANCE THAT YOU WILL BE PROVIDED BY DC HEALTH LINK.

Voter Registration Application

Use this form to register to vote in the District of Columbia, to let us know that your name or address has changed, to register with a political party, or to change your party registration.

To register to vote in the District of Columbia, you must:
- Be a United States citizen
- Be a resident of the District of Columbia
- Not claim voting residence outside the District of Columbia
- Be at least 16 years old
- Not be in jail for a felony conviction
- Not have been found by a court to be legally incompetent to vote

To vote in the District of Columbia, you must:
- Maintain residency for at least 30 days prior to the election in which you intend to vote
- Be at least 17 years old
- Be at least 18 years old by the next general election

To vote in a primary election, you must also:
- Be registered in that party at least 30 days prior to the election unless you are registering for the first time

Please complete all items on this form. You are not officially registered to vote until the Board of Elections has approved this application. If you do not receive a voter registration card in the mail within three weeks of mailing this application, call 202-727-2525. If you are registering to vote in the District of Columbia for the first time and submit this application by mail or on Election Day, you may be required to provide identification at the polls showing your name and current address. Your mailed application must be postmarked by the 30th day preceding the next election. After that date, you can register to vote in person at 441 4th Street NW, Suite 250 North.

Questions? Call 202-727-2525 or 866-328-6837 or visit www.dcbCEO.org.

Información en español: Si le interesa obtener este formulario en español, llame al 202-727-2525.

Hearing impaired: For TDD assistance, call 202-639-8916.

Mail Completed Forms To:
D.C. Board of Elections
One Judiciary Square
441 4th Street, N.W., Suite 250 North
Washington, DC 20001
Instructions to Help You Complete the
Application for Health Coverage & Help Paying Costs (Short Form)

Starting October 1, 2013, you can apply for health coverage through the new 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.

Completing this application will let you know what health coverage choices you qualify for and if you can get help with costs. You’ll be asked about income and other information to make sure you get the most benefits possible.

For your convenience, there are different ways to apply for coverage. 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 number (SSN)
- Document number (if you’re an eligible immigrant who wants health coverage)
- Birth date
- Paystubs, W-2 forms, or other information about your income
- Policy/member numbers for any current health coverage
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 what plans or programs you qualify for.

**Item 22**
If you're not a U.S. citizen but have eligible immigration status, check “yes,” and provide your document type and document ID number (see pages 4–6). If you have more than one of these documents, list all of them.

**Item 24**
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.

**Items 25–26**
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  Current job & income information**

(Page 2)

Provide information about your current income to see if you’re eligible for help paying for health coverage. Include how much you make in wages and tips before taxes are deducted.

**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 page 6 to find out what you can subtract from your gross income.
STEP 3  Your health coverage

(Page 3)

Item 1
If you’re currently enrolled in a type of health coverage listed on the page, check “yes” and the type of coverage. Also include other information as requested.

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’re incarcerated (detained or jailed), but pending disposition, you’ll need to fill out the Application for Health Coverage & Help Paying Costs instead of this application.

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 3)

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

DC Health Link
Department of Human Services
Case Records Management Unit
P.O. Box 91560
Washington DC 20090

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.

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.

<table>
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<tr>
<th>IF YOU HAVE:</th>
<th>LIST THESE FOR THE DOCUMENT ID:</th>
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</table>
| 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
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](http://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 the Marketplace, 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), 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 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)).