Health Insurance Marketplace

Application for exemption from the Shared Responsibility Payment for individuals who experience hardships

Expiration Date
xx/xx/xxxx

DRAFT MOCKUP
OMB No. 0938-1190

Use this application to apply for a hardship exemption from the Shared Responsibility Payment

- Every person needs to have health coverage or make a payment on their federal income tax return called the "Shared Responsibility Payment."
- Some people are exempt from making this payment. This application is for one category of exemption. You may apply for other categories of exemptions when you file your federal income tax return.
- You don't need to apply for an exemption if you're not planning 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?

- **Use this application if you or anyone in your tax household experiences a hardship that keeps you from getting health coverage.** See page 1 for the list of hardships.
- You can use one application for multiple people in your tax household.
- If you get a hardship exemption, you may qualify to enroll in a catastrophic plan, which offers minimal coverage at a lower cost.

What you need to apply

- Documents that support your claim of hardship. See page 1 for a list of documents needed for each hardship exemption. The document must:

  1) Support the reason you're requesting an exemption, **AND**
  2) Include dates showing when you experienced the hardship.

If you can't provide the required documents, call the Health Insurance Marketplace Call Center at **1-800-318-2596** (TTY: 1-855-889-4325).

Why do we ask for this information?

We ask for Social Security numbers and other information to make sure your exemption information is sent to the Internal Revenue Service (IRS) to match your tax return. **We'll keep all the information private and secure, as required by law.** To view the Privacy Act Statement, go to HealthCare.gov/privacy.

Get help with this application

- **Online:** HealthCare.gov/exemptions
- **Phone:** Call the Marketplace Call Center at **1-800-318-2596** (TTY: 1-855-889-4325).
- **In person:** There may be counselors in your area who can help. Visit localhelp.healthcare.gov, or call the Marketplace Call Center for more information.
- **En Español: Llame a nuestro centro de ayuda gratis al 1-800-318-2596.**
- **Other languages:** If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll provide help at no cost to you.

Hardship categories and documentation

You must provide documentation that 1) supports the reason you're requesting the exemption **AND** 2) includes dates showing when you experienced the hardship.

Hardship Number	Category	Required documentation
1	You were homeless.	None
2	You were evicted or were facing eviction or foreclosure.	Eviction or foreclosure notice within the last three years
3	You received a shut-off notice from a utility company.	Shut off notice from an electric, water, or gas utility company that states service has been or will be shut-off. Must be within the last three years.
4	You recently experienced domestic violence.	None
5	You experienced the death of a close family member within the last three years.	Death certificate, death notice from newspaper, funeral service program, funeral expenses, coroner's report, military notification of death, or other official notice of death
6	You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property.	Police or fire report, insurance claim, or other document from a government agency or news source about the event that occurred within the last three years
7	You filed for bankruptcy.	Official bankruptcy filing documents within the last three years
8	You had medical expenses you couldn't pay.	Medical bills from the last three years
9	You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.	Receipts for bills or services related to care like medical bills, home care services, or transportation receipts from the last three years
10	A child you expect to claim as a tax dependent has been denied coverage in Medicaid and the Children's Health Insurance Program (CHIP), and another person is required by court order to give medical support to the child.	Court order that covers the time period for which you want the exemption for the tax dependent **and** copies of eligibility notices showing the dependent has been denied Medicaid and CHIP coverage. Must be within the last three years
11	As a result of a Health Insurance Marketplace appeals decision, you're eligible either for: 1) enrollment in a qualified health plan through the Marketplace; 2) lower costs on your monthly premiums; or 3) cost-sharing reductions for a time period when you weren't enrolled in a Marketplace plan.	Health Insurance Marketplace notice of appeals decision that states that your appeal was granted or approved.
12	An adult in your tax household was determined ineligible for Medicaid because your state did NOT expand eligibility for Medicaid under the Affordable Care Act.	None
13	You got a notice from a current health insurance plan you purchased in the individual market for job-based coverage) saying your policy will be discontinued because it doesn't meet Affordable Care Act requirements, and you consider other available plans unaffordable.	Notice of cancellation from the insurance company. The notice must show the names of everyone in your tax household who wants this exemption
14	You experienced a hardship that kept you from getting health insurance that's NOT listed in categories 1-13.	A limited number of other hardships qualify. Provide information about your hardship under box 14 on page 3 of this application.

STEP 1: Tell us about yourself

The person who files a federal income tax return in your household should be the contact person for this application. If you're applying for an exemption for a child, we need an adult who claims the child on his or her federal income tax return to fill out this information, even if the adult doesn't need the exemption.

Use your legal name

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. County, parish, or township

8. Mailing address ○ *(Select if same as home address)* | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County, parish, or township

Please provide a phone number so we can contact you if necessary. We won't use your number for anything else.

14. Phone number ( ) - Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening ☐ Weekend

15. Other phone number ( ) - Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening ☐ Weekend

16. Do you want to get information by email from the Marketplace?..... ○ Yes ○ No

Email address:

17A. What's your preferred spoken language?

17B. What's your preferred written language?

STEP 2: Tell us about your tax household

Who to include in your application

- The person in line one must be the adult who files a federal income tax return for this household.
- A spouse who's filing taxes jointly with you.
- Anyone that they person in line one claims as a dependent on his or her federal income tax return.

Note: If you don't plan to file a federal income tax return, you don't need to fill out this application *because you won't have to make the Shared Responsibility Payment.*

Who NOT to include in your application

- A spouse who files taxes separately. They should fill out their own exemption application and include on their own application anyone the spouse claims as a dependent on their federal income tax return.
- Anyone who lives with you but isn't a dependent on your federal income tax return.

STEP 2: Tell us about your tax household (start with yourself)

The person in line 1 must be the person who files a federal income tax return, even if the person doesn't need this exemption.

1. First name	Middle name	Last name	Suffix

2. Relationship to you	3. Date of birth (mm/dd/yyyy)	4. Sex
SELF	/ /	○ Male ○ Female

5. Social Security Number (SSN) - -

If you're applying for an exemption for yourself and you have an SSN, you must provide it.
If you don't have an SSN, you can still qualify for an exemption. If you're not applying for an exemption for yourself, providing your SSN can speed up the process. We use SSNs to match exemptions with the right tax returns. To get an SSN, visit **socialsecurity.gov** or call **1-800-772-1213** (TTY: 1-800-325-0778).

6. List the relationship to Person1, names, DOBs, SSN, and sex of anyone that would be on your federal tax return if you were going to file one. If you need this exemption so you can get an exemption from paying the tax penalty or catastrophic insurance, Select **YES** for "Want Exemption?" otherwise select **NO**. Only list a spouse if you would file **a joint return**. Do not list a spouse if you would file married, filing separately. Select Yes if you want the exemption for yourself, otherwise select No. If you would file a single return, skip the table after checking the box below.

a. Do you want this exemption for yourself? ○ **YES.** ○ **NO.**

b. I would file a federal tax return as a single individual. ☐ (skip table if you check this box and go to **Question 7**.

Relationship to Person 1 *(required) (spouse or dependent)*	**First Name** *(required)*	**Last Name** *(required)*	**Date of Birth** *MM/DD/YYYY (required)*	**Social Security Number** *###-##-####*	**Sex**	**Want exemption?** *(required)*
			/ /	- -	○ M ○ F	○ YES ○ NO
			/ /	- -	○ M ○ F	○ YES ○ NO
			/ /	- -	○ M ○ F	○ YES ○ NO
			/ /	- -	○ M ○ F	○ YES ○ NO
			/ /	- -	○ M ○ F	○ YES ○ NO
			/ /	- -	○ M ○ F	○ YES ○ NO

7. Select the type of hardship(s) you're applying for below. Note the date the hardship started, when it will end, or if it's ongoing. You need only one exemption for any given period. You may apply for more than one hardship if the hardship events were at different times during the year.**If you're applying for more than one hardship, you must sumbit documentation for EACH hardship that requires documentation.**

Type of hardship *(Select all that apply.)*	**Tax year for which you need this exemption** (YYYY)	**Date hardship started** (***Note:*** *If your hardship started before 01/01/2014, list the first date you did not have required health coverage. Your hardship cannot start on a date in the future.)*	**Date hardship ended**	**Check if ongoing**
☐ 1. Homeless	2 0			☐
List the first and last names of each member of your tax household who has this hardship reason.				
☐ 2. Eviction/foreclosure	2 0			☐
List the first and last names of each member of your tax household who has this hardship reason.				
☐ 3. Shut-off notice	2 0			☐
List the first and last names of each member of your tax household who has this hardship reason.				
☐ 4. Domestic violence	2 0			☐
List the first and last names of each member of your tax household who has this hardship reason.				

STEP 2: Tell us about your tax household (continued)

Type of hardship *(Select all that apply.)*	Tax year for which you need this exemption (YYYY)	Date hardship started (**Note:** *If your hardship started before 01/01/2014, list the first date you did not have required health coverage. You hardship cannot start on a date in the future.*)	Date hardship ended	Check if ongoing
☐ 5. Death of family member	20			☐
List the first and last names of each member of your tax household who has this hardship reason.				
☐ 6. Disaster	20			☐
List the first and last names of each member of your tax household who has this hardship reason.				
☐ 7. Bankruptcy	20			☐
List the first and last names of each member of your tax household who has this hardship reason.				
☐ 8. Medical Expenses	20			☐
List the first and last names of each member of your tax household who has this hardship reason.				
☐ 9. Increase in expenses to care for family member	20			☐
List the first and last names of each member of your tax household who has this hardship reason.				
☐ 10. Medical support for child	20			☐
List the first and last names of each member of your tax household who has this hardship reason.				
☐ 11. Eligibility appeals decision	20			☐
List the first and last names of each member of your tax household who has this hardship reason.				
☐ 12. Ineligible for Medicaid	20			☐
List the first and last names of each member of your tax household who has this hardship reason.				
☐ 13. Cancellation of individual coverage	----------	**NO LONGER AVAILABLE**	----------	☐
☐ 14. You experienced another hardship	20			☐
List the first and last names of each member of your tax household who has this hardship reason.				

(Explain how this hardship prevented you from getting health insurance):

Optional: *(Check all that apply.)*

8. If Hispanic/Latino, ethnicity: ☐ Mexican ☐ Mexican American ☐ Puerto Rican ☐ Chicano/a ☐ Cuban ☐ Other

9. Race: ☐ White ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Filipino ☐ Japanese ☐ Korean ☐ Asian Indian ☐ Chinese ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other

STEP 3: Read, print & 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 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 hhs.gov/ocr/office/file.

The person on line 1 should be the one to sign this application.
The person who signs this application must be an adult over the age of 18 who files the federal income tax return for your household. If you're an Authorized Representative, you may sign here as long as the person on line one signed Appendix C.

Print out application and sign	Date signed (mm/dd/yyyy)
	/ /

STEP 4: Mail completed application and documents

Note: A page listing the documents to send with your application appears at the end of this application.

Mail your completed application with **copies (not originals)** of the documents listed on the document information page at the end of this application to:

Health Insurance Marketplace - Exemption Processing
465 Industrial Blvd.
London, KY 40741

What happens next?

We'll follow up in about 2 weeks. We may call or send you a letter if we need more information. You'll get a letter in the mail after we've processed your application.

- If your application is approved, we'll send you an Exemption Certificate Number (ECN). You'll use it to complete your federal income tax return for the year you didn't have coverage.
- If you don't qualify for the exemption, the letter will explain why.
- If you don't hear from us within 30 days, contact the Marketplace at **1-800-318-2596** (TTY: 1-855-889-4325).

If you think the decision about your exemption is wrong

If you believe you qualify for a hardship exemption but your application was denied, you can appeal the decision. The letter you get from the Marketplace will explain the appeal process and your rights.

The Health Insurance Marketplace must receive your appeal request with 90 days of the date of the notice of application results.

- You may have a relative, friend, legal counsel, or another spokesperson, including an Authorized Representative, help you file or participate in your appeal request. This is optional.
- The outcome of an appeal could change the eligibility of other members of your tax household.

To appeal your exemption application results and learn more about appeals, visit HealthCare.gov/marketplace-appeals. Or contact the Marketplace Call Center at **1-800-318-2596** (TTY: 1-855-889-4325).

If you claim a hardship exemption, you can buy a "catastrophic" health plan

A "catastrophic" health plan offers lower-priced coverage that mainly protects you from high medical costs if you get seriously hurt or injured. If you get a hardship exemption, you can buy a catastrophic plan, but you don't have to. It's just an option so you can get low-priced health coverage if you want to.

If your hardship exemption application is approved, the letter you get will include information on catastrophic health plans.

For more information, visit Healthcare.gov/choose-a-plan/plans-categories/#catastrophic or call **1-800-318-2596** (TTY: 1-855-889-4325).

Appendix C

Form Approved
OMB No. 0938-1191

Assistance with this application

For certified application counselors, navigators, agents, and brokers only

Complete this section only 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

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 or remove your Authorized Representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

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

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, in block #10 below, you allow the person on this form to sign your application, get official information about this application, and act for you on all future matters related to this application. The person that signs this form, in block #10 below, must be an adult over the age of 18 who files the federal income tax return for the household.

10. Signature of Tax Filer

11. Date signed (mm/dd/yyyy)