Health Insurance Marketplace

Application for a Hardship Exemption

OMB Control Number 0938-1190
Expiration Date: XX/XXXX

Use this application to apply for a hardship exemption

For 2018:

- 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 the Shared Responsibility Payment. This application is for a category of exemptions called "hardships" available through the Marketplace.
- 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.

For 2019 and future years:

- The Shared Responsibility Payment no longer applies. You don't need to apply for an exemption unless you're planning to purchase catastrophic coverage.
- You can enroll in a "catastrophic" health plan if you qualify for a hardship exemption.
- For more information on catastrophic health plans, please see "Step 4" of this application.

Who can use this application?

For 2018, use this application if you or anyone in your tax household experiences a hardship that keeps you from getting health coverage.
See page 1 (following) for the list of hardships.

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

For 2019 and future years, use this application only if you or anyone in your tax household experiences a hardship and you want to enroll in a catastrophic plan.

What you need to apply

- You can provide documents or a written explanation to support your claim of hardship. See the table below for document examples.

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 and to correctly match to your coverage application. **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 trained assisters in your area who can help. Visit localhelp.healthcare.gov, or call the Marketplace Call Center.
- **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. We’ll provide free help in your language.

Hardship categories and documentation

Hardship number	Category	Examples of documentation
1	You were homeless.	None
2	You were evicted or were facing eviction or foreclosure.	Eviction or foreclosure notice. The document must show that the event happened in this calendar year or up to two calendar years prior.
3	You received a shut-off notice from a utility company.	Shut off notice from an electric, water/sewer, or gas utility company that says service has been or will be shut off. The document must show that the shut off happened in this calendar year or up to two calendar years prior.
4	You recently experienced domestic violence.	None
5	You experienced the death of a close family member.	Death certificate, death notice from newspaper, funeral service program, funeral expenses, coroner's report, military notification of death, or other official notice of death. The document must show that the death happened in this calendar year or up to two calendar years prior.
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 disaster. The document must show that the event happened in this calendar year or up to two calendar years prior.
7	You filed for bankruptcy.	Bankruptcy filing document from a court or other legal authority. The document must show that the bankruptcy happened in this calendar year or up to two calendar years prior.
8	You had medical expenses you couldn't pay.	One or more medical bills. The bill(s) must be for this calendar year or up to two calendar years prior.
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 a family member's care, like medical bills, home care services, or transportation receipts. The receipts must be from this calendar year or up to two calendar years prior.
10	A child you expected 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 provide health coverage to the child.	Court order that covers the time period for which you want the exemption for the child **and** copy of eligibility notice that shows the child was denied Medicaid and CHIP coverage from your state. The Medicaid/CHIP document must show eligibility determination for this calendar year or up to two calendar years prior.
11	As a result of a Health Insurance Marketplace or state-based Marketplace appeals decision, you're eligible 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.	Notice of appeal from the Health Insurance Marketplace or your state-based Marketplace. The appeals notice must be from this calendar year or up to two calendar years prior.
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. This exemption is available only for the most recent calendar year.
13	You got a notice from a health insurance plan you purchased on the individual market (not job based coverage) saying your policy was cancelled because it didn't meet Affordable Care Act requirements and you considered other plans unaffordable.	This category is no longer available for 2017 and future years.
14	You experienced a hardship NOT listed in categories 1-13 that kept you from getting health insurance.	Include any documentation that explains why you're requesting a hardship exemption NOT listed in categories 1-13. The documentation must show that the hardship happened within this calendar year or up to two calendar years prior.

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, and is known as "Person 1". If you're applying for an exemption for a child, an adult who claims the child on his or her federal income tax return should fill out and sign this application, 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 correspondence from the Marketplace? ○ Yes ○ No

Email address:

17a. What is your preferred spoken language?

17b. What is your preferred written language?

Optional: *(Select all that apply)*

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

19. **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 2: Tell us about your tax household and the hardship events you experienced

Who to include on this application:

- The adult who files the federal income tax return for this household – list this person, who will be known as "Person 1", on the first line of the table on the next page.
- A spouse who's filing taxes jointly with you.
- Anybody Person 1 claims as a dependent on the federal income tax return.

You should apply for this exemption based on how you file taxes, with the following exception: If you're 21 or older and included as a dependent on someone else's tax return, submit your own exemption application.

Who NOT to include on your application:

- A spouse who files taxes separately from you. Spouses who file separately must fill out a separate exemption application for themselves and include every person they claim on their tax return.
- Anyone who lives with you but isn't (or won't be) listed on your tax return for the year(s) you want this exemption.

For 2017 and 2018, If you don't plan to file taxes, you don't need to apply for an exemption.

STEP 2: Tell us about your tax household and the hardship events you experienced

The person in line 1 below, who will be known as "Person 1", must be the person who files a federal income tax return for the household, even if the person doesn't need an exemption.

For each person included on the federal income tax return, select their relationship to Person 1, the name, date of birth, SSN, sex, and whether they want an exemption.

You must give your Social Security number (SSN) if you have one. In the table below include the SSN for anyone requesting the exemption who has an SSN. An SSN is not necessary to qualify for the exemption. We use SSNs to match exemptions with the right tax returns and to correctly match to your coverage application. For help getting an SSN, visit **socialsecurity.gov** or call 1-800-772-1213. (TTY: 1-800-325-0778)

#	Relationship to Person 1 *(spouse or dependent)*	First name	MI	Last name	Date of birth *(mm/dd/yyyy)*	Social Security number *(###-##-####)*	Sex	Want exemption?
1	Self							
2								
3								
4								
5								
6								
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. Then select each person in your tax household that has experienced that hardship type, if everyone in your household has experienced that hardship type, select all. Each person needs only one exemption for any given time period. You may apply for more than one hardship if the hardship events were at different times during the year.

Type of hardship *(Select all that apply)*	Tax year for which you need this exemption	Date hardship started *(mm/dd/yyyy)* (***Note:*** *Your hardship can't start on a date in the future)*	Date hardship ended or will end? *(mm/dd/yyyy)*	Check if ongoing
☐ 1. Homeless				☐
☐ 2. Eviction/foreclosure				☐
☐ 3. Shut-off notice				☐
☐ 4. Domestic violence				☐

STEP 2: Tell us about your tax household and the hardship events you experienced

Type of hardship *(Select all that apply)*	Tax year for which you need this exemption	Date hardship started *(mm/dd/yyyy)* (***Note:*** *Your hardship can't start on a date in the future)*	Date hardship ended or will end? *(mm/dd/yyyy)*	Check if ongoing
☐ 5. Death of family member				☐
☐ 6. Disaster				☐
☐ 7. Bankruptcy				☐
☐ 8. Medical expenses				☐
☐ 9. Increase in expenses to care for family member				☐
☐ 10. Medical support for child				☐
☐ 11. Eligibility appeals decision				☐
☐ 12. Ineligible for Medicaid				☐
13. Cancellation of individual coverage				
☐ 14. You experienced another hardship				☐

STEP 3: Read, print & sign this application

You won't be able to print and sign your application until you've filled out all required information. We can't process unsigned applications or accept digital signatures.

I agree that:

- 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, known as "Person 1", should sign this application.
The person who signs must be an adult over the age of 18 who files the federal income tax return for the household. If you're an Authorized Representative, you may sign here as long as Person 1 fills out and signs the "Help with this application" form on page 6 of this application.

Print out application and have Person 1 sign.	Date signed (mm/dd/yyyy)

STEP 4: Mail completed application and documents

Note: A page that lists the documents you need to submit will print at the end of this application.

Mail your **signed** application and **copies (do not send originals)** of the documents listed on the page that will print at the end of this application to:

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

What happens next?

We'll call you if we need more information. If we don't reach you by phone, we'll send a letter. You'll get a letter in the mail after we've processed your application.

- If your application is approved, we'll send an Exemption Certificate Number (ECN) for each approved member of your tax household to use on your federal income tax return for the year members of your tax household didn't have coverage. You'll provide the ECN when you file your return for the year your exemption has been approved.
- If you or other members of your tax household 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)

What if I think the results of my exemption application are wrong?

You can appeal. Important information about an appeal:

- The Health Insurance Marketplace must receive your appeal request within 90 days of the date of the application results notice.
- You may have a relative, friend, legal counsel, or another spokesperson, including an Authorized Representative, help you appeal or participate in your appeal. 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, visit HealthCare.gov/marketplace-appeals. Or call the Marketplace Call Center at 1-800-318-2596. (TTY: 1-855-889-4325)

If you qualify for 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. You're not required to buy a catastrophic plan, 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)

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Help with 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 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 (if applicable)

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 who 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)**

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 (if applicable)

4. ID number (if applicable) | 5. Agents/Brokers only: NPN number