

APPENDIX J

DRAFT Model Authorization Form for Certified Application Counselors (CACs) in a Federally-Facilitated Marketplace or State Partnership Marketplace (Marketplace)

CAC Designated Organization Name: _____

CAC Designated Organization Address: _____

CAC Designated Organization Phone Number and Email:

Individual CAC Name and Certification Number:

I. Acknowledgement of Roles and Responsibilities of CACs (see Attachment A)

I have been informed about and understand the CAC roles and responsibilities set forth on Attachment A and have been given the opportunity to discuss them with [Name].¹

II. Definitions and Explanations of Terms Used in This Form

In this authorization form:

- The words “I,” “me,” or “my” include my authorized representative if I have one.
- Personally identifiable information is called “PII.” Examples of my PII include, but are not limited to my name, phone number, email address, home address, immigration status, income, and household size information.
- Health plans available through the Marketplace are called Qualified Health Plans or “QHPs.” Other programs called “insurance affordability programs” are also available through the Marketplace. These programs can help me or my family pay for health coverage, and include public programs, such as Medicaid or the Children’s Health Insurance Program (CHIP), premium tax credits, cost-sharing reductions, and, if one is available in my state, the Basic Health Program.

III. Authorizations

a. General Consent

I, _____, give my permission to [Name], including the individual CACs who are certified by this CAC designated organization, to create, collect, disclose, access, maintain, store, and/or use my PII in order to carry out the following duties of a CAC, unless I have limited that consent as set forth in this document. I understand that [Name] might need to create, collect, disclose, access, maintain, store, and/or use some of my PII in order to provide this assistance.

¹ NOTE TO CAC DESIGNATED ORGANIZATION AND INDIVIDUAL CAC: Each time [Name] appears in this Authorization Form, the Name of the CAC Designated Organization, at a minimum, should be inserted. Individual CAC name(s) may, but are not required, to be inserted.

1. Telling me about the full range of QHP options and insurance affordability programs for which I may be eligible, which includes: providing me with fair, accurate, and impartial information that assists me with submitting a Marketplace eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping me make informed decisions during the health coverage selection process. I understand that [Name] might need to ask about and keep notes on my health coverage needs in order to help me.
2. Helping me to apply for health coverage through the Marketplace.
3. Helping me to enroll in a QHP.
4. Ensuring that tools and help provided are accessible and usable for me if I have disabilities. If [Name] can't provide me with my accessibility needs, [Name] will refer me to a Marketplace Navigator or in-person assistance personnel, or the federal Marketplace Call Center, who can meet my specific needs. I understand that [Name] might need to ask about and keep notes on any supports and services I need and might need to disclose my information to other assisters in order to help me.
5. Providing me with this form and storing a signed copy of it.

b. Specific Consents

I also permit [Name] to create, collect, disclose, access, maintain, store, and/or use my PII, for the following purpose(s):

- To follow-up with me by the end of the applicable coverage year to learn whether I would like help with re-enrolling in Marketplace coverage and/or insurance affordability programs. My preferred contact information is found below.

[NOTE TO CAC DESIGNATED ORGANIZATION AND INDIVIDUAL CAC: insert text for any additional consents that may be requested here.]

IV. Exceptions or Limitations to Consent

I understand that I can revoke, limit or otherwise change the consents I provide through this form at any time. If I don't make any limitations, exceptions, or changes to my consents now, I can still do so at any time in the future by notifying [Name]. I make the following exceptions, limitations, or changes:

V. Additional Information

I understand that:

1. I don't have to provide [Name] with any information that I do not want to provide. However, the help [Name] provides is based only on the information I provide, and if the information given is inaccurate or incomplete, [Name] may not be able to offer all the help that is available for my situation.

2. I understand that [Name] will ask me to provide only the minimum amount of my PII that is necessary to help me.
3. [Name] will make sure that my PII is kept private and secure when creating, collecting, disclosing, accessing, maintaining, storing, and/or using my PII. [Name] will follow the privacy and information security standards that apply to them.
4. If I give my contact information when signing this form, my general consent includes permission for [Name] to follow up with me about applying for or enrolling into coverage after my first meeting with them.
5. I understand that [Name] is not required to help me in a language I understand under the CAC program rules, but [Name] may be required by other federal, state, or local laws to provide these services to me. If [Name] does not have the resources or skills to help me right away in a language I understand, he or she will refer me to a Marketplace Navigator or in-person assistance personnel, or to the federal Marketplace Call Center, who can meet my specific needs sooner. If [Name] needs to refer me to another source of help, he or she will refer me to the source that is easiest for me to access. I understand that [Name] might need to share my contact information and information about my needs with possible referral sources in order to help me.
6. I understand that once I have signed this authorization form, I can expect [Name] to help me without asking me to sign another authorization form.
7. [Name] will provide me with a copy of my Authorization Form and this Attachment A, once complete.
8. [Name] is required to collect, handle, disclose, access, maintain, store, and/or use my PII to carry out activities required under a state law or regulation. [Name] has listed below the specific state requirements that apply.

[NOTE TO CAC DESIGNATED ORGANIZATION AND INDIVIDUAL CAC: any state requirements that might require use, disclosure, etc. of consumer PII (for example, state reporting) should be inserted here, if applicable. Otherwise, this item should not be included on the form.]

Please complete, sign, and date the form:

| | |
|--|---|
| _____ Date _____ | |
| Consumer/Consumer's Legal or Marketplace Authorized Representative Signature. Circle one of these to show if you are the consumer or the consumer's representative. PLEASE NOTE: Consumers may sign this consent form themselves, or may choose to have a legal or Marketplace Authorized Representative sign it. | |
| Printed Consumer Name | Printed Authorized Representative Name (if applicable) |
| Ways I agree to be contacted (optional): | |
| ___ By mail or in-person at _____ | |
| ___ By phone at _____ (XXX) XXX-XXXX | |

By text message at _____ (XXX) XXX-XXXX [Note: to the extent a CAC entity wishes to contact individuals on their cell phones or via text message, it should obtain individual legal advice on what the consent language should say.]

By email at _____ XXXXX@XXXXX.XXX

Attachment A: Roles and Responsibilities of Certified Application Counselors (CACs)

1. [Name] must tell me about the full range of qualified health plan (QHP) options and insurance affordability programs for which I may be eligible, which includes: providing me with fair, accurate, and impartial information that assists me with submitting a Marketplace eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping me make informed decisions during the health coverage selection process.
2. [Name] must help me to apply for health coverage through the Marketplace, if I want that help.
3. [Name] must help me to enroll in a QHP, if I want that help, but [Name] can't and won't choose a plan for me.
4. [Organization Name] is designated by the Marketplace to certify individuals to act as CACs after showing that it meets all required standards and must follow the terms of its agreement with the Marketplace.
5. All individuals who help me have been certified by [Organization Name] to help consumers after showing that they meet all required standards and must follow the terms of their agreements with [Organization Name]. If I have a concern about the help provided by any of these individuals I should contact [INSERT Organization Contact].
6. All CAC individuals who help me must complete and receive a passing score in a Marketplace-approved training course before providing help to consumers, and must take additional training every year before being recertified by the organization to continue helping consumers.
7. [Name] must act in my best interests.
8. [Name] won't discriminate against me based on my race, color, national origin, disability, age, sex, gender identity, or sexual orientation. If [Name] receives federal funds to provide services to a specific population (such as a Ryan White HIV/AIDS program or an Indian health provider), it may limit their services to that population, as long as they don't discriminate within that specific population.
9. [Name] must ensure that tools and help provided are accessible and usable for me if I have disabilities. If [Name] can't provide me with my accessibility needs, [Name] will refer me to a Marketplace Navigator or in-person assistance personnel, or the federal Marketplace Call Center, who can meet my specific needs.
10. [Name] must provide me with information about the roles and responsibilities of CACs, including through this form.
11. [Name] must comply with Marketplace standards for keeping my PII private and secure, must obtain my consent before accessing my PII, and must permit me to revoke my consent at any time.
12. [Name] will not charge me a fee for any help provided.
13. [Name] does not receive any funding or payments from any health or stop-loss insurance issuer in connection with the enrollment of any individuals in a QHP or a non-QHP and will inform me of any conflicts of interest they might have.

14. Beginning on November 15, 2014, [Name] won't be paid by [Organization Name] based on the number of applications they help complete, based on the number of people they help, or based on the number of enrollments they help complete.
15. [Name] won't give me any gifts (including gift cards or cash) that are over \$15 in value, or give me things that market or promote the products or services of another individual or business, as a way to persuade me to enroll in health coverage. [Name] is permitted—but not required—to provide me gifts, gift cards, or cash that are over \$15 in value to reimburse me for things I might have to buy or pay for in order to get application assistance from [Name] (such as travel or mailing expenses).
16. [Name] is not allowed to contact consumers to provide application or enrollment help by going door-to-door or otherwise contacting persons who have not already asked for help, unless [Name] already has a relationship with a consumer, but [Name] can go door-to-door or contact persons who have not already asked for help when providing general outreach and education to the public. Because I have a relationship with [Name], [Name] is allowed to come to my door and/or to call me directly to provide application or enrollment help, so long as [Name] follows other laws that might apply to that activity.
17. [Name] is not allowed to make “robo-calls” to consumers (by using an automatic dialing system or pre-recorded or artificial voice) unless [Name] already has a relationship with the consumer. Because I have a relationship with [Name], [Name] is permitted to contact me using “robo-calls” so long as [Name] follows other laws that might apply to that activity.
18. [Name] must also meet any applicable state and local requirements when providing services to me.