

**Model Certified Application Counselor (CAC) Recertification Request Form for Federally-facilitated and State Partnership Marketplaces**

<b>TO BE COMPLETED BY CAC DESIGNATED ORGANIZATION:</b>											
<b>1) CAC designated organization (CDO):</b> <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/>	<b>2) Organization Designee ID:</b> <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/>										
<b>3) Financial, business, or contractual relationships organization has or expects to have with health insurance companies that offer qualified health plans (QHPs) or with insurance affordability programs (e.g., Medicaid, CHIP, APTCs/CSRs), or other potential nondisqualifying conflicts of interest:<sup>1</sup> [note to CDO: complete if organization is fulfilling its duty, as required by 45 CFR 155.225(d)(2), to inform consumers of any existing or anticipated relationships it has with QHPs or insurance affordability programs or other potential conflicts of interest through its individual CACs]</b>  <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/> <hr style="border: 0; border-top: 1px solid black; margin-top: 5px;"/> <hr style="border: 0; border-top: 1px solid black; margin-top: 5px;"/> <hr style="border: 0; border-top: 1px solid black; margin-top: 5px;"/>											
<b>TO BE COMPLETED BY INDIVIDUAL STAFF OR VOLUNTEER:</b>											
<b>4) Individual CAC Name:</b>  <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/>	<b>5) Unique ID Number:</b>  <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/>	<b>6) Date of Initial Certification:</b>  <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/>									
<b>7) Location(s) in which I provide or will provide CAC services:</b>  <table style="width:100%; border: none;"> <tr> <td style="width: 33%; border: none;"><hr style="border: 0; border-top: 1px solid black;"/></td> <td style="width: 33%; border: none;"><hr style="border: 0; border-top: 1px solid black;"/></td> <td style="width: 33%; border: none;"><hr style="border: 0; border-top: 1px solid black;"/></td> </tr> <tr> <td style="border: none;"><hr style="border: 0; border-top: 1px solid black;"/></td> <td style="border: none;"><hr style="border: 0; border-top: 1px solid black;"/></td> <td style="border: none;"><hr style="border: 0; border-top: 1px solid black;"/></td> </tr> <tr> <td style="border: none;"><hr style="border: 0; border-top: 1px solid black;"/></td> <td style="border: none;"><hr style="border: 0; border-top: 1px solid black;"/></td> <td style="border: none;"><hr style="border: 0; border-top: 1px solid black;"/></td> </tr> </table>			<hr style="border: 0; border-top: 1px solid black;"/>	<hr style="border: 0; border-top: 1px solid black;"/>	<hr style="border: 0; border-top: 1px solid black;"/>	<hr style="border: 0; border-top: 1px solid black;"/>	<hr style="border: 0; border-top: 1px solid black;"/>	<hr style="border: 0; border-top: 1px solid black;"/>	<hr style="border: 0; border-top: 1px solid black;"/>	<hr style="border: 0; border-top: 1px solid black;"/>	<hr style="border: 0; border-top: 1px solid black;"/>
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<b>8) Languages spoken, other than English:</b> <hr style="border: 0; border-top: 1px solid black; margin-top: 5px;"/>											

<sup>1</sup> Effective July 28, 2014, an individual or entity has a disqualifying conflict of interest and cannot become or continue to serve as a CAC or CAC designated organization, if the individual or entity receives any consideration directly or indirectly from a health insurance or stop loss insurance issuer in connection with the enrollment of any individuals in a QHP or non-QHP. In a Federally-facilitated Marketplace, however, no health care provider shall be ineligible to operate as a CAC or CAC designated organization solely because it receives consideration from a health insurance issuer for health care services provided. 45 CFR 155.225(g)(2).

<p><b>9) My availability to provide CAC services:</b></p> <p>M: _____</p> <p>T: _____</p> <p>W: _____</p> <p>Th: _____</p> <p>F: _____</p> <p>Sa: _____</p> <p>Su: _____</p>	<p><b>10) Date of Achieving a Passing Score on 2015 CAC Training:</b></p> <p>_____</p> <p><b>Proof of training attached? (select one)</b></p> <p style="text-align: center;">YES                      NO</p>
<p><b>11) Financial, business, or contractual relationships I have or expect to have with health insurance companies that offer qualified health plans or with insurance affordability programs (e.g., Medicaid, CHIP, APTCs/CSRs), or other potential nondisqualifying conflicts of interest:<sup>2</sup></b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p><b>12) Individual's signature</b></p> <p>_____</p> <ul style="list-style-type: none"> <li>• By signing this form, I affirm that I wish to be recertified as a CAC.</li> <li>• I understand that my CDO may review my work as a CAC for the CDO as a part of the recertification process.</li> <li>• I understand that I must complete annual CAC training before the anniversary date of my initial certification and provide proof of my successful completion to my CDO.</li> <li>• I understand that my training certificate is not my official CAC certificate, and that my CDO will issue a new official CAC certificate to me if it recertifies me.</li> <li>• I understand that in order to be recertified, I may be required to sign and enter into a new agreement with my CDO. My CDO will inform me whether a new agreement is necessary.</li> <li>• I understand that if my CDO does not recertify me, I must adhere to the termination provisions of my agreement with my CDO that apply, including those that prohibit me from holding myself out as a CAC and require me to protect personally identifiable information (PII).</li> </ul>	<p><b>13) Date:</b></p> <p>_____</p>

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