



Get a SHOP eligibility determination here.

To be eligible to enroll in health insurance through the Small Business Health Options Program (SHOP), your small business or non-profit organization must:

- Have a primary business address in the state where you're buying coverage.
- Have at least one employee enrolling in coverage who isn't the owner, business partner, or spouse of the owner or business partner.
- Have from 1 to 50 [full-time equivalent \(FTE\)](#) employees.
- Offer SHOP coverage to all full-time employees.

This form will determine your eligibility for SHOP.

QUESTIONS?

<https://www.healthcare.gov/contact-us/>

PRA DISCLOSURE: 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 0938-1193, expiration date is XX/XX/20XX. The time required to complete this information collection is estimated to take up to 0.16 hours per applicant per year, including the time to review instructions, gather the information 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. \*\*\*\*CMS Disclosure\*\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Elliot Klein at [Elliot.Klein@cms.hhs.gov](mailto:Elliot.Klein@cms.hhs.gov).





Business Name:

Business Email (Optional):

Don't use a personal email address unless it's the one you also use for your business.

Business Phone Number: xxx-xxx-xxxx

Business Address:

Employer Identification Number (EIN):

Enter your 9 digit number after the leading 0

Date current SHOP plan year began, or will begin:

mm/dd/yyyy





To be eligible to enroll in SHOP insurance, you must indicate that your small business or non-profit organization meets all the following qualifications. Answer "Yes" or "No" to the following questions.

This business has from 1 to 50 full-time equivalent (FTE) employees or participated in SHOP last year.

[Learn how to count FTE employees.](#)

Yes

No





This business has a primary business address in the state where I'm applying for this SHOP coverage.

Yes

No





All full-time employees of my business will be offered SHOP coverage.

Yes

No





This business has at least one employee enrolling in coverage who isn't an owner or business partner, or the spouse of the owner or business partner.

Yes

No



This business is ELIGIBLE to enroll in SHOP coverage. You can enroll in a plan through an insurance company or with an agent or broker. Please confirm the information in your business' eligibility determination below.

I confirm the information about this business is correct and this business is therefore eligible for SHOP coverage.

Review your information before you click **Submit**.

**Business Name:** X, inc.

**Business Email (optional):**

**Don't use a personal email address unless it's the one you also use for your business.** xxx.xxx@yyy.com

**Business Address:**

10 X Street, X City, X State, XXXXX

10 X Street, X City, X State, XXXXX

10 X Street, X City, X State, XXXXX

10 X Street, X City, X State, XXXXX

**Employer Identification Number (EIN):**

**Enter your 9 digit number after the leading 0**

\*\*\*\*\*

**Date current SHOP plan year began, or will begin:**

**mm/dd/yyyy**

01/01/2023

**This business has from 1 to 50 full-time equivalent (FTE) employees or participated in SHOP last year.**

[Learn how to count FTE employees.](#)

Yes

**This business has a primary business address in the state where I'm applying for this SHOP coverage.** Yes

**All full-time employees of my business will be offered SHOP coverage.** Yes

**This business has at least one employee enrolling in coverage who isn't an owner or business partner, or the spouse of the owner or business partner.** Yes

**Retain your eligibility determination for your records:**

Your eligibility determination will be sent to the email address you provided.

If you didn't provide an email address, please be sure to print or save your responses.





Thank You!  
You have completed your SHOP eligibility determination.

**ELIGIBLE BUSINESSES**

- If you're already working with an agent or broker or an insurance company, present them with your eligibility confirmation email or printed page.
- To browse SHOP plans and prices visit [HealthCare.gov](https://www.healthcare.gov).
- To find a SHOP agent or broker use the [Find Local Help tool](#).

**NON-ELIGIBLE BUSINESSES:**

- If you don't agree with your eligibility determination you can file an [appeal](#).