

# Application for Exemption from the Shared Responsibility Payment for Individuals who Experience Hardships

THINGS TO KNOW



## Use this application to apply for an exemption from the shared responsibility payment

- Starting in 2014, 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 includes one category of exemption. There are other applications for other categories of exemptions. You may apply for certain other categories of exemptions when you file your federal income tax return.
- You don’t need to ask for an exemption if you’re not going to file a federal income tax return because your income is below the filing threshold. If you aren’t sure, you may want to ask for an exemption.



## Who can use this application?

- **Use this application if you and/or anyone in your tax household have experienced a hardship that keeps you from getting health coverage. See page 1 for the list of hardships.**
- If you get a hardship exemption, you may qualify for catastrophic coverage.
- You can use one application to ask for this exemption for more than one person in your tax household.



## What you need to apply

- Documents that support your claim of hardship (**see page 1.**) If you can’t obtain the documents, call the Health Insurance Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.
- Social Security numbers (SSNs), if you have them.
- Information about people in your tax household.



## Why do we ask for this information?

We ask for Social Security numbers and other information to make sure your exemption is counted when you file your federal income tax return. **We’ll keep all the information you give private and secure, as required by law.** To view the Privacy Act Statement, go to [HealthCare.gov](http://HealthCare.gov) or see instructions.



## What happens next?

Except for cancellations, send your complete, signed application to the address on page 4. We’ll follow-up with you within 1–2 weeks and let you know if we need additional information. If you get this exemption, we’ll give you an Exemption Certificate Number that you’ll put on your federal income tax return. If you don’t hear from us, visit [HealthCare.gov](http://HealthCare.gov), or call the Health Insurance Marketplace Call Center at **1-800-318-2596**. See page 4 for next steps for cancellations.



## Get help with this application

- **Online:** [HealthCare.gov](http://HealthCare.gov).
- **Phone:** Call the Health Insurance Marketplace Call Center at **1-800-318-2596**.
- **In person:** There may be counselors in your area who can help. Visit [HealthCare.gov](http://HealthCare.gov) or call **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596**.



**NEED HELP WITH YOUR APPLICATION?** Visit [HealthCare.gov](http://HealthCare.gov) or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. 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 get you help at no cost to you. TTY users should call **1-855-889-4325**.

## Hardship Categories and Documentation

You may qualify for a hardship exemption if you experienced one of the following:

Hardship number (Put this number in box 8 on page 3.)	Category	Submit this documentation with your application
1	You were homeless.	None
2	You were evicted in the past 6 months or were facing eviction or foreclosure.	Copy of eviction or foreclosure notice
3	You received a shut-off notice from a utility company.	Copy of shut-off notice from a utility company
4	You recently experienced domestic violence.	None
5	You recently experienced the death of a close family member.	Copy of death certificate, copy of death notice from newspaper, or copy of other official notice of death
6	You experienced a fire, flood, or other natural human-caused disaster that caused substantial damage to your property.	Copy of police or fire report, insurance claim, or other document from government agency, private entity, or news source documenting event
7	You filed for bankruptcy in the last 6 months.	Copy of bankruptcy filing
8	You had medical expenses you couldn't pay in the last 24 months.	Copies of medical bills
9	You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.	Copies of receipts related to care
10	You expect to claim a child as a tax dependent who's 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.	Copy of medical support order AND copies of eligibility notices for Medicaid and CHIP showing that the child has been denied coverage
11	As a result of an eligibility appeals decision, you're eligible either for: 1) enrollment in a qualified health plan (QHP) 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 QHP through the Marketplace.	Copy of notice of appeals decision
12	You were determined ineligible for Medicaid because your state didn't expand eligibility for Medicaid under the Affordable Care Act.	Copy of notice of denial of eligibility for Medicaid
13	You received a notice saying that your current health insurance plan is being cancelled, and you consider the other plans available unaffordable.	Copy of notice of cancellation
14	You experienced another hardship in obtaining health insurance.	Please submit documentation if possible



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## STEP 1 Tell us about yourself.

(We need one adult in the tax household to be the contact person for your application.)

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
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State □ □	12. ZIP code □ □ □ □ □ □	13. County
14. Phone number ( □ □ □ ) □ □ □ - □ □ □ □		15. Other phone number ( □ □ □ ) □ □ □ - □ □ □ □	
16. Do you want to get information about this application by email? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Email address: _____			
17. What is your preferred spoken or written language (if not English)?  _____			

## STEP 2 Tell us about your tax household.

### Who do you need to include on this application?

Tell us about each person in the tax household who needs an exemption (don't include dependents who aren't asking for this exemption for themselves.) If your request for an exemption is approved, you'll get an Exemption Certificate Number with your approval letter. Keep this for your records. You'll need to put this number on your federal income tax return at the time you file taxes.

### Complete Step 2 for each person in your tax household, except for dependents who aren't asking for this exemption for themselves.

Start with yourself, then add all other adults (whether or not they're requesting this exemption) and any dependents, if you want this exemption for them. Make additional copies of page 3 and attach them for each additional person. You don't need to give a Social Security number (SSN) for members of your tax household who don't need this exemption. Someone asking for an exemption may still be eligible for one even if they don't have an SSN. We'll keep all the information you provide private and secure, as required by law. We'll use personal information only to check if you're eligible for an exemption.



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**STEP 2**

**If you have more than one person to include, make a copy of this page and complete.**

Complete Step 2 for yourself and/or anyone on your same federal income tax return. Don't fill this out for any dependents who aren't asking for this exemption for themselves.

1. First name Middle name Last name Suffix

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

5. Social Security number (SSN)  -  -

**If you're requesting an exemption for yourself and you have an SSN, you must provide it. You aren't required to have an SSN to get this exemption. If you're not requesting an exemption for yourself, providing your SSN can be helpful since it can speed up the application process.** We use SSNs to help make sure that if you get an exemption, it's applied correctly on your taxes. We also use SSNs to check income and other information to see who's eligible for help with health coverage costs. For help getting an SSN, call **1-800-772-1213** or visit [socialsecurity.gov](http://socialsecurity.gov). TTY users should call **1-800-325-0778**.

**6. Tell us about the federal income tax return that you plan to file.**

- a. Will you file jointly with a spouse?  Yes  No  
**If yes**, name of spouse: \_\_\_\_\_
- b. Will you claim any dependents on your tax return who are requesting this exemption?  Yes  No  
**If yes**, list name(s) of dependents: \_\_\_\_\_
- c. Will you be claimed as a dependent on someone's tax return?  Yes  No  
**If yes**, please list the name of the tax filer: \_\_\_\_\_  
 How are you related to the tax filer? \_\_\_\_\_

7. Do you need this exemption?  
 **YES.**  **NO.** **If no**, leave the rest of this page blank.

**If you have multiple hardships to include, please make a copy of this page for each hardship and answer questions 8-11.**

8. Use page 1 to write the number of the hardship you experienced in this box:

9. Unless you're applying for hardship #12 (**Medicaid ineligibility**) or #13 (**cancellation**), please explain how this hardship kept you from getting health coverage for the time period for which you're requesting an exemption:

10. When did this hardship start? (mm/dd/yyyy)  
 /  /

11. When did this hardship end? (mm/dd/yyyy). If you're still experiencing this hardship, check this box:   
 /  /

You must include any documents described on page 1 for the exemption you're requesting. If you can't get the documents, call the Marketplace Call Center at 1-800-318-2596.

**12. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

- Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other \_\_\_\_\_

**13. Race (OPTIONAL—check all that apply.)**

- |  |   |                                   |  |   |
|--|---|-----------------------------------|--|---|
| <input type="checkbox"/> White                     | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese      | <input type="checkbox"/> Guamanian or Chamorro  |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Japanese | <input type="checkbox"/> Other Asian     | <input type="checkbox"/> Samoan                 |
|  | <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Korean   | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Other Pacific Islander |
|  |   |                                   |  | <input type="checkbox"/> Other _____            |

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## STEP 3 Read & 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 provide false and/or untrue information.
- I know that I must tell the Health insurance Marketplace if anything changes (and is different than) what I wrote on this application within 30 days of that change. I can call **1-800-318-2596** to report any changes. I understand that a change in my information could affect the eligibility for an exemption for myself or member(s) of my household.
- 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 [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file).

### What should I do if I think the results of my application are wrong?

If you don't agree with the results of your application, you can ask for an appeal. Here's important information to consider when requesting an appeal:

- The Health Insurance Marketplace must receive your appeal request within 90 days of the date of the notice of the application results.
- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal the results of your application, call **1-800-318-2596**. TTY users should call **1-855-889-4325**. You can also mail an appeal request form or your own letter requesting an appeal to **Health Insurance Marketplace – Exemption Processing**, 465 Industrial Blvd., London, KY 40741.

**Sign this application.** The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you've provided the required information listed in Appendix A.

Signature

Date (mm/dd/yyyy)

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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## STEP 4

### CANCELLATIONS ONLY: Provide this form & documents to a health plan.

In order to get catastrophic coverage, provide this form and a copy of the notice of cancellation you received to the health insurance company that offers the catastrophic plan you want.

You can get information about available catastrophic plans by visiting [HealthCare.gov/health-plan-information](http://HealthCare.gov/health-plan-information) or by calling **1-800-318-2596**. TTY users can call **1-855-889-4325**.

### ALL OTHER TYPES: Mail completed application & documents.

Mail your signed application and the documents listed on page 1 for the exemption you're requesting to:

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

#### PRA Disclosure Statement

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 0938-1190. The time required to complete this information collection is estimated to average 16 minutes per response, including the time to review instructions, search existing data resources, gather the data 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.



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# APPENDIX A

## Assistance with completing 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 your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)				
2. Address			3. Apartment or suite number	
4. City		5. State <input type="text"/> <input type="text"/>	6. ZIP code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
7. Phone number ( <input type="text"/> <input type="text"/> <input type="text"/> ) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
8. Organization name				
9. ID number (if applicable) <input type="text"/> <input type="text"/>				
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.				
10. Your signature			11. Date (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

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

Complete this section 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) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
2. First name, Middle name, Last name, & Suffix				
3. Organization name				
4. ID number (if applicable) <input type="text"/> <input type="text"/>			5. Agents/Brokers only: NPN number <input type="text"/> <input type="text"/>	

