November 7, 2019

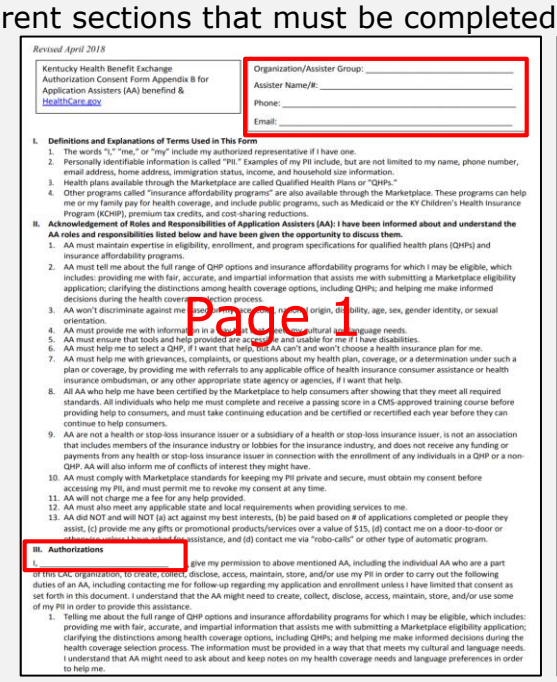
Volume 2 – Issue 3

Application Assister Open Enrollment *Insight*

The Insight newsletter provides useful updates and helpful tips for Application Assisters when processing Federal Marketplace and Medicaid applications.

Appendix B Consent Form

Application Assisters should make sure all information on the Appendix B is written clearly and no information is missing or skipped over before it is submitted. It should contain the Application Assister's name, the correct case number and the individual's name and signature. For every Appendix B form that is submitted, there are three different sections that must be completed:



Revised April 2018

Kentucky Health Benefit Exchange Authorization Consent Form Appendix B for Application Assisters (AA) benefind & HealthCare.gov

Organization/Assister Group: _____

Assister Name/#: _____

Phone: _____

Email: _____

I. **Definitions and Explanations of Terms Used in This Form**

1. The words "I," "me," or "my" include my authorized representative if I have one.
2. 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.
3. Health plans available through the Marketplace are called Qualified Health Plans or "QHPs."
4. 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 KY Children's Health Insurance Program (KCHIP), premium tax credits, and cost-sharing reductions.

II. **Acknowledgement of Roles and Responsibilities of Application Assisters (AA): I have been informed about and understand the AA roles and responsibilities listed below and have been given the opportunity to discuss them.**

1. AA must maintain expertise in eligibility, enrollment, and program specifications for qualified health plans (QHPs) and insurance affordability programs.
2. AA must tell 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.
3. AA won't discriminate against me based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation.
4. AA must provide me with information in a way that meets my cultural and language needs.
5. AA must ensure that tools and help provided are accessible and usable for me if I have disabilities.
6. AA must help me to select a QHP, if I want that help, but AA can't and won't choose a health insurance plan for me.
7. AA must help me with grievances, complaints, or questions about my health plan, coverage, or a determination under such a plan or coverage, by providing me with referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman, or any other appropriate state agency or agencies, if I want that help.
8. All AA who help me have been certified by the Marketplace to help consumers after showing that they meet all required standards. All individuals who help me must complete and receive a passing score in a CMS-approved training course before providing help to consumers, and must take continuing education and be certified or recertified each year before they can continue to help consumers.
9. AA are not a health or stop-loss insurance issuer or a subsidiary of a health or stop-loss insurance issuer, is not an association that includes members of the insurance industry or lobbies for the insurance industry, and 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. AA will also inform me of conflicts of interest they might have.
10. AA 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.
11. AA will not charge me a fee for any help provided.
12. AA must also meet any applicable state and local requirements when providing services to me.
13. AA did NOT and will NOT (a) act against my best interests, (b) be paid based on # of applications completed or people they assist, (c) provide me any gifts or promotional products/services over a value of $15, (d) contact me on a door-to-door or [illegible] unless I have asked for assistance, and (d) contact me via "robo-calls" or other type of automatic program.

III. **Authorizations**

I, _____, give my permission to above mentioned AA, including the individual AA who are a part of this CAC organization, to create, collect, disclose, access, maintain, store, and/or use my PII in order to carry out the following duties of an AA, including contacting me for follow-up regarding my application and enrollment unless I have limited that consent as set forth in this document. I understand that the AA might need to create, collect, disclose, access, maintain, store, and/or use some of my PII in order to provide this assistance.

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. The information must be provided in a way that that meets my cultural and language needs. I understand that AA might need to ask about and keep notes on my health coverage needs and language preferences in order to help me.

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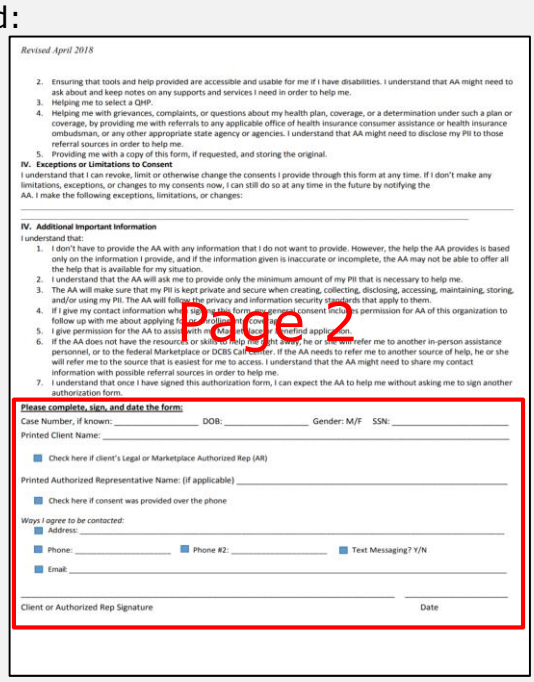

Revised April 2018

2. Ensuring that tools and help provided are accessible and usable for me if I have disabilities. I understand that AA might need to ask about and keep notes on any supports and services I need in order to help me.
3. Helping me to select a QHP.
4. Helping me with grievances, complaints, or questions about my health plan, coverage, or a determination under such a plan or coverage, by providing me with referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman, or any other appropriate state agency or agencies. I understand that AA might need to disclose my PII to those referral sources in order to help me.
5. Providing me with a copy of this form, if requested, and storing the original.

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 the AA. I make the following exceptions, limitations, or changes:

_____

_____

IV. **Additional Important Information**

I understand that:

1. I don't have to provide the AA with any information that I do not want to provide. However, the help the AA provides is based only on the information I provide, and if the information given is inaccurate or incomplete, the AA may not be able to offer all the help that is available for my situation.
2. I understand that the AA will ask me to provide only the minimum amount of my PII that is necessary to help me.
3. The AA will make sure that my PII is kept private and secure when creating, collecting, disclosing, accessing, maintaining, storing, and/or using my PII. The AA will follow the privacy and information security standards that apply to them.
4. If I give my contact information when I sign this form, my consent includes permission for AA of this organization to follow up with me about applying for [illegible] coverage.
5. I give permission for the AA to assist with my application for benefind application.
6. If the AA does not have the resources or skills to help me right away, he or she will refer me to another in-person assistance personnel, or to the federal Marketplace or DCBS Call Center. If the AA 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 the AA might need to share my contact information with possible referral sources in order to help me.
7. I understand that once I have signed this authorization form, I can expect the AA to help me without asking me to sign another authorization form.

Please complete, sign, and date the form:

Case Number, if known: _____ DOB: _____ Gender: M/F SSN: _____

Printed Client Name: _____

☐ Check here if client's Legal or Marketplace Authorized Rep (AR)

Printed Authorized Representative Name: (if applicable) _____

☐ Check here if consent was provided over the phone

Ways I agree to be contacted:

☐ Address: _____

☐ Phone: _____ ☐ Phone #2: _____ ☐ Text Messaging? Y/N

☐ Email: _____

_____ _____

Client or Authorized Rep Signature Date

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Application Assisters should use one of the following methods listed below to submit the Appendix B once all three sections have been filled out completely.

For Non-Emergency & Future Scheduled Appointments:

Fax or mail the Appendix B consent form:

a. Fax Number: 1-502-573-2007
   - The fax **must** be right-side up. If the Appendix B is faxed upside down, the mailroom will receive a blank fax.
   - Application Assisters should make it a habit to check for a successful fax confirmation.

b. Mailing Address: P.O Box 2104, Frankfort, KY 40602

Please Note: If an Application Assister chooses this method, there is an allowable 15-day turn-around period for task completion by the DCBS worker.

For In-Person Appointments:

Call the Professional Services Line (PSL) at 1-855-326-4650

The PSL representative will identify the Application Assister and confirm the identity of the individual. Once identified, the PSL representative will be able to make the case association over the phone.

Please Note: The Application Assister should ask the PSL representative to only associate them to the *Active* case for the individual.

For Emergencies:

ONLY in the event of an emergency or if the Application Assister needs immediate assistance, complete the Fax Cover Sheet for the DCBS Help Desk and attach the Appendix B.