**FAX** 502-848-4099

**TO:** DCBS Help Desk

**FROM:** Health Benefit Exchange Assister

Organization/Assister Group:_____

Assister Name/#: _____

Phone: _____

Email:_____

**DATE:**

**SUBJECT:** **Emergency Request for Assister Association**

**REASON FOR EMERGENCY:**

**ANY ADDIITONAL CLIENT INFORMATION NOT INCLUDED ON CONSENT FORM:**

**PAGES:** **INCLUDE**
**Authorization Consent Form Appendix B for Application Assisters (AA) benefind & HealthCare.gov**