

Model Authorization Form for Navigators in a Federally-facilitated Marketplace¹ (Marketplace)

Navigator Organization Name: _____

Navigator Organization Address: _____

Navigator Organization Phone Number and Email Address:

Individual Navigator Name or Staff/Volunteer Name and Certification Number:

I. Acknowledgement of Roles and Responsibilities of Navigators (see Attachment A)

I have been informed about and understand the Navigator roles and responsibilities set forth on **Attachment A** and have been given the opportunity to discuss them with [NAME].²

II. Definitions and Explanations of Terms Used in This Form

In this authorization form:

- The words “I,” “me,” or “my” include my authorized representative if I have one.
- 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.
- Health plans available through the Marketplace are called Qualified Health Plans or “QHPs.”
- 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 Children’s Health Insurance Program (CHIP), premium tax credits, cost-sharing reductions, and, if one is available in my state, the Basic Health Program.

III. Authorizations

a. General Consent

I, _____, give my permission to [NAME], including the individual Navigators who are a part of this Navigator organization, to create, collect, disclose, access, maintain, store,

¹ Including Federally-facilitated Marketplaces where the state performs plan management functions.

² **Note to Navigator Organization and Individual Navigator:** Each time [NAME] appears in this Authorization Form, the Name of the Navigator Organization, at a minimum, should be inserted. Individual Navigator name(s) may, but are not required, to be inserted.

and/or use my PII in order to carry out the roles and responsibilities of a Navigator that are authorized by federal statute and regulation and generally summarized in **Attachment A**, unless I have limited that consent as set forth in this document. I understand that [NAME] might need to create, collect, disclose, access, maintain, store, and/or use some of my PII in order to provide this assistance.

The roles and responsibilities of a Navigator include but are not limited to the following:

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 meets my cultural and language needs. I understand that [NAME] might need to ask about and keep notes on my health coverage needs and language preferences in order to help me.
2. Maintaining expertise in eligibility, enrollment, and program specifications for QHPs and insurance affordability programs, and conducting public education activities to raise awareness about the Marketplace. [NAME] should not need to create, collect, disclose, access, maintain, store and/or use my PII for these functions. If [NAME] does create, collect, disclose, access, maintain, store and/or use my PII for these functions, [NAME] will obtain my consent for those specific activities. [NAME] will keep my PII private and secure except when I have consented to sharing my PII publicly.
3. Ensuring that tools and help provided are accessible and usable for me if I have disabilities. I understand that [NAME] might need to ask about and keep notes on any supports and services I need in order to help me.
4. Helping me to select a QHP.
5. Helping me with grievances, complaints, or questions about my health plan, coverage, or a determination under my 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 [NAME] might need to disclose my PII to those referral sources in order to help me.
6. Helping me with the following topics:
 - Understanding the process of filing a Marketplace eligibility appeal,
 - Understanding and applying for an exemption from the requirement to maintain minimum essential coverage granted through the Marketplace,
 - Explaining the Marketplace-related components of the premium tax credit reconciliation process and the availability of Internal Revenue Service (IRS) resources on the process.

- Understanding basic concepts and rights about health coverage and how to use it, and
- Providing referrals to licensed tax advisers, tax preparers, or other resources for help with tax preparation and tax advice related to questions I might have about the Marketplace application and enrollment process, and premium tax credit reconciliations.

7. Providing me with this form and storing a signed copy of it.

I also understand that [NAME] may be required to create, collect, handle, disclose, access, maintain, store, and/or use my PII to carry out activities required under a state law or regulation. [NAME] has listed below the specific state requirements that apply.

[NOTE TO NAVIGATOR ORGANIZATION AND INDIVIDUAL NAVIGATOR: Any state requirements that might require use, disclosure, etc. of consumer PII (for example, state reporting) should be inserted here, if applicable. Otherwise, this item should not be included on the form.]

b. Specific Consents

I also permit [NAME] to create, collect, disclose, access, maintain, store, and/or use my PII, for the following purpose(s):

- ☐ **[NOTE TO NAVIGATOR ORGANIZATION AND INDIVIDUAL NAVIGATOR:** Insert text for any additional consents that may be requested here.]

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 [NAME]. I make the following exceptions, limitations, or changes:

V. Additional Information

I understand that:

1. I don't have to provide [NAME] with any information that I do not want to provide. However, the help [NAME] provides is based only on the information I provide, and if the

information given is inaccurate or incomplete, [NAME] may not be able to offer all the help that is available for my situation.

2. [NAME] should ask me to provide only the minimum amount of my PII that is necessary to help me.
3. [NAME] must make sure that my PII is kept private and secure when creating, collecting, disclosing, accessing, maintaining, storing, and/or using my PII. [NAME] must follow the privacy and information security standards that apply to them.
4. If I give my contact information when signing this form, my general consent includes permission for [NAME] to follow up with me about applying for or enrolling into coverage after my first meeting with them.
5. If [NAME] does not have the resources or skills to help me right away, he or she should refer me to another Marketplace Navigator, or to the Marketplace Call Center, who can meet my specific needs sooner. If [NAME] needs to refer me to another source of help, he or she generally should refer me to the source that is easiest for me to access. I understand that [NAME] might need to share my contact information and information about my needs with possible referral sources in order to help me.
6. Once I have signed this authorization form, I can expect [NAME] to help me without asking me to sign another authorization form.
7. [NAME] should provide me with a copy of my Authorization Form and this **Attachment A**, once complete.

Please, complete, sign, and date the form:

Consumer/Consumer's Legal or Marketplace Authorized Representative Signature

Circle one of these to show if you are the consumer or the consumer's representative.

PLEASE NOTE: Consumers may sign this consent form themselves, or may choose to have a legal or Marketplace Authorized Representative sign it.

Date Printed Consumer Name Printed Authorized Representative Name (if applicable)

Ways I agree to be contacted (optional):

___ **By mail or in-person at** _____

___ **By phone at** _____ **(XXX) XXX-XXXX**

This is a wireless phone (circle one): Y N

___ **By text message at** _____ **(XXX) XXX-XXXX** *[Note: To the extent a Navigator entity wishes to contact individuals on their cell phones or via text message, it should obtain individual legal advice on what the consent language should say.]*

Attachment A: Roles and Responsibilities of Navigators

1. **[NAME]** must maintain expertise in eligibility, enrollment, and program specifications for qualified health plans (QHPs) and insurance affordability programs, and must conduct public education activities to raise awareness about the Marketplace.
2. **[NAME]** 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. **[NAME]**: The following item should be included if the Navigator is providing assistance in a state with a Federally-facilitated Small Business Health Options Program (SHOP):] **[NAME]** must be prepared to serve consumers in both the individual market Marketplace and in the Small Business Health Options Program.
4. **[NAME]** is not allowed to discriminate against me based on my race, color, national origin, disability, age, sex, or sexual orientation.
5. **[NAME]** must provide me with information in a way that meets my cultural and language needs, at no cost to me.
6. **[NAME]** must ensure that tools and help provided are accessible and usable for me if I have disabilities, at no cost to me.
7. **[NAME]** must help me to select a QHP, if I want that help, but **[NAME]** is not allowed to choose a health insurance plan for me.
8. **[NAME]** must help me with grievances, complaints, or questions about my health plan, coverage, or a determination under my 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.
9. **[NAME]** is also required to provide me with information and assistance on the following topics:
 - a. Helping me understand the process of filing a Marketplace eligibility appeal,
 - b. Helping me understand and apply for exemptions from the requirement to maintain minimum essential coverage granted through the Marketplace,
 - c. Helping me with the Marketplace-related components of the premium tax credit reconciliation process, and helping me understand the availability of IRS resources on this process,
 - d. Helping me understand basic concepts and rights about health coverage and how to use it, and
 - e. Helping me with referrals to licensed tax advisers, tax preparers, or other resources for help with tax preparation and tax advice related to questions I might have about the Marketplace application and enrollment process, and premium tax credit reconciliations.
10. All individual Navigators who help me must be certified by the Marketplace after showing that they meet all required standards and must follow the terms and conditions of **[NAVIGATOR ORGANIZATION NAME]**'s grant from CMS.
11. All individual Navigators who help me must complete and receive a passing score in a CMS-approved training course before providing education, outreach, or help to consumers, and must take continuing education and be certified or recertified each year before they can continue to provide education, outreach, or help to consumers.

12. [NAME], including the Navigator organization and any Navigator who helps me, must not be a health or stop-loss insurance issuer or a subsidiary of a health or stop-loss insurance issuer, must not be an association that includes members of the insurance industry or lobbies for the insurance industry, and is not allowed to receive any consideration directly or indirectly from any health or stop-loss insurance issuer in connection with the enrollment of any individuals in a QHP or a non-QHP. [NAME], including the Navigator organization and any Navigator who helps me, must also inform me of certain non-prohibited relationships that they might have with insurance issuers.
13. [NAME] must provide me with information about the roles and responsibilities of Navigators, including through this form.
14. [NAME], and any Navigator who helps me, is not acting as a tax adviser or attorney when providing assistance as a Navigator and cannot provide tax or legal advice while acting as a Navigator.
15. [NAME] 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.
16. [NAME] is not allowed to charge me a fee for any help provided while acting as a Navigator.
17. [NAVIGATOR ORGANIZATION NAME] is not allowed to pay individual Navigators based on the number of applications they help complete, based on the number of people they help, or based on the number of enrollments they help complete.
18. [NAME] is not allowed to give me gifts of any value, including gift cards, cash cards, cash, or things that market or promote the products or services of another individual or business, if I must enroll in health coverage in order to receive the gift. [NAME] is allowed—but not required—to give me gifts for other reasons, including to encourage me to seek or receive application help, but only if the total value of the gifts given during a single event or meeting is not more than \$15 in value. [NAME] is allowed to reimburse me for things I might have to buy or pay for in order to get application assistance from [NAME] (such as travel or mailing expenses), even if the total value of this reimbursement is over \$15.
19. [NAME] is not allowed to use any funds provided by the Marketplace to buy for me any gifts, gift cards, or things that market or promote the products or services of another individual or business.
20. [NAME] must also meet any applicable state and local requirements when providing services to me.

Attachment B

[NAME OF COVERED ENTITY] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. [NAME OF

COVERED ENTITY] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

[NAME OF COVERED ENTITY]:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact **[NAME OF CIVIL RIGHTS COORDINATOR]**

If you believe that **[NAME]** has discriminated against you on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **[NAME AND TITLE OF CIVIL RIGHTS COORDINATOR, if applicable]**, **[MAILING ADDRESS]**, **[TELEPHONE NUMBER]**, **[TTY number—if organization has one]**, **[EMAIL]**. If you need help filing a grievance, **[NAME AND TITLE OF CIVIL RIGHTS COORDINATOR, if applicable]** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
 200 Independence Avenue, SW
 Room 509F, HHH Building
 Washington, D.C. 20201
 1-800-368-1019, 1-800-537-7697 (TDD)
 Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

[NOTE TO NAVIGATOR ORGANIZATION AND INDIVIDUAL NAVIGATOR]: Insert text for taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the state(s) you serve. See this page for more information: <http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/>