Model Authorization Form for Certified Application Counselors (CACs) in a Federally-facilitated Marketplace[1] (Marketplace)

CAC Designated Organization Name: _____

CAC Designated Organization Address: _____

CAC Designated Organization Phone Number and Email:

_____

Individual CAC Name and Certification Number:

_____

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

I have been informed about and understand the CAC 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.

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

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

III. Authorizations

a. General Consent

I, _____, give my permission to [**NAME**], including the individual CACs who are certified by this CAC designated organization, to create, collect, disclose, access, maintain, store, and/or use my PII in order to carry out the roles and responsibilities of a CAC that are authorized by federal 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 CAC 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. I understand that [**NAME**] might need to ask about and keep notes on my health coverage needs in order to help me.
2. Helping me to apply for health coverage through the Marketplace.
3. Helping me to enroll in a QHP and/or insurance affordability program.
4. Ensuring that information provided is accessible for me if I have disabilities. If [**NAME**] can't provide me with my accessibility needs, [**NAME**] must refer me to a Marketplace Navigator, or the Marketplace Call Center, who can meet my specific needs. I understand that [**NAME**] might need to ask about and keep notes on any supports and services I need and might need to disclose my information to other assisters in order to help me.
5. 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 state law or regulation. [**NAME**] has listed below the specific state requirements that apply.

[**NOTE TO CAC DESIGNATED ORGANIZATION AND INDIVIDUAL CAC**: 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 CAC DESIGNATED ORGANIZATION AND INDIVIDUAL CAC**: 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. Once I have signed this authorization form, I can expect [**NAME**] to help me without asking me to sign another authorization form.

6. [**NAME**] should provide me with a copy of my Authorization Form and **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 CAC 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 Certified Application Counselors (CACs)

1. [**NAME**] must tell me about the full range of qualified health plan (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.
2. [**NAME**] must help me to apply for health coverage through the Marketplace, if I want that help.

3. [**NAME**] must help me to enroll in a QHP and/or insurance affordability program, if I want that help, but [**NAME**] is not allowed to choose a plan for me.
4. [**ORGANIZATION NAME**] is designated by the Marketplace to certify individuals to act as CACs after showing that it meets all required standards and must follow the terms of its agreement with the Marketplace.
5. All CAC individuals who help me must be certified by [**ORGANIZATION NAME**] to help consumers after showing that they meet all required standards and must follow the terms of their agreements with [**ORGANIZATION NAME**]. If I have a concern about the help provided by any of these individuals I should contact [**ORGANIZATION CONTACT**].
6. All CAC individuals who help me must complete and receive a passing score in a Marketplace-approved training course before providing help to consumers, and must take additional training every year before being recertified by the organization to continue helping consumers.
7. [**NAME**] must act in my best interests.
8. [**NAME**] is not allowed to discriminate against me based on my race, color, national origin, disability, age, sex, or sexual orientation. If **[ORGANIZATION NAME**] receives federal funds to provide services to a specific population (such as a Ryan White HIV/AIDS program or an Indian health provider), it may limit its services to that population, as long as it doesn't discriminate within that specific population.
9. [**NAME**] must ensure that information provided is accessible to me if I have disabilities. If [**NAME**] can't meet my accessibility needs, [**NAME**] must refer me to a Marketplace Navigator, or the Marketplace Call Center, who can meet my specific needs.
10. [**NAME**] must provide me with general information about the roles and responsibilities of CACs, including through this form.
11. CACs, including those who are certified by [**ORGANIZATION NAME**], are not acting as tax advisers or attorneys when providing assistance as CACs and cannot provide tax or legal advice within their capacity as CACs.
12. [**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.
13. [**NAME**] is not allowed to charge me a fee for any help provided while acting as a CAC.
14. [**NAME**], including the CAC organization and any CAC who helps me, 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 and must inform me of any conflicts of interest they might have.

15. [**ORGANIZATION NAME**] is not allowed to pay individual CACs 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.
16. [**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.
17. [**NAME**] must also meet any applicable state and local requirements when providing services to me.

[**NOTE TO CAC DESIGNATED ORGANIZATION AND INDIVIDUAL CAC**: If you or your organization is a covered entity subject to section 1557 of the Affordable Care Act, other language may have to be included in a separate section of this form. Please refer to https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/appendix-b-sample-translated-taglines-51916-ea-mm-508.pdf for translations of the following General Tagline, “If you, or someone you’re helping, has questions about [insert name], you have the right to get help and information in your language at no cost. To talk to an interpreter, call [insert number here]."]