



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



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

- 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 is for one category of exemption. You may apply for certain other categories of exemptions when you file your federal income tax return.
- You don't need to apply for an exemption if you're not going to file a federal income tax return. If you're not sure you'll file a tax return, you may want to apply for an exemption anyway.



## 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 single 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 for descriptions of which documents are needed for each hardship exemption.**) The document(s) you submit must show dates from the same time period you're requesting this exemption for. 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.



## Get help with this application

- **Online:** [HealthCare.gov/exemptions](http://HealthCare.gov/exemptions).
- **Phone:** Call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.
- **In person:** There may be counselors in your area who can help. Visit [HealthCare.gov](http://HealthCare.gov), or call the Marketplace Call Center at **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596**.
- **Other languages:** 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.



## Hardship Categories and Documentation

Look at the hardship categories and the required documents listed below to see if you qualify for a hardship exemption.

Hardship number	Category	Required documentation (Send <b>COPIES</b> of one of the documents listed below for your hardship.)
1	You were homeless.	None.
2	You were evicted in the past 6 months or were facing eviction or foreclosure.	Eviction or foreclosure notice. The date of the notice must be within the last 6 months.
3	You received a shut-off notice from a utility company.	Shut-off notice from a utility company which states service has or will be shut-off.
4	You recently experienced domestic violence.	None.
5	You recently experienced the death of a close family member.	Death certificate, death notice from newspaper, funeral service program, funeral expenses, coroner's report, military notification of death, or other official notice of death.
6	You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property.	Police or fire report, insurance claim, or other document from government agency, private entity, or news source about the event.
7	You filed for bankruptcy in the last 6 months.	Official bankruptcy filing documents from a date within the last 6 months.
8	You had medical expenses you couldn't pay in the last 24 months.	Medical bills from a date within the last 24 months.
9	You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.	Receipts for bills or services related to care, like medical bills, home care services, or transportation receipts.
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.	Court order that covers the time period for which you want the exemption AND copies of eligibility notices for Medicaid and CHIP which show 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.	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.	Notice of denial of eligibility for Medicaid. The notice must be from a date during the time period for which you're requesting the exemption.
13	You received a notice saying that your current health insurance plan purchased on the individual market (non-group coverage) will be cancelled, and you consider the other plans available unaffordable.	Notice of cancellation from the insurance company.
14	You experienced a hardship that kept you from getting health insurance that's NOT listed in categories #1-13.	There are a limited number of other hardships that qualify. Go to <a href="https://www.healthcare.gov/fees-exemptions/hardship-exemptions/">HealthCare.gov/fees-exemptions/hardship-exemptions/</a> to see this list, and follow the instructions to claim another hardship on page 3.



Please print in capital letters using black or dark blue ink only. Fill in the circles (○) like this → ●.

### STEP 1: Tell us about yourself.

(The person who files a federal income tax return in your household should be the contact person for this application. If you're applying for an exemption for a child, we need an adult who claims the child on his or her federal income tax return to fill out this information even if the adult doesn't need the exemption.)

Give your legal name

1. First name	Middle name	Last name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number
<input type="text"/>	<input type="text"/>

4. City	5. State	6. ZIP code	7. County, parish, or township
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

8. Mailing address (if different from home address)	9. Apartment or suite number
<input type="text"/>	<input type="text"/>

10. City	11. State	12. ZIP code	13. County, parish, or township
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

14. Daytime 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"/>	15. Evening 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"/>
--	--

Please give us a phone number so the Marketplace can contact you if we need more information to process your application. We won't use your phone number for any other purpose.

16. Do you want to get information by email from the Marketplace? .....  Yes  No

Email address:

17. What's your preferred spoken language? What's your preferred written language?

### STEP 2: Tell us about your tax household.

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

You need to complete Step 2 for every person in your household who is on the same federal income tax return. If the person **doesn't want an exemption**, just answer questions 1-7 of Step 2.

#### For Person 1:

Person 1 must be an adult who files a federal income tax return in your household, even if they don't want an exemption.

#### For Person 2:

Person 2 can be either:

- A spouse who files taxes jointly with Person 1.
- Anyone that Person 1 claims as a dependent on the same tax return.

#### Who not to include:

- A spouse who files taxes separately. Spouses who file separately need to fill out a separate application for themselves and for each person they claim on their tax return.
- Anyone who lives with you but who isn't listed on your tax return. Each person who needs an exemption must be on an application with the person who lists them on a tax return.

#### If you don't plan to file taxes, you don't need to apply for an exemption.

You'll get an eligibility determination letter in the mail after your application is processed. If you get this exemption, we'll give you an Exemption Certificate Number (ECN) with your approval letter. **Keep the letter for your records.** You'll need to put this number on your federal income tax return at the time you file taxes.

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.



## STEP 2: PERSON 1

Person 1 must be the person who files a federal income tax return, even if the person doesn't need this exemption.

1. First name	Middle name	Last name	Suffix
2. Relationship to you?		3. Date of birth (mm/dd/yyyy)	4. Sex
SELF		<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="radio"/> Male <input type="radio"/> 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. If someone wants 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. Do you plan to file a federal income tax return?  Yes  No

a. Will you file jointly with a spouse?  Yes  No  
**If yes**, write name of spouse: \_\_\_\_\_

b. Will you claim any dependents on your tax return?  Yes  No  
**If yes**, list name(s) of dependents: \_\_\_\_\_

7. Do you want this exemption?  **YES. If yes**, answer all the questions below.  **NO. If no**, skip to question 9.

8. Select the type of hardship(s) you're applying for below. Note the date the hardship started, when it will end, and if it is ongoing. You only need one exemption for any given time period. Or, you may apply for more than one hardship type if the hardship events were at different times during the year. **If you're applying for more than one hardship category, you must submit documentation for EACH category you're applying for.**

**CHECK THE TABLE ON PAGE 1 TO SEE WHICH DOCUMENTS YOU NEED FOR EACH CATEGORY.**

Type of hardship <i>(Select all that apply. See descriptions on page 1.)</i>	Date hardship started <i>(mm/dd/yyyy)</i> <small>(Note: if your hardship started before 01/01/2014, just list the start date as 01/01/2014, which is the first date people were required either to get health coverage or qualify for an exemption.)</small>	Date hardship ended/ will end <i>(mm/dd/yyyy)</i>	Fill in if no expected end date <i>(ongoing)</i>
<input type="radio"/> 1. Homelessness			<input type="radio"/>
<input type="radio"/> 2. Eviction/foreclosure			<input type="radio"/>
<input type="radio"/> 3. Shut-off notice			<input type="radio"/>
<input type="radio"/> 4. Domestic violence			<input type="radio"/>
<input type="radio"/> 5. Death of family member			<input type="radio"/>
<input type="radio"/> 6. Disaster			<input type="radio"/>
<input type="radio"/> 7. Bankruptcy			<input type="radio"/>
<input type="radio"/> 8. Medical expenses			<input type="radio"/>
<input type="radio"/> 9. Increase in expenses to care for family member			<input type="radio"/>
<input type="radio"/> 10. Medical support for child			<input type="radio"/>
<input type="radio"/> 11. Eligibility appeals decision			<input type="radio"/>
<input type="radio"/> 12. Ineligible for Medicaid			<input type="radio"/>
<input type="radio"/> 13. Cancellation of individual coverage			<input type="radio"/>
<input type="radio"/> 14. You experienced another hardship. If you <b>didn't</b> experience one of the 13 hardships listed above, there's a limited number of other hardships you may qualify for. (To see a list of other hardships, go to <a href="http://HealthCare.gov/fees-exemptions/hardship-exemptions/">HealthCare.gov/fees-exemptions/hardship-exemptions/</a> ). In the box below, tell us how this hardship kept you from getting health coverage:			

**Optional:** (Fill in all that apply.)

9. If Hispanic/Latino, ethnicity:  Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other \_\_\_\_\_

10. Race:  White  Black or African American  American Indian or Alaska Native  Filipino  Japanese  Korean  Asian Indian  Chinese  Vietnamese  Other Asian  Native Hawaiian  Guamanian or Chamorro  Samoan  Other Pacific Islander  Other \_\_\_\_\_



# STEP 2: PERSON 2

Make a copy of this page if there are more than 2 people in your household.

Fill out this page for a spouse who files taxes jointly with you and for anyone you claim as a dependent on your federal income tax return.

1. First name	Middle name	Last name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2. Relationship to PERSON 1?	3. Date of birth (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>	4. Sex <input type="radio"/> Male <input type="radio"/> Female
------------------------------	---	---

5. Social Security Number (SSN)  -  -

If PERSON 2 is requesting an exemption and has an SSN, he or she must provide it. PERSON 2 isn't required to have an SSN to get this exemption. We use SSNs to help make sure that if you get an exemption, it's applied correctly on your taxes. If someone wants 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. Does PERSON 2 plan to file a federal income tax return?  Yes  No  
 If yes, answer 6a and 6b. If no, go to question 7.

a. Will PERSON 2 file jointly with a spouse?  Yes  No  
 If yes, write name of spouse: \_\_\_\_\_

b. Will PERSON 2 claim any dependents on his/her tax return?  Yes  No  
 If yes, list name(s) of dependents: \_\_\_\_\_

7. Will PERSON 2 be claimed as a dependent on PERSON 1's tax return?  Yes  No  
 If yes, please list the name of the tax filer: \_\_\_\_\_ How is PERSON 2 related to the tax filer? \_\_\_\_\_

Note: If PERSON 2 isn't listed on PERSON 1's tax return as a spouse or as a dependent, PERSON 2 must file a separate application.

8. Does PERSON 2 want this exemption?  YES. If yes, answer all the questions below.  NO. If no, skip to question 10.

9. Select the type of hardship(s) PERSON 2 is applying for below. Note the date the hardship started, when it will end, and if it is ongoing. Only one exemption is needed for any given time period. Or, PERSON 2 may apply for more than one hardship type if the hardship events were at different times during the year. If PERSON 2 is applying for more than one hardship category, PERSON 2 must submit documentation for EACH category applied for.

CHECK THE TABLE ON PAGE 1 TO SEE WHICH DOCUMENTS ARE NEEDED FOR EACH CATEGORY.

Type of hardship (Select all that apply. See descriptions on page 1.)	Date hardship started (mm/dd/yyyy) (Note: if your hardship started before 01/01/2014, just list the start date as 01/01/2014, which is the first date people were required either to get health coverage or qualify for an exemption.)	Date hardship ended/ will end (mm/dd/yyyy)	Fill in if no expected end date (ongoing)
<input type="radio"/> 1. Homelessness			<input type="radio"/>
<input type="radio"/> 2. Eviction/foreclosure			<input type="radio"/>
<input type="radio"/> 3. Shut-off notice			<input type="radio"/>
<input type="radio"/> 4. Domestic violence			<input type="radio"/>
<input type="radio"/> 5. Death of family member			<input type="radio"/>
<input type="radio"/> 6. Disaster			<input type="radio"/>
<input type="radio"/> 7. Bankruptcy			<input type="radio"/>
<input type="radio"/> 8. Medical expenses			<input type="radio"/>
<input type="radio"/> 9. Increase in expenses to care for family member			<input type="radio"/>
<input type="radio"/> 10. Medical support for child			<input type="radio"/>
<input type="radio"/> 11. Eligibility appeals decision			<input type="radio"/>
<input type="radio"/> 12. Ineligible for Medicaid			<input type="radio"/>
<input type="radio"/> 13. Cancellation of individual coverage			<input type="radio"/>
<input type="radio"/> 14. PERSON 2 experienced another hardship. If PERSON 2 didn't experience one of the 13 hardships listed above, there's a limited number of other hardships PERSON 2 may qualify for. (To see a list of other hardships, go to <a href="http://HealthCare.gov/fees-exemptions/hardship-exemptions/">HealthCare.gov/fees-exemptions/hardship-exemptions/</a> ). In the box below, tell us how this hardship kept PERSON 2 from getting health coverage:			

**Optional:** (Fill in all that apply.)

10. If Hispanic/Latino, ethnicity:  Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other \_\_\_\_\_

11. Race:  White  Black or African American  American Indian or Alaska Native  Filipino  Japanese  Korean  Asian Indian  Chinese  Vietnamese  Other Asian  Native Hawaiian  Guamanian or Chamorro  Samoan  Other Pacific Islander  Other \_\_\_\_\_



### 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 intentionally provide false or untrue information.
- I know that I must tell the Health Insurance Marketplace within 30 days if anything changes (and is different than) what I wrote on this application. I can visit [HealthCare.gov](https://www.healthcare.gov) or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect my eligibility as well as eligibility for 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 [hhs.gov/ocr/office/file](https://www.hhs.gov/ocr/office/file).

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

If you don't agree with the results of your exemption application, you can ask for an appeal. Below is 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 may have a relative, friend, legal counsel, or another spokesperson, including an Authorized Representative, help you make an appeal request or participate in your appeal. This is optional.
- The outcome of an appeal could change the eligibility of other members of your tax household.

To appeal your exemption application results, visit [HealthCare.gov/marketplace-appeals/](https://www.healthcare.gov/marketplace-appeals/). Or call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.

**PERSON 1 should sign this application.** If you're an authorized representative, you may sign here as long as PERSON 1 signed Appendix C. The person who signs this application must be the person who files a federal income tax return and is an adult over the age of 18.

Signature	Date signed (mm/dd/yyyy)										
	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 10px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 10px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										

### STEP 4: Mail completed application

Mail your signed application and the documents listed on page 1 to:

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

#### What happens next?

Send your complete, signed application with required documents to the address above. We'll follow up with you within 1–2 weeks. You may receive a call from the Marketplace if we need more information. You'll get an eligibility determination letter in the mail after we process your exemption application. If you qualify for this exemption, we'll give you an Exemption Certificate Number (ECN) that you'll put on your federal income tax return. If you don't hear from us, call the Health Insurance Marketplace Help Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.

#### Cancellations only

##### Provide this form and 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](https://www.healthcare.gov/health-plan-information) or by calling **1-800-318-2596**. TTY users can call **1-855-889-4325**.

**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.

**NEED HELP WITH YOUR APPLICATION?** Visit [HealthCare.gov](https://www.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**.

# Appendix C



Form Approved  
OMB No. 0938-1191

## Assistance with completing this application

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

### 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 or remove 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) <input type="text"/>		
2. Address <input type="text"/>		3. Apartment or suite number <input type="text"/>
4. City <input type="text"/>	5. State <input type="text"/>	6. ZIP code <input type="text"/>
7. Phone number ( <input type="text"/> ) <input type="text"/> - <input type="text"/>		
8. Organization name <input type="text"/>		
9. ID number (if applicable) <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. Signature of PERSON 1 listed on this application <input type="text"/>	11. Date signed (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>
--	--

