



Instructions to Help You Complete an Exemption Application at the Health Insurance Marketplace

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. You may claim certain other categories of exemptions when you file your federal income tax return instead of completing an exemption application.

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. You can find exemption applications at HealthCare.gov/exemptions.

HOW TO USE THIS INSTRUCTION MANUAL: At the Marketplace, you can request different types of exemptions. On pages 2 and 3, you’ll find instructions for the general questions and information found on most of the applications.

On pages 4 through 15, you’ll find instructions to help you with questions found only on those applications.

On pages 16 through 20, you’ll find materials referenced earlier in the instructions.

Below is a chart listing the different type of exemption applications and page numbers for where you’ll find application-specific instructions. Which application you use depends on your situation. These instructions include additional help for some of the items in the applications.

Exemption type	See these pages for instructions
Unable to afford coverage (if you live in a state using HealthCare.gov)	4–6
Unable to afford coverage (if you live in certain states with a State-based Marketplace)	7–8
Hardship	9–10
American Indians and Alaska Natives and other individuals who are eligible to receive services from an Indian health care provider	11–12
Membership in recognized religious sects or divisions	13
Membership in a health care sharing ministry	14
Incarcerated	15

For more details on the individual shared responsibility payment and exemptions, visit HealthCare.gov/exemptions.

NOTE: For most exemptions, the deadline to apply is a few weeks before you plan to file your federal income tax return, generally due on April 15 of each year.

REMEMBER: If you get an exemption from the Marketplace, you must keep the letter that the Marketplace sends you with your Exemption Certificate Number (ECN). You’ll need to write the ECN on your income tax return.

Instructions for General Questions and Information Found on Most of the Applications

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

STEP 1: Tell us about yourself as the person completing the form.

An adult (18 or older) must complete the contact information in Step 1. We need this information so we can follow up with you if we have questions.

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.

STEP 2: Tell us about your tax household.

Start with yourself for each application. Who else you include on the application depends on the type of exemption application you're completing—see your application's specific instructions for further instructions.

PERSON 1

(The person who files a federal income tax return, even if the person doesn't need this exemption.)

Items 1-5

Complete the contact information at the top of the page for yourself.

Item 6

Tell us about the federal income tax return you plan to file next year. If you get an exemption you'll need to file taxes to use it.

- If you plan to file your federal income tax return jointly with your spouse, fill in "yes" and write his or her name on the line provided. If not, fill in "no."
- If you will claim any dependents on your tax return, fill in "yes" and list the names of the dependent(s). If you're filing jointly, list the dependents on Step 2 for each tax filer. If you will not claim any dependents on your tax return, fill in "no."

Item 7

Fill in "yes" if you're applying for an exemption for yourself. Some people will file applications to request an exemption only for someone else. If this applies to you, don't fill in this circle.

The ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS) better understand and improve the health and health care for all Americans. Providing this information won't impact your eligibility for an exemption in any way.

PERSON 2

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

Item 2

If you are including another person on the application, use these relationships to describe how PERSON 2 is related to you:

- Husband/wife
- Domestic partner
- Parent
- Stepparent
- Parent's domestic partner
- Son/daughter
- Stepson/stepdaughter
- Child of domestic partner
- Sibling
- Uncle/aunt
- Nephew/niece
- First cousin
- Grandparent
- Grandchild
- Other relative
- Other unrelated

Item 7

If PERSON 2 will be claimed as a dependent on PERSON 1's tax return, describe how he or she is related to PERSON 1. 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.

The ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS) better understand and improve the health and health care for all Americans. Providing this information won't impact your eligibility for an exemption in any way.

Read & sign this application.

Read the statements in this section of the application, sign your name, and write today's date. By signing, you're agreeing that the information you provided is true and correct.

If an authorized representative helped you fill out this application, they can sign your application for you, but you'll need to complete Appendix C, "Assistance with Completing this Application," and submit it with your application.

Mail completed application.

Once you have completed the application, you can mail your original, signed application (and any appendices or documents that the application says you need to include) to:

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

Be sure to use the correct amount of postage when you mail your application. The postage rate will depend on the weight of your application, which will be based on the number of pages you've included.

APPENDIX C: Assistance with completing this application

Certified application counselors, navigators, in-person assistance counselors, and other assisters:

These are professional individuals or organizations trained to help consumers, including help with completing this application. Services are free to consumers. You can ask to see certification showing they're authorized to perform this work. They can help you complete this section. The ID number is the navigator's identification number. This is a unique alphanumeric ID (13 letters and numbers) given to each navigator.

The following instructions are for the specific questions and information found on each of the separate applications.

Instructions for Completing the Application for Exemption from the Shared Responsibility Payment for Individuals who are Unable to Afford Coverage and are in a State with a Federally Facilitated Marketplace

Use this application to apply for an exemption if:

- You can't afford coverage.
- You live in Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, West Virginia, Wisconsin, or Wyoming.

In order to apply for this exemption, you may need:

- Social Security Numbers (SSNs), if you have them
- Employer and income information for everyone in your family (for example, from pay stubs, W-2 forms, or wage and tax statements)
- Information about any job-related health insurance available to your family
- Proof of your yearly income, such as:
 - Wages and tax statement (W-2)
 - Pay stub
 - Letter from employer
 - Self-employment ledger
 - Cost of living adjustment letter and other benefit verification notices
 - Lease agreement
 - Copy of a check paid to the household member
 - Bank or investment fund statement
 - Document or letter from Social Security Administration (SSA)
 - Form SSA 1099 Social Security benefits statement
 - Letter from government agency for unemployment benefits

If you expect your income to go up or down during the year you are requesting this exemption, you can provide other documents, like a document that states when contract work will end. If any of your income comes from freelance work, you can fill out a self-employment ledger that includes your expected income.

STEP 1: Tell us about yourself.

(Page 1)

PERSON 1

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.

STEP 2: Tell us about your tax household.

(Page 1)

You need to complete Step 2 for every person in your household who is on the same federal income tax return. Read the information under “Who do you need to include on this application?” carefully to figure out which people to add in Step 2.

(Page 2)

PERSON 1

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

Item 15

If you're not a U.S. citizen but have eligible immigration status, fill in “yes” and provide your document type and document ID number(s) (see pages 17–18 of these instructions). If you have more than one of these documents, list all of them.

(Page 3)

Item 18

If any of the people applying for an exemption are currently enrolled in a type of health coverage listed in item 18 of the application, fill in the circle for the type of coverage, and include other information as requested.

Item 19

If anyone in your family is offered health coverage from a job (whether it's their own job or another person's job), fill in “yes,” even if they're offered coverage but aren't currently enrolled. If someone in your family is offered coverage, **you must** complete Appendix A: Health Coverage from Jobs, and submit it with your application.

Current job & income information

Items 21–25

We ask about your current income to see if you qualify for an exemption based on coverage being unaffordable. Include information about any income you have made or expect to make from a job, self-employment, unemployment, retirement, pensions, rental property, fishing/farming, alimony, and Social Security (if taxable). You don't have to include amounts taken out of your check by your employer for child care, health insurance, or retirement plans that are “not taxable” (sometimes called “pre-tax deductions”).

Item 26

If you don't expect to get this income from your current job every month, write in the year and fill in the month(s) that you expect to get income from that job.

(Page 4)

Items 33–36

If you're self-employed: Fill in the type of work you do, the amount of net income you get, and how often you get this net income. Net income means the amount left over after you've taken out business expenses. The amount can be positive or negative. See the list of self-employment income deductions on page 18 of these instructions to find out what you can subtract from your gross income. If you don't expect to get self-employment income every month, write in the year and fill in the month(s) that you expect to get self-employment income.

(Page 5)

Item 37

Other income: Tell us about other income you report on a federal income tax return. You don't need to tell us about income that's not reported on a tax return, like child support, veteran's payments, or food stamps. If you get Social Security benefits that are taxable, include the taxable amount listed on your most recent tax return. Don't include amounts for disability benefits, survivor's benefits, old age benefits that aren't taxable, or any Supplemental Security Income (SSI) benefit.

Item 38

Deductions: If you pay for certain things that can be deducted on a federal income tax return (see IRS Form 1040, lines 23–35), fill in information about which deductions you plan to take. We list some common types of deductions. If you have additional deductions from IRS Form 1040, lines 23–35 not listed, fill them in under “Other”. If you don’t plan to take any deductions, fill in the circle above the table.

PERSON 2**(Pages 6–9)**

PERSON 2 can be either a spouse who files taxes jointly with PERSON 1 or anyone that PERSON 1 claims as a dependent on the same tax return.

Fill out Step 2: PERSON 2 (pages 6, 7, 8 and 9) for a spouse who files taxes jointly with you and for anyone you claim as a dependent on your federal income tax return. Make a copy of these pages if there are more than 2 people in your household.

Use the same instructions given for PERSON 1 to complete Step 2: PERSON 2. To find the right question number for PERSON 2, just add “+1” to the items above. For example, Item 19 for PERSON 1 is Item 20 (19 +1) for PERSON 2.

STEP 3: Proof of yearly income.

(Page 10)

You MUST submit proof of each type of income you listed for each person on this application. We can’t approve your exemption without proof of income. The table on page 10 lists possible documents for each type of income; you may submit other documents not on the list if they show the income amount you listed on your application.

If you expect your income to go up or down during the year you are requesting this exemption, you can provide other documents, like a document that states when contract work will end. If any of your income comes from freelance work, you can fill out a self-employment ledger that includes your expected income.

STEP 4: Read & sign this application.

(Page 11)

Read the statements on this page, sign your name, and write today’s date. By signing, you’re agreeing that the information you provided is true and correct. If you or someone applying for an exemption on this application is incarcerated (detained or jailed), write their name on the line provided. If the person is pending disposition, fill in the circle next to their name.

If an authorized representative helped you fill out this application, they can sign the form for you, but they’ll need to complete Appendix C: Assistance with Completing this Application, and submit it with your application.

APPENDIX A: Health Coverage from Jobs

If anyone in your family has an offer of health coverage from a job, including through a parent or spouse, give information on the offer of coverage, regardless of whether the person is currently enrolled. Complete one page for each employer that offers health coverage.

Instructions for Completing the Application for Exemption from the Shared Responsibility Payment for Individuals who are Unable to Afford Coverage and are in Certain States with a State-based Marketplace

Use this application to apply for an exemption if:

- You can't afford coverage.
- You live in California, Colorado, the District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, or Washington.

STEP 1: Tell us about yourself.

(Page 1)

PERSON 1

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.

STEP 2: Tell us about your tax household.

(Page 2)

You need to complete Step 2 for every person in your household who is on the same federal income tax return.

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.

Item 8

We need to know about any income you made or expect to make from a job, self-employment, unemployment, retirement, pensions, rental property, fishing/farming, alimony, and taxable amount of Social Security benefits (see Internal Revenue Service (IRS) Form 1040 line 20b or IRS Publication 915). The income you list should be the same income amount you put on your health coverage application for your state's Marketplace, EXCEPT you should subtract any Social Security benefit amounts that are not taxable. You also need to submit at least one support document for each type of income you include in your estimate.

Item 10

If you're offered health coverage from a job (whether it's your own job or another person's job), fill in "yes," even if you're offered coverage but aren't currently enrolled. If you're offered coverage, **you must** complete Appendix A: Health Coverage from Jobs, and submit it with your application.

Items 11-12

Ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS). Providing this information won't impact your eligibility for an exemption in any way.

(Page 3)

PERSON 2

PERSON 2 can be either a spouse who files taxes jointly with PERSON 1 or anyone that PERSON 1 claims as a dependent on the same tax return.

Use the same instructions given for PERSON 1 to complete Step 2: PERSON 2. To find the right question number for PERSON 2, just add "+1" to the items above. For example, Item 8 for PERSON 1 is Item 9 (8 + 1) for PERSON 2.

STEP 3: Lowest cost Marketplace plan.

(Page 4)

For anyone who's applying for this exemption who isn't offered health coverage through a job, including a spouse or parent's job, your ability to get this exemption is based on the cost of the lowest-cost bronze plan that is available through your state's Marketplace, after applying any tax credits you can get.

This information is only available through your state's Marketplace.

So, if anyone answered "no" to question 10 above—meaning that they aren't offered health coverage through a job—you need to submit an application for health insurance to your state's Marketplace, complete the process, and send us **2 things** with this application:

- A copy of the eligibility notice from your application to your state's Marketplace. The notice needs to show the maximum premium tax credit you qualify for (if you qualify for any).
- Information from your state Marketplace's web page that lists the health coverage plans available for you to buy. Print and mail us a screen shot that shows the monthly premium amount of the lowest-cost bronze level plan you can buy. Include the plan that's available to everyone who wants this exemption.

Note: If there isn't a single bronze plan that covers everyone in your tax household who is requesting an exemption, send us the screens showing the lowest-cost bronze plans that add together to have the lowest cost for everyone.

Important: We can't process your application without this information. Visit your state's Marketplace website or call them at the phone number listed in the application if you need help getting this information.

STEP 4: Proof of yearly income.

(Page 5)

You **MUST** submit proof of each type of income you listed for each person on this application. We can't approve your exemption without proof of income. The table on page 5 lists possible documents for each type of income; you may submit other documents not on the list if they show the income amount you listed on your application.

If you expect your income to go up or down during the year you are requesting this exemption, you can provide other documents, like a document that states when contract work will end. If any of your income comes from freelance work, you can fill out a self-employment ledger that includes your expected income.

STEP 5: Read & sign this application.

(Page 6)

Read the statements on this page, sign your name, and write today's date. By signing, you're agreeing that the information you provided is true and correct. If you or someone applying for an exemption on this application is incarcerated (detained or jailed), write their name on the line provided. If the person is pending disposition, fill in the circle next to their name.

If an authorized representative helped you fill out this application, they can sign the form for you, but they'll need to complete Appendix C: Assistance with Completing this Application, and submit it with your application.

APPENDIX A: Health Coverage from Jobs

If anyone in your family has an offer of health coverage from a job, including through a parent or spouse, give information on the offer of coverage, regardless of whether the person is currently enrolled. Complete one page for each employer that offers health coverage.

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

Use this application to apply for an exemption if you've experienced a hardship. You may qualify for a "hardship" exemption if:

- You were homeless.
- You were evicted in the past 6 months or were facing eviction or foreclosure.
- You received a shut-off notice from a utility company.
- You recently experienced domestic violence.
- You recently experienced the death of a close family member.
- You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property.
- You filed for bankruptcy in the last 6 months.
- You had medical expenses you couldn't pay in the last 24 months.
- You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.
- 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.
- 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.
- You were determined ineligible for Medicaid because your state didn't expand eligibility for Medicaid under the Affordable Care Act.
- You received a notice saying that your current health insurance plan purchased on the individual market (non-group coverage) is being cancelled, and you consider the other plans available unaffordable.
- You experienced a hardship that kept you from getting health insurance that's NOT listed above.

STEP 2: Tell us about your tax household.

(Page 2)

You need to complete Step 2 for every person in your household who is on the same federal income tax return.

(Page 3)

PERSON 1

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

Item 8

Provide the information requested to explain your hardship. 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 have more than one hardship, you'll need to make a copy of Step 2 (page 3) and complete item 8 for each hardship you're applying for. **If you're applying for more than one hardship category, you must submit documentation for EACH category you're applying for.**

Items 9–10

Ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS). Providing this information won't impact your eligibility for an exemption in any way.

(Page 4)

PERSON 2

PERSON 2 can be either a spouse who files taxes jointly with PERSON 1 or anyone that PERSON 1 claims as a dependent on the same tax return.

Item 9

Provide the information requested to explain your hardship. 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 have more than one hardship, you'll need to make a copy of Step 2 (page 4) and complete item 9 for each hardship you're applying for. **If you're applying for more than one hardship category, you must submit documentation for EACH category you're applying for.**

Items 10–11

Ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS). Providing this information won't impact your eligibility for an exemption in any way.

Instructions for Completing the Application for Exemption for American Indians and Alaska Natives and Other Individuals Who are Eligible to Receive Services from an Indian Health Care Provider

Use this application to apply for an exemption if you or anyone in your tax household is:

- A member of a federally recognized tribe or Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder.
- An individual who's eligible for health services through the Indian Health Service, tribes and tribal organizations, or urban Indian organizations.

Each person who is asking for an exemption on this application must submit copies of documentation that shows their membership in an Indian tribe, Alaska Native corporation, or eligibility for services through an Indian health care provider.

STEP 2: Tell us about your tax household.

You need to complete Step 2 for every person in your household who is on the same federal income tax return. Read the information under "Who do you need to include on this application?" carefully to figure out which people to add in Step 2.

(Page 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.

Item 8

Fill in the circle for "yes" if you're a member of an Indian tribe. This means you're a member of a federally recognized tribe or Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder. If you answered "yes," you may leave the rest of this page blank. If you're not a member of an Indian tribe, fill in "no," and go to Item 9.

Item 9

If you're eligible to get services through an Indian health care provider, fill in "yes" and answer items 10 through 12.

Item 10

If you haven't always been eligible for services through an Indian health care provider, provide the date you became eligible for services (this might apply to you if you gained eligibility through marriage). Leave blank if you've been eligible since birth.

Item 11

If you're ONLY eligible to get services through an Indian health care provider because you're pregnant with the child of an individual eligible for services from an Indian health care provider, give us the due date and leave the rest of this page blank.

Item 12

If you know that your eligibility for services through an Indian health care provider has ended or will end, fill in the date when your eligibility for services through an Indian health care provider has or will end. For example, if you're eligible for services because you're the spouse of an American Indian or Alaska Native, and you're in the process of ending your marriage, this will be the date you receive a court order ending your marriage. If you're a non-Indian or Alaska Native child, this might be the date on which you'll turn 19 years of age.

(Page 3)

PERSON 2

PERSON 2 can be either a spouse who files taxes jointly with PERSON 1 or anyone that PERSON 1 claims as a dependent on the same tax return.

Use the same instructions given for PERSON 1 to complete Step 2: PERSON 2. To find the right question number for PERSON 2, just add "+1" to the items above. For example, Item 8 for PERSON 1 is Item 9 (8 +1) for PERSON 2.

STEP 5: Documents to support your application.

(Page 5)

For each person asking for an exemption on this application, you need to submit copies (not originals) of documents that show membership in an Indian tribe, shareholder status in an Alaska Native corporation, or eligibility for services through an Indian health care provider. **Be sure to make copies of both sides and all pages of the documents you submit.**

Instructions for Completing the Application for Exemption from the Shared Responsibility Payment for Members of Recognized Religious Sects or Divisions

Use this application if you and/or anyone in your tax household is a member of an approved religious sect or division which is described in section 1402(g)(1) of the Internal Revenue Code, and an adherent of established tenets or teachings of such sect or division, including conscientious opposition to acceptance of the benefits of any private or public insurance which makes payments in the event of death, disability, old-age, or retirement or makes payments toward the cost of, or provides services for, medical care (including Medicare and Social Security).

STEP 2: Tell us about your tax household.

(Page 1)

You need to complete Step 2 for every person in your household who is on the same federal income tax return. Read the information under “Who do you need to include on this application?” carefully to figure out which people to add in Step 2.

(Page 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.

Item 8

Fill in “yes” if you have an approved IRS Form 4029 (“Application for Exemption from Social Security and Medicare Taxes and Waiver of Benefits”), and attach a copy to your application. You don't need to have an approved IRS Form 4029 to get this exemption.

Item 9

Give us the full name of your religious sect or division, the district or congregation name, and its address.

Item 10

Give the date you became a member of this religious sect or division. If your religious sect or division doesn't allow children to be members until a certain date, list their birthdate.

Item 11

Give the date you ended your membership if you're not currently a member of this religious sect or division.

Items 12-13

Ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS). Providing this information won't impact your eligibility for an exemption in any way.

(Page 3)

PERSON 2

PERSON 2 can be either a spouse who files taxes jointly with PERSON 1 or anyone that PERSON 1 claims as a dependent on the same tax return.

Use the same instructions given for PERSON 1 to complete Step 2: PERSON 2. To find the right question number for PERSON 2, just add “+1” to the items above. For example, Item 9 for PERSON 1 is Item 10 (9 +1) for PERSON 2.

Instructions for Completing the Application for Exemption from the Shared Responsibility Payment for Members of a Health Care Sharing Ministry

Use this application to apply for an exemption if you or anyone in your tax household is/was a member of a health care sharing ministry that is recognized by the Health Insurance Marketplace.

A health care sharing ministry is an organization whose members share a common set of ethical and religious beliefs and share medical expenses among themselves in accordance with these beliefs.

Use this application only if you're requesting an exemption for months of membership in a health care sharing ministry for the current year. If you want to request this exemption for a calendar year after that year ends, you'll need to claim it on your federal income tax return.

STEP 2: Tell us about your tax household.

(Page 1)

You need to complete Step 2 for every person in your household who is on the same federal income tax return. Read the information under "Who do you need to include on this application?" carefully to figure out which people to add in Step 2.

(Page 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.

Item 8

Give the full name and address of your health care sharing ministry.

Item 9

Give the dates for when you were a member in good standing—that is, periods when you met all membership requirements, including making any financial contributions required to remain a member. You can only get this exemption for months in the past.

Items 10-11

Ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS). Providing this information won't impact your eligibility for an exemption in any way.

(Page 3)

PERSON 2

PERSON 2 can be either a spouse who files taxes jointly with PERSON 1 or anyone that PERSON 1 claims as a dependent on the same tax return.

Use the same instructions given for PERSON 1 to complete Step 2: PERSON 2. To find the right question number for PERSON 2, just add "+1" to the items above. For example, Item 8 for PERSON 1 is Item 9 (8 + 1) for PERSON 2.

Instructions for Completing the Application for Exemption from the Shared Responsibility Payment for Individuals who are Incarcerated (Detained or Jailed)

Use this application if you or anyone in your tax household was incarcerated (detained or jailed), AFTER a court issued a final decision on charges.

STEP 2: Tell us about your tax household.

(Page 1)

You need to complete Step 2 for every person in your household who is on the same federal income tax return. Read the information under “Who do you need to include on this application?” carefully to figure out which people to add in Step 2.

(Page 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.

Item 8

Give dates of entry and release for each time period you were incarcerated (detained or jailed) and the name and full address of the facility where you were incarcerated. Don't include time periods you were being held pending disposition of charges. If you have more than three periods of incarceration for which you would like an exemption, make a copy of page 2 and complete.

Items 9–10

Ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS). Providing this information won't impact your eligibility for an exemption in any way.

(Page 3)

PERSON 2

PERSON 2 can be either a spouse who files taxes jointly with PERSON 1 or anyone that PERSON 1 claims as a dependent on the same tax return.

Item 9

If PERSON 2 was incarcerated, and if PERSON 2 wants an exemption for any time periods he or she was incarcerated, PERSON 2 must answer item 10.

Item 10

Give dates of entry and release for each time period you were incarcerated (detained or jailed) and the name and full address of the facility where you were incarcerated. Don't include time periods you were being held pending disposition of charges. If you have more than three periods of incarceration for which you would like an exemption, make a copy of page 3 and complete.

Items 11–12

Ethnicity and race questions are optional. This information will help the U.S. Department of Health and Human Services (HHS). Providing this information won't impact your eligibility for an exemption in any way.

Reference Materials

Eligible immigration status list:

If you're an eligible non-citizen applying for the exemption from the shared responsibility payment for individuals who are unable to afford coverage, and you're in a state with a federally facilitated Marketplace, then use this list to answer questions about your eligible immigration status. We do **not** collect this information for any other exemption application. If you see your immigration status below, fill in the circle that says "yes."

- Lawful permanent resident (LPR/Green Card holder)
- Asylee
- Refugee
- Cuban/Haitian entrant
- Paroled into the U.S.
- Conditional entrant granted before 1980
- Battered spouse, child, or parent
- Victim of trafficking and his or her spouse, child, sibling, or parent
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
- Individual with non-immigrant status (including worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Deferred Action Status (Deferred Action for Childhood Arrivals (DACA) isn't an eligible immigration status for applying for health coverage.)
- **Applicant for:**
 - Special Immigrant Juvenile Status
 - Adjustment to LPR Status with an approved visa petition
 - Victim of trafficking visa
 - Asylum who has either been granted employment authorization, OR is under 14 and has had an application for asylum pending for at least 180 days.
 - Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) who has either been granted employment authorization, OR is under 14 and has had an application for withholding of deportation or withholding of removal under the immigration laws or under the CAT pending for at least 180 days.
- **Certain individuals with employment authorization document:**
 - Registry applicants
 - Order of supervision
 - Applicant for Cancellation of Removal or Suspension of Deportation
 - Applicant for Legalization under IRCA
 - Applicant for Temporary Protected Status (TPS)
 - Legalization under the LIFE Act
- Lawful temporary resident
- Granted an administrative stay of removal by the Department of Homeland Security (DHS)
- Member of a federally recognized Indian tribe or American Indian born in Canada
- Resident of American Samoa

Immigration status and document types:

If you're an eligible non-citizen applying for the exemption from the shared responsibility payment for individuals who are unable to afford coverage, and you're in a state with a federally facilitated Marketplace, then list your immigration document. We do **not** collect this information for any other exemption application.

See the list below for some common document types. If the document you have isn't listed, you can still write its name. If you're not sure, or you have an eligible status but no document, call the Marketplace Call Center at **1-800-318-2596** for help.

If You Have:	List these for the Document ID:
Permanent Resident Card, "Green Card" (I-551)	<ul style="list-style-type: none"> • Alien registration number • Card number
Reentry Permit (I-327)	<ul style="list-style-type: none"> • Alien registration number
Refugee Travel Document (I-571)	<ul style="list-style-type: none"> • Alien registration number
Employment Authorization Card (I-766)	<ul style="list-style-type: none"> • Alien registration number • Card number • Expiration date • Category code
Machine Readable Immigrant Visa (with temporary I-551 language)	<ul style="list-style-type: none"> • Alien registration number • Passport number
Temporary I-551 Stamp (on passport or 1-94/1-94A)	<ul style="list-style-type: none"> • Alien registration number
Arrival/Departure Record (I-94/I-94A)	<ul style="list-style-type: none"> • I-94 number
Arrival/Departure Record in foreign passport (I-94)	<ul style="list-style-type: none"> • I-94 number • Passport number • Expiration date • Country of issuance
Foreign passport	<ul style="list-style-type: none"> • Passport number • Expiration date • Country of issuance
Certificate of Eligibility for Nonimmigrant Student Status (I-20)	<ul style="list-style-type: none"> • SEVIS ID
Certificate of Eligibility for Exchange Visitor Status (DS2019)	<ul style="list-style-type: none"> • SEVIS ID
Notice of Action (I-797)	<ul style="list-style-type: none"> • Alien registration number or an I-94 number
Other	<ul style="list-style-type: none"> • Alien registration number or an I-94 number • Description of the type or name of the document

For more eligible immigration documents or statuses, continue to the next page.

You can also list these documents or statuses:

- Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada (Note: This is considered an eligible immigration status for Medicaid, but not for a Qualified Health Plan (QHP).)
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of Homeland Security (DHS)
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Cuban/Haitian entrant
- Resident of American Samoa

For people who are self-employed:

If you have any of these expenses, you can subtract them from your gross income to get an amount for your net self-employment income:

- Car and truck expenses (for travel during the workday, not commuting)
- Employee wages and fringe benefits
- Interest (including mortgage interest paid to banks, etc.)
- Rent or lease of business property and utilities
- Advertising
- Repairs and maintenance
- Property, liability, or business interruption insurance
- Depreciation
- Legal and professional services
- Commissions, taxes, licenses, and fees
- Contract labor
- Certain business travel and meals

NOTES

Privacy Act Statement

Permission for information submitted

By submitting this application, you represent that you have permission from all of the people whose information is on the application to both submit their information to the Marketplace, and receive any communications about their eligibility and enrollment.

Privacy Act Statement – effective 10/1/2013

We are authorized to collect the information on this form and any supporting documentation, including Social Security Numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act.

We need the information provided about you and the other individuals listed on this form to determine eligibility for: (1) enrollment in a qualified health plan through the Federal Health Insurance Marketplace, (2) insurance affordability programs (such as Medicaid, CHIP, advanced payment of the premium tax credits, and cost sharing reductions), and (3) certifications of exemption from the individual responsibility requirement. As part of that process, we will verify the information provided on the form, communicate with you or your authorized representative, and eventually provide the information to the health plan you select so that they can enroll any eligible individuals in a qualified health plan or insurance affordability program. We will also use the information provided as part of the ongoing operation of the Marketplace, including activities such as verifying continued eligibility for all programs, processing appeals, reporting on and managing the insurance affordability programs for eligible individuals, performing oversight and quality control activities, combatting fraud, and responding to any concerns about the security or confidentiality of the information.

While providing the requested information (including Social Security Numbers) is voluntary, failing to provide it may delay or prevent your ability to obtain health coverage through the Marketplace, advanced payment of the premium tax credits, cost sharing reductions, or an exemption from the shared responsibility payment. If you don't have an exemption from the shared responsibility payment and you don't maintain qualifying health coverage for three months or longer during the year, you may be subject to a penalty. If you don't provide correct information on this form or knowingly and willfully provide false or fraudulent information, you may be subject to a penalty and other law enforcement action.

In order to verify and process applications, determine eligibility, and operate the Marketplace, we will need to share selected information that we receive outside of CMS, including to:

1. Other federal agencies, (such as the Internal Revenue Service, Social Security Administration and Department of Homeland Security), state agencies (such as Medicaid or CHIP) or local government agencies. We may use the information you provide in computer matching programs with any of these groups to make eligibility determinations, to verify continued eligibility for enrollment in a qualified health plan or Federal benefit programs, or to process appeals of eligibility determinations. Information provided by applicants won't be used for immigration enforcement purposes;
2. Other verification sources including consumer reporting agencies;
3. Employers identified on applications for eligibility determinations;
4. Applicants/enrollees, and authorized representatives of applicants/enrollees;
5. Agents, Brokers, and issuers of Qualified Health Plans, as applicable, who are certified by CMS who assist applicants/enrollees;
6. CMS contractors engaged to perform a function for the Marketplace; and
7. Anyone else as required by law or allowed under the Privacy Act System of Records Notice associated with this collection (CMS Health Insurance Exchanges System (HIX), CMS System No. 09-70-0560, as amended, 78 Federal Register, 8538, March 6, 2013, and 78 Federal Register, 32256, May 29, 2013).

Identity Verification

To protect your privacy, you will need to complete Identity Verification successfully before requesting higher account privileges. You are providing consent to Experian, an external identity verification provider, to access your personal information to conduct ID Verification on behalf of CMS. Below are a few items to keep in mind.

Ensure that you have entered your legal name, current home address, primary phone number, date of birth, and email address correctly. We will collect personal information only to verify your identity with Experian.

Identity Verification involves Experian using information from your consumer report profile to help confirm your identity. As a result, you may see an entry called a "soft inquiry" on your Experian consumer report. Soft inquiries are visible only to you, will never be presented to third parties, and do not affect your credit score. The soft inquiry will be titled "CMS Proofing Services" and will be removed from your Experian consumer report after 25 months.

You may need to have access to your personal and consumer report information, as the Experian application will pose questions to you, based on data in their files.

This statement provides the notice required by the Privacy Act of 1974 (5 U.S.C. § 552a(e)(3)). You can learn more about how we handle your information at: <https://www.healthcare.gov/how-we-use-your-data>.