maryland health connection
marylandhealthconnection.gov

Application for Exemption

Section 1: Contact Information

The person who files a federal income tax return in your household should be the contact person for this application and is known as Person 1. If you're applying for an exemption for a child, an adult who claims the child on his or her federal income tax return should complete and sign the application even if the adult doesn't need the exemption.

First Name: _____ Middle Name: _____

Last Name: _____ Suffix: _____

Home Address: _____ Apt or Suite #: _____

City, County, State, Zip: _____

Mailing Address (if different): _____

Phone Number 1: _____ Phone Number 2: _____

Email Address: _____

Preferred spoken language? _____

Preferred written language? _____

Section 2: Household Information

Who to include on this application:

- The adult who files the federal income tax return for this household – list this person, who will be known as Person 1, on the first line of the table.
- A spouse who is filing taxes jointly with you.
- Anyone Person 1 claims as a dependent on the federal income tax return.

You should apply for this exemption based on how you file taxes, with the following exception: If you're 21 or older and included as a dependent on someone else's tax return, submit your own exemption application.

Who NOT to include in this application:

- A spouse who files taxes separately. Spouses who file separately must fill out a separate exemption application for themselves and include every person they claim on their tax return.
- Anyone who lives with you but isn't (or won't be) listed on your tax return for the year(s) you want this exemption.

For each person included on your federal income tax return, select the relationship to Person 1 (either spouse or dependent).

Include the SSN for anyone who has an SSN, however an SSN is not necessary to qualify for the exemption. We use SSNs to match exemptions with the right tax returns and to correctly match to your coverage application. For help getting an SSN, visit socialsecurity.gov or call 800-772-1213 or TTY: 800-325-0778.

Relationship to Person 1	First Name	MI	Last Name	Date of birth	SSN	Gender	Want exemption? Yes/No
Self							

Section 3: Hardship Information

If you are applying for catastrophic coverage for the upcoming year and are seeking an exemption based on the affordability of marketplace or employer-based coverage rather than one of the hardships listed below, skip this section and go to Section 4.

Select the type of hardship(s) you're applying for below and indicate the household member who experienced this hardship. If everyone experienced the same hardship, say All. Each person needs only one exemption for any given time period. You may apply for more than one hardship if the hardship events were at different times during the year. Note the date the hardship started, when it will end, or if it's ongoing.

Type of Hardship	Name of person with this hardship or say "All"	Tax Year Needed	Date Started (m/d/year)	Date ended (m/d/year)	Check if ongoing
Homeless					
Eviction/Foreclosure					
Shut-off notice					
Domestic violence					
Death of family member					
Disaster					
Bankruptcy					
Medical expenses					

Increase in expenses to care for family member					
Medical support for child					
Eligibility appeals decision					
Other hardship					

Section 4: Income Information

Complete Section 4 if you are seeking an affordability exemption to enroll in catastrophic coverage for the upcoming year.

Provide the income you or any other member of your tax household expect to make from a job, self-employment, unemployment, retirement, pensions, rental property, fishing/farming, Social Security, or alimony. (For alimony awarded prior to 1/1/19, the receiving spouse must claim alimony as income if the paying spouse expects to take the alimony payments as a tax deduction.)

First Name	MI	Last Name	Total estimated yearly income

Include with this application proof of yearly income for each type of income listed for each person on this application. The table below lists possible documents for each type of income, but 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 can provide additional documents such as a letter stating when contract work will end, or a self-employment ledger that includes expected income.

Income Type	Documents
All income types	• A copy of your most recent federal income tax return, Form 1040, if your income and/or deductions listed on this application are similar to your last tax return.
Job	• One or more pay stubs that show the typical pay and hours you work at the job. The pay stubs should show the gross amount and any tips, commissions, bonuses, or overtime pay. • Wages and tax statement (W-2) from the most recent year. • 1099-MISC (Non-employee compensations).
Net self-employment	• Self-employment ledger. • Schedule C. • Form 1120S. • Other recent tax documents showing self-employment. • Copy of a check for the self-employment services.
Other Income	**Documents**
Unemployment	• Letter from government agency for unemployment benefits. If the document doesn't list the start and end dates, write your best guess at when the benefits will end on the document.
Retirement (taxable amounts ONLY)	• 1099 or relevant tax document that list any withdrawal amounts. • Documents showing taxable amount from account withdrawals.
Pension	• Pension letter. • 1099 or relevant tax document.
Rental/royalties (net)	• Lease agreement for land or property you own with lease amount/frequency. • Document showing royalty income. • 1099-MISC (royalty/rental income fields).
Alimony paid/received	• Court order or legal document showing the monthly alimony amount and the start and end dates (if applicable).
Farming/fishing (net)	• Schedule C, F. • 1099-G.
Social Security (taxable amounts ONLY)	• Copy of most recent Form 1040 that shows the taxable amount in line 20b. Don't send copies of your benefit or COLA letter UNLESS the taxable amount is listed on it.

Are you or any other individuals on this application offered health coverage from a job? (Select yes if that coverage is from someone else's job, such as a parent or spouse. Select yes if you are offered coverage from a job even if you have not signed up for it.)

☐ Yes

☐ No

If yes, provide the name of each person offered health coverage from a job and provide the cost of the premium for that person and any other family members eligible for coverage from that employer. Do not include any premium amount that is paid by the employer.

First Name	MI	Last Name	Cost of premium

Is everyone on this application seeking an exemption based on the affordability of coverage offered through a job?

- ☐ Yes
- ☐ No

If anyone on this application is seeking an exemption based on the affordability of coverage offered through the marketplace, you must complete an application on the marketplace to determine the monthly premium of the lowest cost metal level plan you can buy and your eligibility for any premium tax credit. If you need help completing an application, please contact the Maryland Health Connection Call Center for assistance at (855) 642-8572.

Section 5: Authorized Representative

You can choose an Authorized Representative to talk about this application with us, see your information, act for you on matters related to this application, and sign this application on your behalf. If you ever need to change or remove your Authorized Representative, contact Maryland Health Connection. If you are a legally appointed representative, include a copy of court documents as evidence of your appointment with this application.

Authorized Representative Name

First Name: _____ MI: _____

Last Name: _____ Suffix: _____

Address: _____

Phone number: _____

Organization (if applicable): _____

For Certified Application Counselors, Navigators, or Brokers only

Name: _____

Address: _____

Organization name: _____

ID Number of NPN if Broker: _____

Section 6: Terms of Acceptance

☐ I understand 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 or state law if I intentionally provide false or untrue information.

☐ I understand that under federal law, discrimination isn't permitted on the basis of race, color, national origin, gender, age, sexual orientation or identity, or disability. I can file a complaint of discrimination by visiting: https://www.marylandhealthconnection.gov/policies-accessibility/nondiscrimination-accessibility-requirements-notice/

The person known as Person 1 should sign this application. The person who signs must be an adult over the age of 18 who files a federal income tax return for the household. If you are an Authorized Representative, you may sign as long as Section 6 is complete.

_____

Person 1 or Authorized Representative signature

_____

Date

Section 7: Submission

Mail your signed application and copies of supporting documents (do not send originals) to:

Maryland Health Connection

PO Box 857

Lanham, MD 20703

If we need more information, we will contact you via phone or mail. Once we have processed your application, you will receive a decision via mail. If you do not hear from us within 15 days, please call us at (855) 642-8572 (Deaf and hard of hearing use Relay service).

If we are unable to process your application because there is missing information, we will close your case without a decision after 90 days.

If you think we made the wrong decision on your application, you may appeal within 90 days of the decision. For more information about the case review and appeals process, please visit www.marylandhealthconnection.gov/appeals/.