

Application for Exemption from the Individual Responsibility Requirement

According to federal law effective as of 2014, every person needs to have health coverage or make a payment on his or her federal income tax return called the “shared responsibility payment.” Some people are exempt from making this payment. This application includes only certain categories of exemptions. You may apply for other categories of exemptions when you file your federal income tax return.

Who should use this application?

You should apply for an exemption through HealthSource RI if you meet the following criteria:

- You are a member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare;
- You are a member of a recognized healthcare sharing ministry;
- You were incarcerated;
- You are a member of a federally recognized tribe or eligible for services through an Indian Health Services provider;
- The lowest-priced health coverage available to you in the current plan year is more than a certain percentage of your projected household income (for more information on this exemption and this year’s income requirements, visit <https://www.healthcare.gov/exemptions-tool/#/results/2015/details/marketplace-affordability>; or
- You’ve experienced a hardship that has prevented you from being able to purchase health coverage (see list of hardship reasons on page 2).

What do I need to apply?

Please include documents that support your claim (see page 2). If you can’t obtain the documents, call HealthSource RI at 1-855-840-4774.

In order for us to process your application, you must have an account with HealthSource RI. To create a HealthSource RI account, you can go to www.HealthSourceRI.com or call us at 1-855-840-4774.

What happens next?

Send your complete, signed application to the address provided on page 6. We’ll follow up with you and let you know if we need additional documentation. If the documents are not provided, your request will be denied. Once we have a complete application from you, we will send a notice to you containing our decision. If your exemption is granted, we’ll include an Exemption Certificate Number. This is the number you will use when you file your federal income tax return.

Did you know that you may qualify for no-cost health coverage or tax credits that can lower the cost of your health coverage? While we evaluate your exemption request, you can complete an application for coverage through HealthSource RI at www.HealthSourceRI.com or by calling our Customer Support Center at 1-855-840-4774 or 1-888-657-3173 (TTY).

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

If you don't agree with our decision, you can file an appeal. HealthSource RI must receive your appeal request within 35 days of the date on the notice denying your request for an exemption. To appeal the results of your application, you may call HealthSource RI at 1-855-840-4774, visit HealthSourceRI.com to file an appeal through your account, or you may complete a Request for Hearing Form (DHS-121).

Exemption Reasons and Documentation Required with Application

You may qualify for an exemption if you experienced one of the following:

Exemption Reason	Documentation Required	Duration
You are a member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare (45 CFR 155.605(c)(1))	The name and address of the religious sect. If available, a copy of an approved IRS Form 4029 ("Application for Exemption from Social Security and Medicare Taxes and Waiver of Benefits")	Continuous until person reports that they no longer meet eligibility criteria or they have reached the age of 21. At age 21, person must reapply.
You are a member of a recognized healthcare sharing ministry (45 CFR 155.605(d)(1))	The name and address of the healthcare sharing ministry	Continuous
You were incarcerated (45 CFR 155.605(e)(1))	Documents showing the name and address of the facility where you were incarcerated, and the time periods of incarceration	Calendar Year
You are a member of a federally recognized tribe or eligible for services through an Indian Health Services provider (45 CFR 155.605(f)(1))	Documents showing tribal membership or eligibility for services from the Indian Health Service, a tribal provider, or an urban Indian healthcare provider	Calendar Year
You've experienced a hardship that prevented you from purchasing health insurance (45 CFR 155.605(g)(1))	See hardship reasons in table below	At least the month before, the months during, and the month after the hardship
The lowest-priced health coverage available for the current plan year is more than 8.05% of projected household income (45 CFR 155.605(g)(2))	You must complete an application for health insurance coverage through Health Source RI.	Calendar Year

Hardship Exemption Reasons:

Hardship Reason	Documentation Required
You were homeless.	None
You were evicted in the past 6 months or were facing eviction or foreclosure.	Copy of eviction or foreclosure notice
You received a shut-off notice from a utility company.	Copy of shut-off notice from a utility company or proof of more than 6 months behind on payments if utility can't be shut off (for reasons of medical necessity or hardship)
You recently experienced domestic violence.	None
You recently experienced the death of a close family member.	Copy of death certificate, copy of death notice from newspaper, or copy of other official notice of death
You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property.	Copy of police or fire report, insurance claim, or other document from government agency, private entity, or news source documenting event
You filed for bankruptcy in the last 6 months.	Copy of bankruptcy filing
You had unreimbursed medical expenses in the last 24 months that resulted in substantial debt.	Copies of medical bills
You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging	Copies of receipts related to care

You expect to claim as a tax dependent a child 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.	Copy of medical support order AND copies of eligibility notices for Medicaid and CHIP showing that the child has been denied coverage. Exemption is only for the months the medical support order is in effect.
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	Copy of notice of appeals decision
You received a notice saying you're your individual insurance plan was cancelled after June 30, 2013, and you consider the other available plans unaffordable.	Copy of notice of cancellation

Exemptions That May Only Be Claimed On Tax Return

Exemption Reason	Explanation
Coverage offered for the previous year is considered unaffordable	The amount you would have paid for employer-sponsored coverage or a bronze level health plan (depending on your circumstances) is more than 8.05% of your actual household income for the year as computed on your tax return.
Short coverage gap	You went without coverage for less than three consecutive months during the year.
Household income below the return filing threshold	Your household income is below the minimum threshold for filing a tax return
Citizens living abroad and certain noncitizens	You are neither a U.S. citizen, a U.S. national, nor an alien lawfully present in the U.S.

Application for Exemption from the Individual Responsibility Requirement

Print and complete this form only if you are applying for an exemption from the healthcare coverage requirement. You must either provide your HealthSource account ID or answer all the demographic questions below. All applicants must complete the exemption information on page 5.

Please note that this is an individual exemption application. **A separate application must be completed for each family member applying for an exemption from the individual responsibility requirement.** If you need additional applications, please photocopy the next three pages or call 1-855-840-4774 to request additional copies mailed to you.

Applicant's Name*: _____ If you have an account with HealthSource RI, you do not need to answer the demographic information below. Do you have an account with HealthSource RI? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what is your Account ID (located on your account dashboard or in the upper right corner of any formal notices sent to you by HealthSource RI)? _____		
Date of birth*: ___ / ___ / _____ Month Day If under 21 years old, parent or guardian's name: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	If this applicant will be a dependent on someone else's tax return, please provide the Tax Filer's Name and Social Security Number: Name: _____
Current address*: _____		
City*: _____	State*: _____	ZIP Code*: _____
Mailing address (if different from current address above): _____		
City: _____	State: _____	ZIP Code: _____
For which dates are you applying for the individual exemption?* From: _____ / _____ to: _____ / _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Month Year Month Year </div>		

Check the type of exemption for which you are applying. You must include any documents described on page 2 for the exemption you're requesting.

A. Member of Recognized Religious Sect or Division _____

Name of Religious Sect _____

Address of Religious Sect _____

B. Member of a Healthcare Sharing Ministry _____

Name of Healthcare Sharing Ministry _____

Address of Healthcare Sharing Ministry _____

C. Incarceration _____

D. Member of a federally recognized Indian Tribe _____

E. Hardship _____

Specify which hardship you've experienced (see pg. 2): _____

When did this hardship start? _____ / _____ / _____

When did this hardship end? _____ / _____ / _____

If you're still experiencing this hardship, check this box

Please explain how this hardship kept you from getting health coverage for the time period for which you're requesting an exemption and include any supporting documentation:

F. Affordability based on Projected Income

For anyone who is applying for this exemption, your ability to get this exemption is based on your projected household income for this year as calculated by HealthSource RI and the cost of the lowest-cost bronze plan that is available to you through HealthSource RI (after applying any tax credits for which you qualify or through your employer. You must complete the general application for health care coverage through HealthSource RI and

include your Account Number (located in the upper right = corner of your Combined Notice of Eligibility.
Account Number:

Read and Sign This Application

By signing this application, I certify and attest under penalty of perjury that my answers are correct, and complete to the best of my knowledge.

- I understand the questions and statements on this application.
- I understand the penalties for providing false information, including penalties for violation of the Rhode Island False Claims Act, RIGL 9-1-1 et. al.
- I know that under the state of Rhode Island General Laws, Section 40-6-15, a maximum fine of \$1,000, or imprisonment of up to five (5) years, or both, may be imposed for a person who obtains or attempts to obtain, or aids or abets any person to obtain, public assistance to which he or she is not entitled or who willfully fails to report income, resources, or personal circumstances or increases therein which exceed the amount previously reported.
- Under penalty of perjury, I attest to the identity of the minor children identified herein and that all of the information contained in this application is true. I understand that I am breaking the law if I give wrong information and can be punished under federal law, state law or both.

Signature of Applicant or Parent/Guardian of Applicant Date

Print your name here if Authorized Representative Date

There are multiple ways for you to send in your application:

- 1) Upload the application to your HealthSource RI account, HealthSourceRI.com/.
- 2) Mail your completed application to:
HealthSource RI
Attn: Exemptions Processing
401 Wampanoag Trail
East Providence, RI 02915
- 3) Fax your completed application to HealthSource RI at 401-223-6317.

Please allow 45 days for HealthSource RI to respond. If you have not received a response after 45 days, please call HealthSource RI at 1-855-840-4774.