Consent form for Application In-Person Assistance for Online Enrollment on the Maryland Health Connection & Disclosure of Interest

Name of Application Counselor Program Organization: _____

Name of Application Counselor: _____AC Certification #: _____

_____ I understand the enrollment process involves the creation of an online account with Maryland Health Connection.

_____ I hereby consent to the person/organization named above to:

- provide assistance to me in establishing and/or accessing an account with Maryland Health Connection, including assistance with password change or reset;
- help me complete my application for health coverage, or make a change to an existing application in Maryland Health Connection;
- assist me with documentation upload into Maryland Health Connection;
- inform me and/or my authorized representative about the full range of health coverage options and insurance affordability programs for which I am eligible;
- help me enroll in a Qualified Health Plan or an insurance affordability program for which I'm eligible, and,
- contact me in the case where additional information is needed for my application.

_____ I have been made aware of the relationship _____ (certified Application Counselor) has with _____ (organization). I am aware this may present a potential conflict of interest regarding the outcome of my application. I have been given information about other sources for assistance including the Maryland Health Connection call center, the Maryland Health Connection Navigator program, and local health departments and departments of social services.

_____ I understand the above named application counselor/organization is required to act in my best interest, and will not charge me a fee for any application and enrollment assistance provided.

_____ I understand the above named application counselor/organization cannot provide tax or legal advice in connection with my application for health care coverage and is not acting as a tax adviser or attorney when providing application and enrollment assistance.

Consent form for Application In-Person Assistance for Online Enrollment on the Maryland Health Connection & Disclosure of Interest (continued)

Name of Application Counselor Program Organization: _____

Name of Application Counselor: _____AC Certification #: _____

_____ I understand the Application counselor & Organization named above will follow privacy and information security standards when creating, collecting, disclosing, accessing, maintaining, storing, and/or using my Personally Identifiable Information (PII) and/or the PII of my authorized representative.

_____ I understand that this authorization period is for one year & that I may contact the person/ entity named above at any time to revoke this authorization at any time.

_____ I understand that my eligibility is determined by the Maryland Health Connection and not by the application counselor.

Signature of Consumer/Consumer's Authorized Representative

PLEASE PRINT NAME

Date

[Application ID]