Text

Description automatically generated

**[Health Center Name]**

**Authorization for Application and Enrollment Assistance**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give my permission to [Health Center Name] and to

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a Certified Application Counselor with [Health Center Name], to help me understand my health coverage options and/or complete an application for health coverage through the Virginia Health Benefit Exchange at HealthCare.gov, Virginia Medicaid, or Virginia FAMIS program.

I give person to [Health Center Name] to access my Personally Identifiable Information that is necessary to determine eligibility for health insurance and to enroll into a health plan. This information may include my name, home address, email address, phone number, date of birth, Social Security number, Healthcare.gov username and password, and financial/employment information.

I understand that:

* [Health Center Name] will help me understand the full range of health coverage options and financial assistance programs that may be available to me and my family.
* [Health Center Name] cannot choose a health plan for me.
* [Health Center Name] may need to see, use, and store my personal information to provide assistance, and they will keep that information private and secure, as required by law, and according to [Health Center Name]’s privacy policy. (include link to your health center’s privacy policy)
* [Health Center Name] provides help based on the information I provide. If the information I give is inaccurate or incomplete, [Health Center Name] may not be able to offer all the help that is available for my situation.
* [Health Center Name] will not charge me for any assistance provided.
* [Health Center Name] does not provide legal assistance or tax advice. I am receiving only the services of a Certified Application Counselor and there is no attorney-client relationship.
* [Health Center Name] must keep this Authorization for ten (10) years. I may cancel my consent at any time, and I will notify [Health Center Name] in writing if I cancel my consent.

Name-Printed (please check one): [ ] Consumer or [ ] Authorized Representative

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**