Rev. 07/17 **AUTHORIZATION FOR ENROLLMENT ASSISTANCE**

Certified Enrollment Entity Name	Type of Authorization (Check One)
	☐ *Written* ☐ *Oral*
Entity Address	Site Location Name (If applicable)
Entity Phone Number	Entity Email
Certified Enrollment Counselor Name	Certification Number

I, _____, give my permission, or _____ my Authorized Representative (person acting for me), gives his/her permission, to the Covered California Certified Enrollment Entity and Enrollment Counselor (together called "Counselor") named identified above to provide me or my Authorized Representative (if applicable) with information about my health insurance choices. This is to help me apply for and enroll in health coverage through a Covered California Health Insurance Plan or Medi-Cal. I give permission to the Counselor to access my Personally Identifiable Information that is necessary to determine eligibility for health insurance and to enroll into a health plan. If applicable, my Authorized Representative may give the Counselor with permission to access my Personally Identifiable Information that is necessary to determine eligibility for health insurance and to enroll into a health plan. My Personally Identifiable Information may include my name, home address, email address, phone number, date of birth, social security number, financial information, and employment information.

In this form, the words "me" or "my" include my Authorized Representative if I have one.

I understand that:

1. The Counselor will tell me about all coverage choices I may qualify for, including Covered California Health Plans, Medi-Cal and the Medi-Cal Access Program.
2. The Counselor cannot choose or recommend a health plan for me.
3. The Counselor will make sure my Personally Identifiable Information is private and secure. This is required by law.
4. The Counselor may create, collect, give out, access, keep, store, or use my Personally Identifiable Information and/or my Authorized Representative's Personally Identifiable Information only to perform enrollment assistance and related duties. The Counselor may provide my Personally Identifiable Information to Covered California, Covered California Health Plans, and the California Department of Health Care Services, which runs Medi-Cal. The Counselor may also provide my Personally Identifiable Information to other sources as required by law. However, the Counselor may not use my Personally Identifiable Information for any other purpose or in any manner that violates applicable laws.
5. Certified Enrollment Counselor duties also include:
    - Providing information and services in a fair, accurate, and impartial manner.
    - Providing verbal or written information about all my coverage options in a language and manner that I can understand.
    - If applicable, providing information and assistance in a manner that is easily accessible to persons with disabilities.
    - Helping me choose a Covered California Health Plan, Medi-Cal Plan, or the Medi-Cal Access Program. If I consent, the Counselor will also help me enroll or renew into a plan.
    - Referring me to agencies for help with a grievance, complaint, or question about my health plan, coverage, or a decision made by or about my plan or coverage.

- Referring me to resources for tax preparation and tax advice if I have any tax-related questions about health insurance, financial assistance to pay for health insurance, and any legal requirements pertaining to health insurance.

6. The Counselor must also offer public education activities. The Counselor will not use my Personally Identifiable Information for this purpose.
7. The Counselor is knowledgeable about the rules for enrollment into Covered California Health Plans, Medi-Cal, and the Medi-Cal Access Program.
8. If I give incorrect information to the Counselor, he or she may not be able to help me make the best decision regarding health insurance. The Counselor can only rely on the information that either my Authorized Representative or I provide.
9. If the Counselor can't help me, he or she will refer me to another Counselor, or to the Covered California Service Center, who can help me.
10. The Counselor cannot charge me any fees. This assistance is free.
11. I must sign this form in order to authorize the Counselor to help me. If I do not sign this form, I can still apply for and enroll in health insurance through Covered California, Medi-Cal, or the Medi-Cal Access Program.
12. This authorization will expire when I communicate to the Counselor that I wish to cancel my authorization. I may cancel or limit my authorization in writing at any time. I will notify the Counselor if I choose to cancel my authorization.
13. The Certified Enrollment Entity must keep this form for ten (10) years.

Covered California needs your name and signature on this form to identify you. If you do not give your name and signature on this form, a Counselor will not be able to help you.

Covered California must give you this Privacy Statement under CA Civil Code § 1798.17. Covered California's Notice of Privacy Practices is available at CoveredCA.com/Privacy. If you have questions about your records, you can call or write to the Privacy Officer at (800) 889-3871 or 1601 Exposition Blvd., Sacramento, CA 95815.

Signature	Date
Print Name	
Application No.	Case No.

For Certified Enrollment Counselor:

I affirm under penalty of perjury that:

- I am a Certified Enrollment Counselor affiliated with a Certified Enrollment Entity as defined in California Code of Regulations Title 10, Chapter 12, Article 8, section 6650.
- I conveyed all information in this form to the applicant in a language and manner which he or she understands.
- I ensured all information on this form was accessible to those with disabilities by providing disability-related modifications or accommodations when necessary, including auxiliary aids, Braille, large print or other tools and services.
- I explained to the applicant the meaning of Personally Identifiable Information and its purpose in applying for insurance. I stated that Personally Identifiable Information will only be used to determine eligibility for health coverage.
- I obtained oral or written authorization from the consumer consenting to the release of his or her Personally Identifiable Information to me in order to fulfill my duties as described in California Code of Regulations Title 10, Chapter 12, Article 8, section 6664.

Signature	Date