



# Application for Exemption from the Shared Responsibility Payment for Individuals who are Incarcerated (Detained or Jailed)



## Use this application to apply for an exemption from the shared responsibility payment

- Every person needs to have health coverage or make a payment on their federal income tax return called the “shared responsibility payment.”
- Some people are exempt from making this payment. This application includes one category of exemption. There are other applications for other categories of exemptions. You may apply for certain other categories of exemptions when you file your federal income tax return.
- You don’t need to apply for an exemption if you’re not going to file a federal income tax return. If you’re not sure you’ll file a tax return, you may want to apply for an exemption anyway.



## Who can use this application?

- **Use this application if you and/or anyone in your tax household was incarcerated (detained or jailed), AFTER a court issued a final decision on charges.**
- You can also ask the Internal Revenue Service (IRS) for this exemption when you file your federal income tax return.
- You can use one single application to ask for this exemption for more than one person in your tax household.



## When can you get this exemption?

- Use this application **only after you’re released** from incarceration, to get an exemption for the time you were incarcerated in the current year. If you want to request this exemption for this year after the year has ended, you’ll need to claim it on your federal income tax return for this year.



## What you need to apply

- Documents showing the name and address of the facility where you were incarcerated, and the dates you entered and were released.
- Social Security Numbers (SSNs), if you have them.
- Information about people in your tax household.



## Why do we ask for this information?

We ask for Social Security Numbers and other information to make sure your exemption is counted when you file your federal income tax return. **We’ll keep all the information you give private and secure, as required by law.** To view the Privacy Act Statement, go to [HealthCare.gov](http://HealthCare.gov) or see instructions.



## Get help with this application

- **Online:** [HealthCare.gov/exemptions](http://HealthCare.gov/exemptions).
- **Phone:** Call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.
- **In person:** There may be counselors in your area who can help. Visit [HealthCare.gov](http://HealthCare.gov), or call the Marketplace Call Center at **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596**.
- **Other languages:** If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We’ll get you help at no cost to you.



Please print in capital letters using black or dark blue ink only. Fill in the circles (○) like this → ●.

### STEP 1: Tell us about yourself.

(The person who files a federal income tax return in your household should be the contact person for this application. If you're applying for an exemption for a child, we need an adult who claims the child on his or her federal income tax return to fill out this information even if the adult doesn't need the exemption.)

Give your legal name

1. First name	Middle name	Last name	Suffix
---------------	-------------	-----------	--------

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number
--	------------------------------

4. City	5. State	6. ZIP code	7. County, parish, or township
---------	----------	-------------	--------------------------------

8. Mailing address (if different from home address)	9. Apartment or suite number
---	------------------------------

10. City	11. State	12. ZIP code	13. County, parish, or township
----------	-----------	--------------	---------------------------------

14. Daytime phone number ( ) -	15. Evening phone number ( ) -
-----------------------------------	-----------------------------------

Please give us a phone number so the Marketplace can contact you if we need more information to process your application. We won't use your phone number for any other purpose.

16. Do you want to get information by email from the Marketplace? .....  Yes  No

Email address:

17. What's your preferred spoken language? What's your preferred written language?

### STEP 2: Tell us about your tax household.

#### Who do you need to include on this application?

You need to complete Step 2 for every person in your household who is on the same federal income tax return. If the person **doesn't want an exemption**, just answer questions 1-7 of Step 2.

#### For Person 1:

Person 1 must be an adult who files a federal income tax return in your household, even if they don't want an exemption.

#### For Person 2:

Person 2 can be either:

- A spouse who files taxes jointly with Person 1.
- Anyone that Person 1 claims as a dependent on the same tax return.

#### Who not to include:

- A spouse who files taxes separately. Spouses who file separately need to fill out a separate application for themselves and for each person they claim on their tax return.
- Anyone who lives with you but who isn't listed on your tax return. Each person who needs an exemption must be on an application with the person who lists them on a tax return.

#### If you don't plan to file taxes, you don't need to apply for an exemption.

You'll get an eligibility determination letter in the mail after your application is processed. If you get this exemption, we'll give you an Exemption Certificate Number (ECN) with your approval letter. **Keep the letter for your records.** You'll need to put this number on your federal income tax return at the time you file taxes.

We'll keep all the information you provide private and secure, as required by law. We'll use personal information only to check if you're eligible for an exemption.

**NEED HELP WITH YOUR APPLICATION?** Visit [HealthCare.gov](http://HealthCare.gov), or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.



# STEP 2: PERSON 1

Person 1 should be the person who files a federal income tax return, even if the person doesn't need this exemption.

1. First name	Middle name	Last name	Suffix
<input type="text"/>			
2. Relationship to you?	3. Date of birth (mm/dd/yyyy)		4. Sex
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>		<input type="radio"/> Male <input type="radio"/> Female

5. Social Security Number (SSN)  -  -

**If you're requesting an exemption for yourself and you have an SSN, you must provide it. You aren't required to have an SSN to get this exemption. If you're not requesting an exemption for yourself, providing your SSN can be helpful since it can speed up the application process.** We use SSNs to help make sure that if you get an exemption, it's applied correctly on your taxes. If someone wants help getting an SSN, call **1-800-772-1213** or visit [socialsecurity.gov](http://socialsecurity.gov). TTY users should call **1-800-325-0778**.

6. **Do you plan to file a federal income tax return?** .....  Yes  No

a. Will you file jointly with a spouse? .....  Yes  No

**If yes**, write name of spouse:

b. Will you claim any dependents on your tax return? .....  Yes  No

**If yes**, list name(s) of dependents:

7. Do you want this exemption?  **YES.**  **NO. If no, skip to question 9.**

8. Tell us the entry and release dates for each time period you were incarcerated (detained or jailed) for which you would like an exemption, and where you were incarcerated. Don't include time periods that you were being held pending disposition of charges). **If you have more than three periods of incarceration for which you would like an exemption, make a copy of this page and complete.**

	Entry date (mm/dd/yyyy)	Facility name, Address, City, State, ZIP code
Incarceration period 1	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
	Release date (mm/dd/yyyy)	
Incarceration period 2	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
	Release date (mm/dd/yyyy)	
Incarceration period 3	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
	Release date (mm/dd/yyyy)	

**Optional:** (Fill in all that apply.)

9. **If Hispanic/Latino, ethnicity:**  Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other \_\_\_\_\_

10. **Race:**  White  Black or African American  American Indian or Alaska Native  Filipino  Japanese  Korean  Asian Indian  Chinese  Vietnamese  Other Asian  Native Hawaiian  Guamanian or Chamorro  Samoan  Other Pacific Islander  Other \_\_\_\_\_



# STEP 2: PERSON 2

Make a copy of this page if there are more than 2 people in your household.

Fill out this page for a spouse who files taxes jointly with you and for anyone you claim as a dependent on your federal income tax return.

1. First name	Middle name	Last name	Suffix
<input type="text"/>			

2. Relationship to PERSON 1? <input type="text"/>	3. Date of birth (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>	4. Sex <input type="radio"/> Male <input type="radio"/> Female
--	---	---

5. Social Security Number (SSN)  -  -

**If PERSON 2 is requesting an exemption and has an SSN, he or she must provide it. PERSON 2 isn't required to have an SSN to get this exemption.** We use SSNs to help make sure that if you get an exemption, it's applied correctly on your taxes. If someone wants help getting an SSN, call **1-800-772-1213** or visit [socialsecurity.gov](http://socialsecurity.gov). TTY users should call **1-800-325-0778**.

6. Does PERSON 2 plan to file a federal income tax return? .....  Yes  No  
**If yes**, answer 6a and 6b. **If no**, go to question 7.

a. Will PERSON 2 file jointly with a spouse? .....  Yes  No

**If yes**, write name of spouse:

b. Will PERSON 2 claim any dependents on his/her tax return? .....  Yes  No

**If yes**, list name(s) of dependents:

7. Will PERSON 2 be claimed as a dependent on PERSON 1's tax return? .....  Yes  No

**If yes**, please list the name of the tax filer:

How is PERSON 2 related to the tax filer?

**Note:** If PERSON 2 isn't listed on PERSON 1's tax return as a spouse or as a dependent, PERSON 2 must file a separate application.

8. Does PERSON 2 want this exemption?  YES.  NO. **If no**, skip to question 11.

9. Was PERSON 2 incarcerated, and does PERSON 2 want an exemption for any time periods PERSON 2 was incarcerated?  
 YES.  NO. **If no**, skip to question 11.

10. Tell us the entry and release dates for each time period PERSON 2 was incarcerated (detained or jailed) for which you would like an exemption, and where PERSON 2 was incarcerated. Don't include time periods that PERSON 2 was being held pending disposition of charges). **If PERSON 2 has more than three periods of incarceration that PERSON 2 wants an exemption for, make a copy of this page and complete.**

	Entry date (mm/dd/yyyy)	Facility name, Address, City, State, ZIP code
Incarceration period 1	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
	Release date (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>	
Incarceration period 2	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
	Release date (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>	
Incarceration period 3	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
	Release date (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>	

**Optional:** (Fill in all that apply.)

11. **If Hispanic/Latino, ethnicity:**  Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other \_\_\_\_\_

12. **Race:**  White  Black or African American  American Indian or Alaska Native  Filipino  Japanese  Korean  Asian Indian  Chinese  Vietnamese  Other Asian  Native Hawaiian  Guamanian or Chamorro  Samoan  Other Pacific Islander  Other \_\_\_\_\_

**NEED HELP WITH YOUR APPLICATION?** Visit [HealthCare.gov](http://HealthCare.gov), or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.



### STEP 3: Read & sign this application

- 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 law if I intentionally provide false or untrue information.
- I know that I must tell the Health Insurance Marketplace within 30 days if anything changes (and is different than) what I wrote on this application. I can visit [HealthCare.gov](https://www.healthcare.gov) or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect my eligibility as well as eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting [hhs.gov/ocr/office/file](https://www.hhs.gov/ocr/office/file).

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

If you don't agree with the results of your exemption application, you can ask for an appeal. Below is important information to consider when requesting an appeal:

- The Health Insurance Marketplace must receive your appeal request within 90 days of the date of the notice of the application results.
- You may have a relative, friend, legal counsel, or another spokesperson, including an Authorized Representative, help you make an appeal request or participate in your appeal. This is optional.
- The outcome of an appeal could change the eligibility of other members of your tax household.

To appeal your exemption application results, visit [HealthCare.gov/marketplace-appeals/](https://www.healthcare.gov/marketplace-appeals/). Or call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.

**PERSON 1 should sign this application.** If you're an authorized representative, you may sign here as long as PERSON 1 signed Appendix C. The person who signs this application must be the person who files a federal income tax return and is an adult over the age of 18.

Signature	Date signed (mm/dd/yyyy)
→ <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

### STEP 4: Mail completed application



Mail your signed application and documents showing the date of incarceration, and the release date, if you have one, to:

**Health Insurance Marketplace – Exemption Processing**  
**465 Industrial Blvd.**  
**London, KY 40741**



#### What happens next?

Send your complete, signed application with required documents to the address above. We'll follow up with you within 1–2 weeks. You may receive a call from the Marketplace if we need more information. You'll get an eligibility determination letter in the mail after we process your exemption application. If you qualify for this exemption, we'll give you an Exemption Certificate Number (ECN) that you'll put on your federal income tax return. If you don't hear from us, call the Health Insurance Marketplace Help Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1190. The time required to complete this information collection is estimated to average 16 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**NEED HELP WITH YOUR APPLICATION?** Visit [HealthCare.gov](https://www.healthcare.gov), or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.



# Appendix C

## Assistance with completing this application

### For certified application counselors, navigators, agents, and brokers only

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

### You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change or remove your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Phone number

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

10. Signature of PERSON 1 listed on this application

11. Date signed (mm/dd/yyyy)

