AUTHORIZATION FOR ENROLLMENT ASSISTANCE

Certified Enrollment Entity Name

Entity Address

Entity Phone Number	Entity Email

Certified Enrollment Counselor Name and 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 above to give me and/or my Authorized Representative information about my health coverage 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 for the Counselor to see or use some of my Personally Identifiable Information and to help me enroll in health coverage. 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 AIM for Pregnant Women.
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, and/or use my Personally Identifiable Information and/or my Authorized Representative's Personally Identifiable Information **only** to perform the Certified Enrollment Counselor duties. This may include giving 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 not use my Personally Identifiable Information for any other purposes.
5. Certified Enrollment Counselor duties also include:
   - Giving information and services in a fair, correct, and impartial way.
   - Giving information verbally and/or in writing about all coverage options for which I may qualify in my language and in a way I can understand.
   - Giving information and help in a way that persons with disabilities can access and use.
   - Helping me choose a Covered California Health Plan or Medi-Cal or AIM for Pregnant Women. If I consent, helping me apply for, enroll into, or renew coverage.
   - 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.
6. The Counselor must also offer public education activities. The Counselor will not use my Personally Identifiable Information for this purpose.

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7. The Counselor must know the rules for Covered California Health Plans, Medi-Cal and AIM for Pregnant Women.
8. If the information I give is wrong or incomplete, the Counselor may not be able to help me make the best decisions. The Counselor's help is based only on information I or my Authorized Representative give.
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 will not charge me a fee. The help is free.
11. I must sign this form for the Counselor to give help. If I do not sign this form, I can still apply for and enroll in health coverage through Covered California or Medi-Cal or AIM for Pregnant Women. The Counselor will not be able to help me.
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 Counselor or Covered California must keep this form for six 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. These federal regulations give Covered California the right to collect and keep the information on this form: 45 C.F.R. § 155.210, 45 C.F.R. § 155.215.

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 P.O. Box 1347 Sacramento, CA 95814.

Sign and date on the lines:

Signature ____ **Date______________**

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 gave all information in this authorization form to the applicant in a language and way 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 consumer what information is Personally Identifiable Information and that this will only be used to determine eligibility for health coverage.
- I obtained oral 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______________**