Eligibility Application Confirmation Form

In order to be compliant with new CMS Requirements I must review your eligibility results prior to application submission and go through all information, requirements and make sure that you understand.

Application/Review Date: _____

Data Matching Issues Found in Eligibility Application (If Any):

Verify Citizenship:	☐	Due Date: _____
Verify Immigration Status:	☐	Due Date: _____
Verify Household Income:	☐	Due Date: _____
Verify Incarceration Status:	☐	Due Date: _____
Verify American Indian/Alaska Native Status:	☐	Due Date: _____
Verify No Minimum Essential Job-Based Coverage:	☐	Due Date: _____
Verify Social Security Number:	☐	Due Date: _____

Applicants that Qualify for Other Credible Coverage (Medicaid or C.H.I.P):

Name	DOB	SSN	Medicaid or C.H.I.P	
			Medicaid	C.H.I.P
			☐	☐
			☐	☐
			☐	☐
			☐	☐

I _____ **(Client Name)** verify that my agent _____ **(Agent Name)** went over my eligibility results document with me present and read all necessary attestations. I also verify that my monthly premium and subsidy amounts are correct and that I was made aware of any necessary action that needs to be taken once the application is submitted to keep the policy in force. I understand all the information that was provided to me and understand that I will be emailed a copy of the eligibility results along with my plan details once this meeting has ended.

Agent Signature: _____ **Date:** _____

Client Signature: _____ **Date:** _____