Date:_____

TO COMPLETE THIS FORM ONLINE - VISIT:

www.americanexchange.com/acaassessmentflorida

2017 ACA ASSESSMENT TOOL

New ☐ Renewal ☐

Only select Renewal if they are currently enrolled in a Health Insurance Plan. Do not Select *Renewal* if they have previously been enrolled in Part A or ADAP, but do not have health insurance; that applicant would be considered a *New Applicant*.

IF RENEWAL PLEASE PROVIDE:

2016 Carrier: _____

2016 Member ID #: _____

2016 Plan Name: _____

BASIC APPLICANT INFORMATION

CLIENT FIRST NAME | CLIENT MIDDLE INITIAL | CLIENT LAST NAME

CLIENT HOME ADDRESS (No P.O. Boxes) | CITY | STATE | ZIP | COUNTY

PHONE NUMBER | EMAIL ADDRESS | EMPLOYER

SOCIAL SECURITY NUMBER: - - DATE OF BIRTH: / /

PLEASE CHECK ONE:

GENDER: Male ☐ Female ☐

TOBACCO USE: Yes ☐ No ☐

CIS#: _____ Agency ID# _____

Agency Name: _____

MCM Name: _____

MCM Phone: _____

MCM Email: _____

SPECIAL ENROLLMENT PERIOD - DATE OF EVENT: / /

LOSS OF COVERAGE: ☐ PERMANENT MOVE: ☐ RELEASE FROM INCARCERATION: ☐ MARRIAGE: ☐ DIVORCE: ☐

OTHER (Please Specify): _____

HOUSEHOLD INFORMATION

Please enter any other members of your tax household.

Part A and ADAP premium assistance is for the client only. Family may appear on the policy, but their premium cost and plan expenses will not be covered.

	Name	Date of Birth	Gender (M or F)	Social Security Number	Tobacco Use (Y or N)	Relationship (Applicant, Spouse, Dependent Child)	Seeking Coverage
EX.	Jane Doe	04/12/1987	M	123-45-6789	N	Spouse	Yes
1							
2							
3							
4							
5							

HEALTH INSURANCE INFORMATION

Please check only one of the options below. You can not check both.

Health Insurance Premium Paid by **PART A** : ☐

OR

Health Insurance Premium Paid by **ADAP** : ☐

INCOME INFORMATION

Income Source	Applicant	Other in Household	Annual Gross Amount	If Other in Household, which member?
a. Salary/Wages/Tips/Commissions			$	
b. Alimony Received			$	
c. Supplemental Security Income (SSI)			$	
d. Social Security Retirement/Survivor's Income			$	
e. Social Security Disability Income SSDI Start Date / /			$	
f. Retirement or Pension			$	
g. Unemployment Benefits			$	
h. Veterans Administration (VA) Pension			$	
i. No Income of Any Kind			$	
j. Other Income:			$	

TAX INFORMATION

Did client provide a copy of Federal Income Tax **Return?**	Yes ☐	No ☐
Did client receive a Federal Income Tax **Refund** for returns on advanced premium tax credits?	Yes ☐	No ☐
Do you plan to file a Federal Income Tax return in 2017?	Yes ☐	No ☐
If you plan to file taxes, will you file Single or Married?	Single ☐	Married ☐
Do you claim any dependents on your Taxes?	Yes ☐	No ☐
If Married, will you file a joint tax return with your spouse?	Yes ☐	No ☐

OTHER QUESTIONS

Are you a legal citizen of the United States?	Yes ☐	No ☐	If No, please provide proof of legal residency in the United States.
Are you American Indian or an Alaskan Native	Yes ☐	No ☐	
Are you or anyone in your household offered Health Insurance through an employer?	Yes ☐	No ☐	If yes, who:
Do you currently have health Insurance of any kind?	Yes ☐	No ☐	If yes, what type:
Are any Females on this application currently pregnant?	Yes ☐	No ☐	If yes, who:
Would you be willing to enroll in a plan that restricts where you fill your prescription drugs? For example, Florida Blue can only be fill at Walgreen's.	Yes ☐	No ☐	If No, please explain:

PRESCRIPTION DRUG INFORMATION – ADD ADDITIONAL SHEETS IF NEEDED

NAME OF PRESCRIPTION	DOSAGE	FREQUENCY

MEDICAL INFORMATION

Client's preferred Hospital:	
Client's preferred pharmacy:	
Name of Primary Care Physician:	
Phone # of Primary Care Physician:	
Name of Infectious Disease Provider (last name/first name):	
Phone # of Infectious Disease Provider	
Does the client have any other chronic conditions, such as high blood pressure or diabetes?	
Condition #1:	
Name of Specialist:	Frequency of visit to Specialist:
Condition #2:	
Name of Specialist:	Frequency of visit to Specialist:

How often does the client see the following providers?

Infectious Disease Specialist:

Monthly ☐ Every other Month ☐ Quarterly ☐ Twice per Year ☐ Once per Year ☐

Primary Care Doctor:

Monthly ☐ Every other Month ☐ Quarterly ☐ Twice per Year ☐ Once per Year ☐

Has client been hospitalized in the last 12 months?	☐ Yes	No ☐	
Is the client at risk of hospitalization in the next 12 months?	☐ Yes	No ☐	
Does the client expect to need surgery or another major procedure in the next 12 months?	☐ Yes	No ☐	
Does the client visit urgent care or the emergency room frequently?	☐ Yes	No ☐	If yes, how often:

Is the client in ADAP and approved for ADAP/Part A Wrap Around?

Yes ☐ If Yes, and the client has already decided on a plan enter the plan below. If you or the client has not selected a plan, American Exchange will perform a needs based analysis and select an ADAP Approved plan.

_____

No ☐ If No guidance is given, American Exchange will select most comprehensive and cost effective plan based on information presented in this Assessment Tool and network fit with listed providers, within local Part A Program limitations.

_____

TO SUBMIT THIS FORM FOR PROCESSING

- **Email Form: FL@americanexchange.com**
- **Upload Form Online: www.americanexchange.com/upload-pdf/**
- **Fax : 866-408-1848**

IF YOU SUBMIT APPLICATION WITH ACCURATE INCOME INFORMATION FOR 2017 NO ADDITIONAL INCOME DOCUMENTATION SHOULD NOT BE REQUESTED. HOWEVER, IF ADDITIONAL INFORMATION IS REQUIRED, THEN AMERICAN EXCHANGE ENROLLMENT SPECIALISTS WILL REACH OUT TO THE CASE MANAGER TO MAKE SURE DOCUMENTATION IS SUBMITTED WITHIN 90 DAYS. A GUIDE FOR INCOME AND CITIZENSHIP CAN BE FOUND ON THE LINK BELOW:

http://www.americanexchange.com/wp-content/uploads/2016/07/SEP-and-Data-Mismatch-Guide-7.13.2016.pdf

By submitting this application you are allowing American Exchange to complete your health insurance enrollment. In addition, you are allowing American Exchange to share your health insurance monthly premium information and other PII with Miami – Dade County for administration of your monthly health insurance premium payment.