As employers face difficult decisions ahead, many will have to close their doors or lay off staff.

Through our Covering Kids & Families of Healthy Communities program, we are here to help people Get Covered & Stay Covered.

Covering Kids & Families of Healthy Communities helps individuals and families get coverage through Medicaid, the Healthy Indiana Plan (HIP), the Children’s Health Insurance Program (CHIP) and the Marketplace.

Even if you are not sure what you may need or qualify for, give us a call at 219-809-9094 or email ckf@healthycommunitieslpc.org.

Steps to refer employees and clients:

Have the individual complete
1. AUTHORIZATION FORM FOR HEALTH COVERAGE ASSISTANCE -Required
   a. This is a general release allowing us to contact the client
2. AUTHORIZED REPRESENTATIVE FOR HEALTH COVERAGE -Required
   a. This allows our navigator to contact the Department of Family Resources on behalf of the family. We need one completed for each family member IF POSSIBLE but must have one for the initial client.
3. AUTHORIZATION TO DISCLOSE INFORMATION –Not required but may be helpful
   a. Employers and Organizations should have person complete this if the employer or organization has documents that will assist the person in getting coverage- ex. if you have a birth certificate, paystubs etc. please take the burden off the family and send us those documents along with the form.
4. COVERING KIDS & FAMILIES OF INDIANA COVER SHEET- Not Required but may be helpful
   a. If the individual applied for coverage, complete as much as possible.

Submit forms via fax 219-809-9042 or email ckf@healthycommunitieslpc.org
Authorization Form for Health Insurance Coverage Assistance
Healthy Communities of LaPorte County
422 Franklin Street, Suite E, Michigan City, IN 46360
(219) 809-9094
ckf@healthycommunitieslpc.org

I. Consumer and Navigator Role and Responsibilities

*Healthy Communities of LaPorte County* provides health coverage outreach, education, and enrollment assistance on behalf of Covering Kids & Families of Indiana. Through *Healthy Communities of LaPorte County*, you have access to a certified Indiana Navigator who can (and must) give you fair, accurate, and unbiased information regarding the health coverage options available to you. *Healthy Communities of LaPorte County* can also help you complete your application and maintain enrollment. These services are free of charge.

*Healthy Communities of LaPorte County* is here to help, but you are responsible for providing the information and records needed to complete your health coverage application and meeting your FSSA appointments and enrollment deadlines. **HEALTHY COMMUNITIES OF LAPORTE COUNTY** MAKES NO REPRESENTATION OR WARRANTY OF ANY KIND, EXPRESS OR IMPLIED, INCLUDING, WITHOUT LIMITATION, ANY WARRANTY OF QUALITY OR FITNESS FOR A PARTICULAR PURPOSE.

You do not have to provide *Healthy Communities of LaPorte County* with information that you do not want to provide. However, if you provide information that is inaccurate or incomplete, *Healthy Communities of LaPorte County* may not be able to offer all the help that is available for your situation. You will be asked to provide only the minimum amount of personal information that is necessary to help with your health insurance application and enrollment, ensure quality control, and collect demographic information.

II. Consent to Coverage Assistance

I, ____________________________________________, have read and understand the information above, and I give my permission to *Healthy Communities of LaPorte County*, including the individual Navigators who are a part of *Healthy Communities of LaPorte County*, to create, collect, disclose, access, maintain, store, and/or use my personally identifiable information to help me find and maintain health coverage.

Signature: _______________________________ Date: __________________________

Address: ______________________________________________________________

Phone Number: __________________________ Email Address: __________________

(Note: You do not need to enter your phone number or email address to receive services, but if you do not provide this information, it may be difficult for the Navigator to get in touch with you.)
Section 1
If you want someone to act on your behalf in applying for benefits and/or act for you on an ongoing basis, this form must be completed. Be sure to select the function(s) that the representative is being authorized to do. You can select more than one representative and choose the same or different functions. The representative may be an individual or an organization. Complete ONE form per authorized representative. Both you and your representative must sign and date this form.

Section 2
Name of Representative (Please print clearly)

Covering Kids and Families of Healthy Communities

Check association with applicant/recipient. Please select ONE (1).

- Attorney
- Eligibility Assistance Company
- Friend
- Institution of Residence
- Waiver Case Manager
- Other (Specify): Navigator

Mailing Address (number and street, city, state, and ZIP code)
422 Franklin Street Suite E, Michigan City, In 46360

<table>
<thead>
<tr>
<th>FUNCTION</th>
<th>FUNCTION DESCRIPTION</th>
<th>HEALTH COVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPLY</td>
<td>Sign application and be interviewed.</td>
<td>Apply ✓</td>
</tr>
<tr>
<td></td>
<td>Provide all required proof of information necessary to determine eligibility for benefits.</td>
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</tr>
<tr>
<td></td>
<td>Receive the Notice of the application decision.</td>
<td></td>
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<tr>
<td></td>
<td>Speak on applicant's behalf at a hearing if the application decision is appealed.</td>
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</table>

| ONGOING        | Report changes. | Ongoing ✓ |
|                | Attend periodic redeterminations. | |
|                | Receive the appointment notices and any redetermination mail-in forms. | |

In agreeing to be the authorized representative, I understand that I am expected to be knowledgeable of the applicant's/recipient's circumstances and that this authorization can be revoked by the applicant/recipient at any time. I agree to maintain or be legally bound to maintain the confidentiality of any information regarding the applicant/recipient provided by the Division of Family Resources.

Signature: Angela McCarnell Oches
Date (mm/dd/yyyy): 9/27/2021
Telephone: 219-809-9094

Section 3
I authorize this representative to act for me in taking care of the functions and program eligibility process which I have checked above. (If applicant/recipient is medically incapable to sign authorization, provide medical documentation.) I understand that I am responsible for the information anyone acting as my authorized representative gives, including any information that may be incorrect. I also understand that if at any time I wish to stop the person(s) I chose from being my authorized representative, it is my responsibility to contact the Division of Family Resources.

<table>
<thead>
<tr>
<th>Applicant/Recipient Name</th>
<th>Applicant/Recipient Signature</th>
<th>Date (mm/dd/yyyy)</th>
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<thead>
<tr>
<th>Case Number (Optional)</th>
<th>Applicant/Recipient Date of Birth (mm/dd/yyyy)</th>
<th>Applicant/Recipient Social Security Number</th>
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DFRAZAE01
Authorization to Disclose Information

I, __________________________, hereby authorize Healthy Communities of LaPorte County, a local agency acting on behalf of CKF-IN, ("Healthy Communities of LaPorte County") to disclose and/or discuss certain information about me ("My Information") as indicated by my selection below:

☐ Healthy Communities of LaPorte County may disclose and/or discuss My Information with the following individual(s) who are involved in helping me obtain or maintain insurance coverage:

   Name __________________________   Relationship __________________________
   Phone __________________________   Email __________________________

   Name __________________________   Relationship __________________________
   Phone __________________________   Email __________________________

☐ Healthy Communities of LaPorte County may disclose My Information to social services providers for purposes of community supports such as public benefits, transportation, housing, counseling, or employment services.

My Information

Healthy Communities of LaPorte County may disclose information about or related to my eligibility for health coverage under Indiana Health Coverage Programs or through the Marketplace and the current status of my application or enrollment with Indiana Health Coverage Programs.

Right to Revoke Authorization and Expiration

I understand that I have the right to revoke this authorization, except to the extent that Healthy Communities of LaPorte County has already disclosed My Information in reliance on this authorization. This authorization may be revoked by sending a written request for revocation to Healthy Communities of LaPorte County by mail: 422 Franklin St Suite E, Michigan City, Indiana 46360.

This authorization will remain in effect unless and until I revoke the authorization through the process described above.

My Information May Be Re-Disclosed

I understand that uses or disclosures of My Information pursuant to this authorization may be subject to re-disclosure by a person who receives My Information. I understand that this re-disclosure may or may not be protected by the applicable privacy laws.

This Authorization Is Optional

I understand that that Healthy Communities of LaPorte County does not require me to authorize the disclosure of My Information. Healthy Communities of LaPorte County does not condition its services on whether I sign this authorization. However, I acknowledge that I have agreed to sign this authorization.

This Authorization Must be Signed and Dated

This authorization is effective when signed and dated by the individual named above.

If the individual is at least 18 years of age:

Signature: __________________________   Date: ________________

If the individual is under 18 years of age:

Signature of Legal Representative: __________________________   Date: ________________

If signed by a Legal Representative, indicate the relationship to the individual who is the subject of the disclosure: ☐ parent  ☐ legal guardian ☐ other: ________________

Reminder: A copy of this authorization must be provided to the individual who signed it.
<table>
<thead>
<tr>
<th>CLIENT NAME:</th>
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<tr>
<td>DOB:</td>
</tr>
<tr>
<td>SSN:</td>
</tr>
<tr>
<td>ADDRESS:</td>
</tr>
<tr>
<td>PHONE NUMBER (cell/home):</td>
</tr>
<tr>
<td>CASE CONFIRMATION NUMBER (when app is entered):</td>
</tr>
<tr>
<td>CASE ID NUMBER (when app is approved):</td>
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<tr>
<td>INSURANCE TYPE:</td>
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<tr>
<td>HIP</td>
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<td>MEDICAID</td>
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<td>HHW</td>
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NOTES: