



## **Certified Application Counselor (CAC) Program Designated Organization Application**

Instructions: Organizations interested in being selected as Designated Organizations must complete and email the following application and the signed Certified Application Counselor Designated Organization Agreement to CAC@dc.gov. For more information on the Certified Application Counselor Program, due dates, and criteria, please visit <http://dchbx.com>.

### ***Organization Information***

Organization Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Administrative Physical Address: \_\_\_\_\_

Type of Organization (Government Agency/Health Services Provider/Social Services Organization/Other – please specify): \_\_\_\_\_

Is your organization a Federally Qualified Health Center receiving HRSA funding for outreach and enrollment? Yes  No

Is your organization a DC Health Link Assister Program Grantee? Yes  No

### ***Primary Contact Information***

Last Name: \_\_\_\_\_, First Name: \_\_\_\_\_, Title: \_\_\_\_\_

Email Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### ***Organization Information***

Please briefly describe your organization and its mission. Include in your description how many years your organization has existed and the number of staff and volunteers in the organization

Does your organization currently help individuals or families with financial assistance, application assistance, or enrollment into financial or health programs? Yes  No

Does your organization have policies and procedures in place to protect the privacy of customer information? Yes  No

If yes, please attach to this application.

Does your organization have policies and procedures in place for staff and volunteer FBI fingerprint-based background checks? Yes  No

If no, does your organization agree to develop policies and procedures for staff and volunteer FBI fingerprint-based background checks for those who will serve as CACs? Yes  No

Does your organization have a non-discrimination and inclusion policy that meets federal requirements? Yes  No

Does your organization have ADA accessibility and have policies and practices in place to provide reasonable accommodations that meet ADA requirements? Yes  No

Will your organization agree to refer customers with unmet language interpretation or translation needs to DC Health Link customer service network? Yes  No

Does your organization have general liability insurance in the coverage amounts required? Yes  No

If yes, please attach proof of insurance to this application.

Does your organization agree to provide reporting to DC Health Link and undergo audit of practices on the request of DC Health Link? Yes  No

### ***Organization Disclosures***

Designated organizations are required to disclose conflicts of interest to DC Health Link and to customers.

Is your organization a health insurance issuer, issuer of stop loss insurance, a subsidiary of a health insurance issuer or issuer of stop loss, or an organization that lobbies on behalf of the industry? Yes  No

Does your organization receive compensation directly or indirectly from health insurance issuers or issuers of stop loss insurance? Yes  No  If yes, describe here: \_\_\_\_\_ .

Disclose any funding your agency receives to provide consumer assistance to individuals or households applying/enrolling in health insurance.

### ***Organization Operations***

Please describe how you plan to provide application assistance to customers including: informing customers about your role as a CAC, disclosing conflicts of interest prior to providing assistance,\* ensuring no payment or other consideration is made with respect to the assistance, and the assistance is provided in the best interest of the customer.

Please describe how you will ensure your staff or volunteers have successfully completed training and other certification requirements, and are decertified if necessary.

How many people do you intend to have trained?

*I affirm that I am authorized to submit this application on behalf of the applicant organization and that all of the information contained herein is true and correct.*

Signature/title: \_\_\_\_\_ Date: \_\_\_\_\_

*Please submit this signed application and the signed agreement to [CAC@dc.gov](mailto:CAC@dc.gov).*

\*A sample Conflict of Interest Form is attached.

**Attachment**

**Sample Conflict of Interest Form**

I, \_\_\_\_\_, a Certified Application Counselor, hereby disclose to \_\_\_\_\_, a customer of DC Health Link that I am assisting, that I have the following conflict(s) of interest:

- I have a relationship with the following Qualified Health Plan (QHP) or insurance affordability program:

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(list name of QHP or program and describe the relationship)

I, the undersigned customer, acknowledge that I am aware of the conflict that the Certified Application Counselor has, and I consent to being assisted by the Counselor anyway.

\_\_\_\_\_  
Name of Customer

\_\_\_\_\_  
Date