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, please visit https://hbx.dc.gov/page/certified-application-counselor-program.

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 volunteers to undergo background checks that include an FBI fingerprint-based background check, a state and local background check by DC Metropolitan Police Records Department, and a check of the Department of Justice National Sex Offender Public Website (NSOPW)? Yes ☐ No ☐

If no, does your organization agree to develop policies and procedures for staff and volunteers to undergo the requisite background checks stated above? 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 language interpretation or translation needs to the DC Health Link Contact Center? 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.

*A sample Conflict of Interest Form is attached.

Attachment

DC Health Link Certified Application Counselor

Conflict of Interest Disclosure

A. "Conflict of interest" means having a private or personal interest sufficient to influence, or appear to influence, the objective exercise of an Assister/Navigator/CAC's official duties. Federal requirements require that an Assister/Navigator/CAC disclose some types of information about their business relationships or the business relationships of certain family members to the Exchange and any consumers that receive application assistance from that individual.

B. I, _____ attest that as an Assister/Navigator/CAC affiliated with _____ (Name of Organization) that:

- I do not intend to sell any lines of insurance, including those covered by the prohibitions on conduct in 45 CFR §155.210(d) while carrying out my consumer assistance functions;

- I do not have any existing employment relationships or former employment relationships within the last five years with any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance, including any existing employment relationships between a spouse or domestic partner and any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance; and

- I do not have any existing or anticipated financial, business, or contractual relationships with one or more health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance.

If any of the above statements are not true, I am disclosing to the Exchange the following regarding my business relationships and/or financial or contractual relationships below (please attach an additional page if necessary):

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C. The undersigned attests that the above is true and accurate and agrees that if any additional need for disclosures arises after the date of this signature, the Assister/Navigator/CAC shall immediately make a full disclosure in writing to their Assister/Navigator/CAC-designated organization and the DC Health Benefit Exchange Authority of all additional information.

Date:_____By:_____