Assister Case Association Form (10-2016)

This form should not be submitted if an assister has already used another form of associating with the consumer's application or enrollment (see Policies and Procedures on Navigator One Stop).

From:

ASSISTER NAME*	PHONE NUMBER*	EXTENSION	ASSISTER ID NUMBER*
ASSISTER ORGANIZATION*	ASSISTER EMAIL ADDRESS*		

Re:

PRIMARY APPLICANT NAME*	DATE OF BIRTH*	DATE OF APPLICATION (IF KNOWN)
ADDRESS (STREET, CITY, STATE, ZIP CODE)*		

List all additional household members who are applying for or enrolling in health care coverage:

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
NAME	DATE OF BIRTH	NAME	DATE OF BIRTH

Please select the reason for using this form (only one reason should be selected):

- ☐ Assisted with submitting a paper Renewal Form for a consumer in a "Need to Renew" status.
- ☐ Assisted with submitting a Minnesota Health Care Programs Application for Certain Populations (DHS-3876).
- ☐ Assisted a consumer who submitted an Application for Health Coverage and Help Paying Costs (DHS-6696 or DHS-6741) and the assister was not entered on Appendix C.
- ☐ Assisted a consumer who submitted an online application through MNsure.org and the Assister ID and organization were not entered on the signature page and the assister and consumer were not associated through the assister portal at the time the application was submitted.
- ☐ Assisted a renewing consumer with actively selecting a qualified health plan for the new plan year and the assister and consumer were not associated through the assister portal at the time the enrollment was completed.

With the submission of this form, the identified assister is associated with the case for the purposes of payment and information sharing (a separate Authorization for Release of Information, DHS-3549, will be requested by DHS or the county).

Both the assister and primary applicant must sign this form (electronic signatures are not acceptable).

ASSISTER'S SIGNATURE*	DATE*
PRIMARY APPLICANT'S SIGNATURE*	DATE*

All required (*) fields must be completed or the form cannot be processed.
Fax completed form to the Assister Resource Center within 30 days at 651-431-7572.

1-855-366-7873

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណាត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တကွ်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တီလံာ်မီတခါအံၤန္ဉ်,ကိးဘဉ်လီတဲစိနီၢ်ဂ်ၢ်လၢထးအံၤန္ဉ်တကွ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (8-16)

ADA Advisory

For accessible formats of this publication or assistance with additional equal access to human services, write to AEO@MNsure.org, call 855-366-7873 (MNsure Contact Center) or use your preferred relay service. (ADA1 [9-15])