Consent 2 - Consumer Personal Information Authorization

CFS, Corp.
105 Broadway Street | Vincennes, IN 47591
812-790-2599

Individual Navigator Name and Certification Number:

Navigator: ______________________________ Cert#: ____________________

Client Name: ______________________________ Date: ____________________

I. Acknowledgement of Roles and Responsibilities of Navigators

Navigators exist for the purpose of helping consumers explore their insurance options. These professionals can help you navigate the health insurance Marketplace and Indiana's insurance programs. Navigators are not insurance agents or brokers. They do not sell policies, nor do they receive any payments from insurance companies. Navigators can (and are mandated by law to) give you unbiased information about insurance programs that are tailored to meet your specific needs. A Navigator can screen you for assistance programs that can make your insurance copays or premiums more affordable. This service is absolutely free of charge. Navigators are funded through federal grant funds and must complete comprehensive Navigator training, criminal background checks, and state training and registration prior to assisting consumers.

II. Authorizations- General Consent

I give my permission to CFS, Corp. to collect, disclose, access, maintain, store, and/or use my personal information to help me find and maintain health coverage, unless I limit my consent. I understand that CFS, Corp. will only use my information to help qualify for programs, ensure quality control, follow up to ensure adequate coverage, and collect demographic information for research purposes. I can revoke my consent at any time by notifying CFS, Corp. that I wish to do so. I understand that CFS, Corp. might need to ask about and keep notes on my health coverage needs and language preferences in order to help me.

III. Exceptions or Limitations to Consent

I understand that I can revoke, limit or otherwise change the consents I provide through this form at any time. If I don't make any limitations, exceptions, or changes to my consent now, I can still do so at any time in the future by notifying CFS, Corp. I make the following exceptions, limitations, or changes:

____

Additional Information

I understand that:

- I don't have to provide the Navigator or CFS, Corp. staff with any information that I do not want to provide. However, if the information given is inaccurate or incomplete, the Navigator may not be able to offer all the help that is available for my situation.
- I understand that CFS, Corp. will ask me to provide only the minimum amount of my personal information that is necessary to help me, ensure quality control, and collect demographic information.
- I understand that CFS, Corp. may need to access my login information for the FSSA Benefits Portal for the Indiana Healthcare Application.
- CFS, Corp. will make sure that my personal information is kept private and secure in a way that adheres to federal and state law.
- If CFS, Corp. does not have the resources or skills to help me right away, they will refer me to another Federal Navigator or to the Federal Marketplace Call Center in order to meet my needs sooner. If the Navigator needs to refer me to another source of help, he or she will refer me to the source that is the easiest for me to access. I understand that the Navigator might need to share my contact information and information about my needs with possible referral sources in order to help me.

I have read the above material, acknowledge I can receive a copy of the authorization, understand its implications, and have been given the opportunity to ask questions. I fully understand the information listed above.

Client Signature:________________________________ DOB: ____________ Date: __________

Printed Name:__________________________________ SSN: ____________________________

Address: ____

Phone Number: ___________________________ Email Address: _________________________

I witness the fact that the client received the above mentioned information and said that it was read and understand the same.

Reviewed by: ___________________________ Date: __________________________

Others Applying for Health Coverage

Name: __________________________ SSN: ______________________ DOB: ________________

Name: __________________________ SSN: ______________________ DOB: ________________

Name: __________________________ SSN: ______________________ DOB: ________________

Name: __________________________ SSN: ______________________ DOB: ________________

Name: __________________________ SSN: ______________________ DOB: ________________