Date:_____

TO COMPLETE THIS FORM ONLINE - VISIT:

www.americanexchange.com/missouri

2025 ACA ASSESSMENT TOOL

New or Renewal

-Only select Renewal if they are currently enrolled in a Marketplace Health Insurance Plan.
-Do not select Renewal if they are enrolled in an off Marketplace plan or were not enrolled in a Marketplace plan in the current year.

2024 Carrier: _____
2024 Member ID#: _____
2024 Plan Name: _____

Do you currently have Medicaid (If so, this assessment will be used for re-certification purposes)?

Client's Preferred Health Insurance Carrier for 2025 :

PRIMARY APPLICANT INFORMATION

CLIENT FIRST NAME | CLIENT LAST NAME

CLIENT NAME AS IT APPEARS ON ID, IF DIFFERENT FROM ABOVE:

CLIENT HOME ADDRESS (No P.O. Boxes) | CITY | STATE | ZIP | COUNTY

PHONE NUMBER | EMAIL ADDRESS

SOCIAL SECURITY NUMBER:

DATE OF BIRTH:

TOBACCO USE:

IF YES, DATE OF LAST USE:

GENDER FOR HEALTH INSURANCE PURPOSES:

CM NAME:
CM PHONE:
CM EMAIL:
REGION:
AGENCY:
ASSISTOR NAME:
ASSISTOR EMAIL:

HOUSEHOLD INFORMATION

Please enter any other members in your tax household. Your tax household includes the people that appear on your tax return.

Full Name	Date of Birth	Gender	SSN	Tobacco Use	Relationship

INCOME LEVEL

Primary Applicants whose FPL is at or below 138% FPL will have a full Medicaid Determination submitted on their behalf per programmatic requirements. Additionally, clients meeting criteria for Medicaid Expansion MUST sign the Authorized Representative form allowing AE to communicate with the Missouri Department of Social Services, Family Support Division on their behalf. This form must be submitted with this pre-assessment form to receive continued support through the Missouri ADAP Program for health insurance premium and cost-sharing assistance

PERSONS IN HOUSEHOLD	1	2	3	4	5	6	7	8	9	10
ESTIMATED ANNUAL INCOME	$15,060	$20,440	$25,820	$31,200	$36,580	$41,960	$47,340	$52,720	$58,100	$63,480

INCOME INFORMATION

Income Type	Income Earner	Gross Amount	Frequency	Name of Employer or Nature of Self Employment
Salary/Wages/Tips/Commissions	Applicant		Annually	
Salary/Wages/Tips/Commissions	Applicant		Annually	
Salary/Wages/Tips/Commissions	Applicant		Annually	
Salary/Wages/Tips/Commissions	Applicant		Annually	

Do you have assets? **Specify asset amount:** **Specify source of assets:**

If you selected "No", did you have taxable income previously in the last 90 days?

The specified amount: **Source of taxable income:**

UPLOAD PROOF OF INCOME HERE: https://americanexchange.com/clients/missouri/upload/

TAX INFORMATION

2025 Tax Filing Status:

Does the client plan to file Federal Income Taxes for 2025? If No, the client is not eligible for premium assistance. Did the client provide a copy of their 2023 Federal Income Tax Return?

Did the client receive a Federal Income Tax Refund for returns on Advance Premium Tax Credits?

CITIZENSHIP AND OTHER QUESTIONS

Select your Citizenship Status:

If Naturalized/Derived, then list type of Documentation:

Name as it appears on your documentation:

Alien Number/USCIS #:

I-94/Admission Number:

Category Code:

Card Number:

Document Expiration Date:

Passport Number:

UPLOAD PROOF OF DOCUMENTATION HERE:

For more information on the types of accetpable documentation, visit: https://www.healthcare.gov/help/immigration-document-types/

Is the client a Native American or Alaskan Native?

Is anyone in the client's tax household offered coverage through an employer?

Is the client or any other female household applicant(s) currently pregnant?

PRESCRIPTION DRUG INFORMATION – ADD ADDITIONAL SHEETS IF NEEDED

Please include all HIV ARVs and Boosters including any One a Day medication.
Examples: Atripla, Biktarvy, Complera, Delstrigo, Genvoya, Juluca, Odefsey, Stribild, Symtuza, Triumeq or Cabenuva

NAME OF PRESCRIPTION	DOSAGE	FREQUENCY

MEDICAL INFORMATION

Client's preferred Hospital:	
Client's preferred pharmacy:	
Name of Primary Care Physician:	
Phone # of Primary Care Physician:	
Name of HIV Specialist/ID, if different from PCP:	
Phone # of HIV Speciailist	
Does the client have any other chronic conditions, such as high blood pressure or diabetes?	

DISCLAIMERS AND NOTICES

Please answer the following question and check each box next to each statement to indicate that the client understands each disclaimer.

Is the client in ADAP and approved for ADAP/Part B Wrap Around?

Yes ☐ If Yes, and the client has already decided on a plan enter the plan below. If you or the client has not selected a plan, American Exchange will perform a needs based analysis and select an ADAP Approved plan.

_____

No ☐ If No guidance is given, American Exchange will select most comprehensive and cost effective plan based on information presented in this Assessment Tool and network fit with listed providers, within local Part B Program limitations.

_____

I acknowledge:

☐ *By submitting this application you are allowing American Exchange to complete your health insurance enrollment. In addition, you are allowing American Exchange to share your health insurance monthly premium information and other PHI with Healthcare Strategic Initiatives (HSI) for administration of your monthly health insurance premium payment.*

☐ *I understand that American Exchange will keep my personal and health information it obtains regarding my medical diagnosis(s) and other medical or cost information confidential.*

☐ *I also understand that without my prior written consent, American Exchange will not release the above information to any person or entity other than HSI.*

☐ *I understand that American Exchange is merely acting in an administrative role to assist with processing my health insurance enrollment as part of the Ryan White Health Insurance Continuation Program and that American Exchange does not in any manner accept responsibility or liability for maintaining my insurance coverage or paying for any medical care, and accordingly, I hereby release American Exchange from any liability, should my insurance policy lapse, be canceled or terminated, regardless of the reason for such lapse, cancellation or termination.*

☐ *By submitting this application you are allowing American Exchange to complete your health insurance enrollment. In addition, you are allowing American Exchange to share your health insurance monthly premium information and other PHI with Missouri Part B/ADAP for administration of your monthly health insurance premium payment*

☐ *I understand that American Exchange may contact me to obtain information updates as it pertains to securing or maintaining my insurance plan and/or Advance Premium Tax Credit.*

☐ *By submitting this application, I hereby designate and appoint AE Insurance, LLC dba American Exchange, its agents and employees (collectively "Representatives") to represent me and act in my behalf before any health insurance carrier, The Health Insurance Marketplace or with a relevant Health Department, Case Manager or Healthcare Provider for the purpose of potentially securing or modifying healthcare benefits for me and/or my household*

☐ *Please attach or upload proof of income if your income is over zero, or has been 90 days prior to this assessment being submitted. Income Documentation can include paystubs, bank statements, W2s, 1040 tax form, or Income Attestation Form (as a last resort). I understand that if I do not provide sufficient proof of income or upload Signed Authorization Forms for American Exchange to complete a Medicaid Application on my behalf I will not be enrolled in an ACA Plan.*

☐ *I, the client, understand and agree that I am giving American Exchange permission to complete a Medicaid Application as well as act as my Authorized Representative. I understand and agree that I am authorizing American Exchange to be responsible for helping apply and/or re-certify for MO HealthNet Coverage, act on my behalf if I/we get MO HealthNet, including annual reviews and reporting changes, and access FSD account online communications.*

Client Signature: Date: