

## Statement of Good Faith Effort

### American Indian/Alaska Native Enrollment Verification

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American Indians and Alaska Natives (AI/AN) applying for medical coverage through *Washington Healthplanfinder* must provide verification of enrollment in a federally-recognized tribe or Alaska Native Corporation within 90 days of receiving notice from the *Washington Healthplanfinder* that it was unable to verify AI/AN enrollment.

If you are unable to verify your AI/AN enrollment within the required 90-day time period, please tell us why. Please indicate what efforts you have made to obtain required proof of tribal enrollment documents. These efforts may include (1) written requests; (2) phone calls; and/or (3) personal contact. Please attach any documentation to demonstrate these efforts including copies of your written requests and a letter from the health clinic staff explaining the attempts made to obtain evidence of tribal enrollment.

Complete the information below for each household member that receives medical coverage and does not have proof of tribal enrollment.

#### 1. Household Member

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First name	Last name	Date of birth (mm/dd/yyyy)
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Tell us why this household member was unable to provide verification of tribal enrollment:

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#### 2. Household Member

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First name	Last name	Date of birth (mm/dd/yyyy)
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Tell us why this household member was unable to provide verification of tribal enrollment:

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#### 3. Household Member

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First name	Last name	Date of birth (mm/dd/yyyy)
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Tell us why this household member was unable to provide verification of tribal enrollment:

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Use a separate sheet for additional household members.

### Read and Sign Below

I declare, under penalty of perjury, the information above for each person is true, correct and complete to the best of my knowledge. I understand that I may continue to try to get any necessary documentation unless the *Washington Healthplanfinder* tells me that they already have the necessary documentation.

First name	Middle initial	Last name
Daytime phone number	Email address	
Signature <b>X</b>		Date of Signature (mm/dd/yyyy)

### Submit statement to:

**Washington Health Benefit Exchange**

Mail: PO Box 657, Olympia, Washington 98507

## Discrimination is Against the Law

The Washington Health Benefit Exchange/Health Care Authority complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Washington Health Benefit Exchange/Health Care Authority does not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

The Washington Health Benefit Exchange/Health Care Authority also complies with applicable state laws and does not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained dog guide or service animal by a person with a disability.

The Washington Health Benefit Exchange/Health Care Authority:

- Provides free aids and services to people with disabilities so they can communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact 1-855-923-4633.

If you believe that the Washington Health Benefit Exchange/Health Care Authority has failed to provide these services or discriminated in another way, you can file a grievance with:

Washington Health Benefit Exchange Legal Department ATTN: Legal Division Equal Access/Equal Opportunity Coordinator  PO Box 1757 Olympia, WA 98507-1757 1-855-859-2512 Fax: 360-841-7653 <a href="mailto:appeals@wahbexchange.org">appeals@wahbexchange.org</a>	Health Care Authority Division of Legal Services  ATTN: Compliance Officer  PO Box 42700 Olympia, WA 98504-2700 1-855-682-0787 Fax: 360-586-9551 <a href="mailto:compliance@hca.wa.gov">compliance@hca.wa.gov</a>
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You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Washington Health Benefit Exchange Legal Department/Health Care Authority Division of Legal Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at [www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).

ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-855-923-4633 (TTY: 1-855-627-9604).

Spanish - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-923-4633 (TTY: 1-855-627-9604).

Chinese - 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-855-923-4633 (TTY: 1-855-627-9604)。

Vietnamese - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-923-4633 (TTY: 1-855-627-9604).

Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-923-4633 (TTY: 1-855-627-9604)번으로 전화해 주십시오.

Russian - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-923-4633 (телетайп: ТТУ: 1-855-627-9604).

Tagalog - PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-923-4633 (TTY: 1-855-627-9604).

Ukrainian - УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-923-4633 (телетайп: ТТУ: 1-855-627-9604).

Cambodian (Khmer) - ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរសំរាប់ជំនួយផ្នែកភាសាដោយមិនគិតល្បួល, គឺអាចមានសំរាប់បម្រើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-923-4633 (TTY: 1-855-627-9604)។

Japanese - 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-855-923-4633 (TTY: 1-855-627-9604) まで、お電話にてご連絡ください。

Amharic - ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-855-923-4633 (መስማት ለተሳናቸው: TTY: 1-855-627-9604)።

Oromo - XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-923-4633 (TTY: 1-855-627-9604).

Somali - MUHIIM AH: Haddii aad ku hadashid Af-soomaali, adeegaha caawimaada luuqada, ee lacag la'aanta ah, ayaad heli kartaa. Wac 1-855-923-4633 (TTY: 1-855-627-9604).

Arabic - ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-923-4633 (رقم هاتف الصم والبكم: TTY: 1-855-627-9604).

Punjabi - ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-923-4633 (TTY: 1-855-627-9604) 'ਤੇ ਕਾਲ ਕਰੋ।

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-923-4633 (TTY: 1-855-627-9604).

Lao - ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອ ອັດຕະໂນພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ຈະມີ ພ້ອມໃຫ້ທ່ານ. ໂທ 1-855-923-4633 (TTY: 1-855-627-9604).

French - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-923-4633 (TTY : 1-855-627-9604).

Hindi - ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-923-4633 (TTY: 1-855-627-9604) पर कॉल करें।

Farsi (Persian) - توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-923-4633 تماس بگیرید.

Romanian - ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-923-4633 (TTY: 1-855-627-9604).