

**The Governor’s Office of Volunteer Services**

Member Health Care

AmeriCorps programs must provide, or make available, healthcare insurance to those members serving a 1,700-hour full-time term who are not otherwise covered by a healthcare policy at the time the member begins his/her term of service.

The subgrantee must also provide, or make available, healthcare insurance to members serving a 1,700-hour full-time term to hose members who lose coverage during their term of service as a result of service or through no deliberate act of their own. CNCS will not cover healthcare costs for dependent coverage.

As outlined in § 2522.250 an AmeriCorps member is eligible for childcare benefits if he or she:

* Is a full-time member;
* Is the parent or legal guardian of, or is acting in loco parentis for, a child under 13 who resides with the participant;
* Is not receiving childcare from another available source at the time of acceptance into the program, including a parent or guardian, which would continue to be provided while the participant serves in the program; and
* Has a family income that does not exceed 75 percent the State’s median income for a family of the same size.

|  |  |
| --- | --- |
| Please select one | |
| I am accepting the health care insurance provided through <<Insert Program Name>>. I verify that I am not otherwise covered by a health care policy at the time I begin my term of service.   |  |  | | --- | --- | | Healthcare Insurance Effective Date  Click or tap to enter a date. | Healthcare Insurance End Date  Click or tap to enter a date. |   I am declining the health care insurance provided through <<Insert Program Name>>, effective the signature date. I verify that I am covered by a Minimum Essential Coverage compliant health care policy through one of the following options: staying on parents’ or spouse plan; insurance obtained through the Federal Health Insurance Marketplace of at least the Bronze level plan; insurance obtained through private insurance broker; Medicaid, Medicare or military benefits. I have provided <<Insert Program Name>> with documentation of my health care insurance. I understand I am required to maintain healthcare insurance, and if I lose my current coverage during my term of service as a result of service or through no deliberate act of my own, I must notify <<Insert Program Name>>. I understand that if I decline healthcare coverage, I am not entitled to receive that portion of the health care benefit that I elected to forego during the waiver period. | |
| AmeriCorps Member Name Printed  Click or tap here to enter text. | |
| AmeriCorps Member Signature  X | Date Signed  Click or tap to enter a date. |