# Georgia Access CDO Application Form

Instructions: Complete the information below. **All items below are required unless marked with an asterisk (\*).**

# Section 1: Applicant Information

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| 1. **Basic Information**
 |
| 1. **Organization’s Legal Name**
 |  |
| 1. **Organization’s Employer Identification Number (EIN)**
 |  |
| 1. **Website URL**
 |  |
| 1. **Total Number of Planned Individual CACs**
 |  |
| 1. **Proposed Service Area** (Please list the specific regions, cities, and/or counties)
 |  |
| 1. **Number of In-Person Sites** (list individual site addresses in Section 2)
 |  |
| 1. **Physical Address**
 |
| Street |  |
| City |  |
| State |  |
| County |  |
| Zip / Postal Code |  |
| **Mailing Address\*** (if different from above; P.O. Boxes allowed) |
| Street |  |
| City |  |
| State |  |
| Zip / Postal Code |  |
| 1. **Organization Type** (Non-Profit / For-Profit / Other)
 |  |
| 1. **Is the organization a current or past CDO?**
 | **Yes** | **No** |
|  |  |
| If yes, please provide the CDO ID number |  |
| 1. **Is the organization also applying for Navigator Grant funding this plan year?**
 | **Yes** | **No** |
|  |  |
| 1. **Application Point of Contact**
 |
| 1. **Point of Contact**
 |
| Last Name |  |
| First Name |  |
| 1. **Job Title**
 |  |
| 1. **Telephone Number**
 |  |
| 1. **Email Address**
 |  |
| 1. **General Public Contact Information**
 |
| 1. **Phone Number**
 |  |
| 1. **Email Address**
 |  |
| 1. **Website URL**
 |  |
| 1. **Social Media**
 |  |
| 1. **Physical Address**
 |
| Street |  |
| City |  |
| State |  |
| County |  |
| Zip / Postal Code |  |
| 1. **Communities Served** (i.e. HIV/AIDS, Elderly, Homeless)
 |  |
| 1. **Does the organization maintain current hours of operation?**
 | **Yes** | **No** |
|  |  |
| If no, when do you expect to have the organization’s hours of operation established and publicly available? |
|  |
| If yes, please provide the hours of operation below. |
|  | **Hours Open** |
| Sunday |  |
| Monday  |  |
| Tuesday |  |
| Wednesday |  |
| Thursday |  |
| Friday |  |
| Saturday |  |
| 1. **Organization Details**
 |
| 1. **Is the organization a health care delivery organization?**
 | **Yes** | **No** |
|  |  |
| 1. **Is the organization designated by the Georgia Department of Community Health as a Medicaid and PeachCare for Kids® application assistance program?**
 | **Yes** | **No** |
|  |  |
| 1. **Privacy and Security Standards**
 |
| **Does the organization currently:** |
| 1. **Have a process in place to protect Personally Identifiable Information (PII)?**
 | **Yes** | **No** |
|  |  |
| 1. **Comply with privacy and security standards consistent with CFR 45 155.260, and applicable authentication and data security standards required by federal regulation?**
 | **Yes** | **No** |
|  |  |
| **Describe your organization’s Privacy and Security policies and procedures.** |
|  |

# Section 2: Project Site(s)

You may duplicate the table below as needed to list all project site locations.

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| 1. **Primary Performance Site Location**
 |
| 1. **Organization Name**
 |  |
| 1. **Employer Identification Number (EIN)**
 |  |
| 1. **Physical Address**
 |
| * 1. Street
 |  |
| * 1. City
 |  |
| * 1. State
 |  |
| * 1. Zip / Postal Code
 |  |
| * 1. County
 |  |
| 1. **CDO Service Area**
 |
| * 1. List all counties served by this site (in alphabetical order)
 |  |

# Section 3: Attestations & Signature

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| 1. **OCI Reporting**
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| **As the duly Authorized Representative, I agree that the organization will:** * Maintain a registration process and method to track the participation of CACs.
* Provide quarterly data and information to the State regarding the number and performance of its CACs and regarding the consumer assistance provided by CACs, upon request, in the form and manner specified by the State.
 |
| 1. **Conflict of Interest Disclosure**
 |
| **As the duly Authorized Representative, I certify that the organization:** * Does not intend to sell any lines of insurance, including those covered by the prohibitions on conduct in 45 CFR §155.210(d) while carrying out consumer assistance functions
* Does not have any existing employment relationships or former employment relationships within the last five years with any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance, including any existing employment relationships between a spouse or domestic partner and any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance; and
* Does not have any existing or anticipated financial, business, or contractual relationships with one or more health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance.
 |
| **If any of the above statements are not true, I am disclosing to Georgia Access the following regarding my business relationships and/or financial or contractual relationships below.** |
|  |
| **The undersigned attests that the above is true and accurate and agrees that if any additional need for disclosures arises after the date of this signature, the organization shall immediately make a full disclosure in writing to Georgia Access of all additional information.** |
| 1. **Mandatory Disclosures**
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| 1. **Disclose all information related to violations of state or federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the State’s decision to approve CDO status.**
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|  |
| 1. **Assurances**
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| **As the duly Authorized Representative, I am aware that submission to the Office of Commissioner of Insurance and Safety Fire of the accompanying application constitutes the creation of a public document that may be made available upon request at the completion of the application process. In addition, I certify that the applicant:** * Will give the Georgia Office of Commissioner of Insurance and Safety Fire, or its authorized representatives, access to and the right to examine all records, books, papers, or documents related to the application.
* Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents a real or perceived personal or organizational conflict of interest, or personal gain. This means that the applicant did not have any involvement in the preparation of the application instructions, including development of specifications, requirements, or the evaluation of the submitted applications.
* Will comply with all federal and state statutes and regulations relating to non-discrimination. These include but are not limited to: 1) Title VI of the Civil Rights Act of 1964 (P.L. 88-352;34 CFR Part 100) which prohibits discrimination based on race, color or national origin; 2) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794; 34 CFR Part 104), which prohibits discrimination based on handicaps and the Americans with Disabilities Act (ADA), 42 U.S.C. 12101 et seq.; 3) Age Discrimination Act of 1975, as amended (42 U.S.C. 6101 et. seq.; 45 CFR part 90), which prohibits discrimination on the basis of age; and associated executive orders pertaining to affirmative action and non-discrimination on public contracts; and 4) federal Equal Employment Opportunities Act.
* Will comply with all applicable federal and state laws and regulations.
* Will comply with the Davis-Bacon Act, 40 U.S.C. 276a-276a-5 (29 CFR 5.5).
* Provided a statement of explanation regarding any and all involvement in any litigation, criminal or civil.
* Attests that the applicant is not presently debarred, proposed for debarment, declared ineligible, or voluntarily excluded.
* Understands that any false, fictitious, or fraudulent statements or claims may subject the applicant to criminal, civil, or administrative penalties.
* Attests that all statements contained within the submitted Georgia Access CDO Application are true, complete, and accurate to the best of my knowledge.
* Certifies that the applying organization will comply with all the assurances above.
 |
| 1. **Authorized Representative:** The Authorized Representative, or Authorized Organizational Representative (AOR), is the designated representative of the applicant organization with authority to act on the organization’s behalf regarding the application.
 |
| 1. **Authorized Representative**
 |
| Last Name  |  |
| First Name |  |
| 1. **Title**
 |  |
| 1. **Telephone Number**
 |  |
| 1. **Email**
 |  |
| **Authorized Representative Signature** | **Date** |