State of California—Controller's Office
ACA Tax Credit Notification Intake Form
PPSD 55 (rev. 04/2017)

Instructions: Human Resource's staff are to complete this form when a notification is received from Covered California (the state's health marketplace) or the U.S. Department of Health and Human Services (the federal health marketplace) about employees who received an Advanced Premium Tax Credit (APTC) for purchasing their health coverage through one of the marketplaces. Mail the completed form, the marketplace notification, a copy of the employee's HBD12 (if benefits were elected) or HBD12A (if benefits were declined) and any additional supporting documentation to the address below **within 10 days of receipt of the notification.**

ATTN: ACA Unit
State Controller's Office-Personnel/Payroll Services Division
300 Capitol Mall Suite # 1001
Sacramento, CA 95814

It is important that <u>all</u> information on this form is filled out correctly. SCO will review the documentation provided to determine if it is necessary to appeal the employee's eligibility for an APTC. An appeal will be filed if the employee was offered an opportunity to enroll in employer-sponsored health coverage that met the ACA's affordability and minimum value standards. Appealing an employee's eligibility determination for an APTC could reduce the department's exposure to a penalty assessment from the Internal Revenue Service under the ACA's Employer Shared Responsibility Provisions.

Department Information
Department Name (include facility if applicable) _____

3-Digit Agency Code _____

Contact Person _____

Phone Number _____

Email _____

Employee Information
Employee's SSN _____   Employee's Name _____

1. Was the employee appointed to a position eligible for health benefits during the timeframe indicated on the notice?
   ☐ No   ☐ Yes, date of eligibility _____

2. Was health coverage offered to the employee?

   ☐ No   ☐ Yes, date offered _____

3. Was the employee enrolled in health coverage during the timeframe indicated on the notice?

   ☐ No   ☐ Yes, effective date of coverage _____

Notes _____
_____
_____
_____
_____
_____

SCO Use Only

Date Received _____   Analyst Assigned _____   Appeal Required ☐ Yes   ☐ No