

District Direct  
Case Records Management Unit  
441 4<sup>th</sup> Street, NW, Suite 1C-15,  
Washington, DC 20001

**\*Beneficiary Name**

**\*Beneficiary Street Address**

Washington, DC 20011

**\*Available language options**

- This Notice has Important Information. This notice has important information about your application or coverage through District Direct. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-202-727-5355.
- Este aviso contiene información importante acerca de su solicitud o su seguro con District Direct. Preste atención a las fechas que aparecen en este aviso, puesto que podría ser necesaria alguna acción por su parte antes de determinada fecha a fin de mantener su seguro médico con nosotros o sus ayudas con el coste. Usted tiene derecho a recibir esta información y soporte en su idioma sin coste adicional. Llame al 1-202-727-5355.
- ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም ስለ District Direct ሽፋን አስፈላጊ መረጃ አለው። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀናቸን ፈልጉ። የጤና ሽፋንዎን ለመጠበቅ እና በአከፋፈሉ እርዳታ ለማግኘት በተወሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ ለማግኘት እና ያለ ምንም ክፍያ በቋንቋዎ እርዳታ የማግኘት መብት አልዎት። በ 1-202-727-5355 ላይ ይደውሉ።
- 本通知包含重要信息。本通知包含有关您通过 District Direct 提交申请和保险的重要信息。请查看本通知中的关键日期。您可能需要在特定截止日期前采取行动，以便维持您的健康保险或有助于降低费用。您有权免费以自己的母语获得本信息和帮助。请致电 1-202-727-5355。
- Cet avis contient des informations importantes. Cet avis contient des informations importantes au sujet de votre demande ou de la couverture par District Direct. Cherchez les dates clés dans cet avis. Vous devrez peut-être prendre des mesures en respectant certaines échéances afin de maintenir votre couverture de santé ou d'assumer des coûts. Vous avez le droit d'obtenir ces informations et d'être aidé dans votre langue sans frais. Appelez le 1-202-727-5355.
- May Importanteng Impormasyon ang abisong ito. May Importanteng Impormasyon ang abisong ito tungkol sa aplikasyon mo o proteksiyon mo sa District Direct. Tingnan ang mga importanteng petsa na nasa abisong ito. Maaaring may mga kailangan kang gawin bago sumapit ang ilang deadline para mapanatili ang proteksiyon mo sa kalusugan o para makatulong sa mga gastusin. Karapatan mong makuha ang impormasyon na ito at makakuha ng tulong na nasa wika mo nang walang gastos. Tumawag sa 1-202-727-5355.

- В настоящем уведомлении содержится важная информация. В этом уведомлении содержится важная информация о вашем заявлении или страховом покрытии посредством District Direct. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощи на вашем языке. Звоните по телефону 1-202-727-5355.
- Este aviso contém informações importantes. Este aviso contém informações importantes sobre o seu pedido ou cobertura através da District Direct. Procure as datas chave neste aviso. Poderá necessitar de tomar providências dentro de certos prazos para manter a sua cobertura de saúde ou para obter ajuda com custos. Tem o direito de obter estas informações e ajuda no seu idioma sem qualquer custo. Ligue 1-202-727-5355.
- Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso District Direct. Cerca le date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o una sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 1-202-727-5355.
- Thông báo này có Thông tin Quan trọng. Thông báo này có thông tin quan trọng về đơn hoặc hợp đồng bảo hiểm của bạn qua District Direct. Xin xem những ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo đúng thời hạn để duy trì bảo hiểm sức khỏe hoặc giúp đỡ chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-202-727-5355.
- Libihne lini li gwe banga bi niigana. Libihne lini li gwe banga bi niigana kolbaha ni ndjombi yoŋ tole ma teeda moŋ loŋ ni District Direct. Yeŋ ma kel ma tobo tobo munu libihne lini. Bebeg le u ga bana nguim mam i boŋ nwaa le guim di loo di kola i nyu I teda mateda tole nsaa u mboo woŋ. U gwee kundei kosna biniguene bini ni mahola ni hop wong ngui nsaa wogui wo. Sebel I nsinga ini 1-202-727-5355.
- Ihe Nkwupùta a were ozi di mkpa banyere ya. Ihe Nkwupùta a were ozi di mkpa banyere ya gbasara maka aririŋo gi ma obu oŋwugwo site na District Direct. Lee anya maka ubochi di-kariri mkpa na ihe nkwupùta a. I were ike icho ime ihe na ufodu oge mgwucha ka idebe oŋwugwo ahụ ike gi ma obu enyemaka na ikwu ugwo. Inwere ikike inweta ozi a na enyemaka na asusu gi n'efu. Kpoo 1-202-727-5355.
- Àkíyesí yíí ní Ifitoniletí Pàtàkì Nínu. Àkíyesí yíí ní ifitoniletí pàtàkì nípa leta-isebèèrè tàbí idójútòfò rẹ nípa District Direct nínu. Se àwárí àwọn ojo pàtàkì tí n bẹ nínu àkíyesí yíí. O le ní látí gbe awon igbese ní íbámu pẹlu awon ojo to gbeyin kan ní pátó látí le pa idójútòfò ìlera rẹ tàbí iseranwo fun o mo pẹlu sísanwo. O ní ẹto lati rí iranwo àti ifitoniletí yíí gbà ní èdè rẹ láisanwó. Pè sórí 1-202-727-5355.
- এই নোটিশটিতে গুরুত্বপূর্ণ তথ্য আছে। District Direct এর মাধ্যমে আপনার আবেদন পত্র বা কভারেজ সম্বন্ধে এই নোটিশে গুরুত্বপূর্ণ তথ্য আছে। মূল তারিখগুলির জন্য এই নোটিশটি দেখুন। কিছু নির্দিষ্ট সময়সীমা অনুসারে আপনার স্বাস্থ্য কভারেজ বা তার মূল্যের ক্ষেত্রে আপনার কোন কর্মপ্রক্রিয়া গ্রহণ করার প্রয়োজন হতে পারে। আপনার এই তথ্যটি বিনামূল্যে আপনার ভাষায় পাওয়ার অধিকার আছে। 1-202-727-5355 নম্বরে কল করুন।

- この通知には重要な情報が含まれています。この通知には District Direct の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。1-202-727-5355 までお電話ください。
- 본 통지서는 중요한 정보를 포함하고 있습니다. 이 통지서는 District Direct 관련 귀하 또는 귀하의 보험 적용 대상자에 대한 정보가 들어 있습니다. 이 통지서에 나와 있는 중요 날짜를 참조하시기 바랍니다. 건강 보험을 유지하거나 보험료 지원을 받으시려면 해당 만료일자까지 연장하시기 바랍니다. 이에 대한 정보를 귀하의 언어로 비용 부담없이 지원을 받으실 수 있습니다. 해당 언어의 통역사에게 문의하시려면 1-202-727-5355 로 전화하십시오.
- ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน District Direct ดูกำหนดการในประกาศนี้  
คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 1-202-727-5355
- Die Nachricht enthält wichtige Informationen bezüglich Ihres Antrags bei oder Ihres Versicherungsschutzes durch District Direct. Suchen Sie nach Schlüsseldaten in dieser Nachricht. Sie müssen eventuell vor einer bestimmten Frist reagieren, um Ihren Versicherungsschutz aufrechtzuerhalten oder um Hilfe bezüglich der Kosten zu erhalten. Sie haben das Recht, diese Information und Hilfe kostenfrei in Ihrer Sprache zu erhalten. Wählen Sie hierfür 1-202-727-5355.
- يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات هامة بخصوص طلبك أو تغطيتك من خلال District Direct. ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصول على هذه المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بـ 1-202-727-5355.



## \*Conversion Renewal Sample Notice\*

# GOVERNMENT OF THE DISTRICT OF COLUMBIA



Notice Date: 04/01/2023  
\*Date agency mailed notice.

Account ID: \*8-digit Account/Case Number

\*Beneficiary Name  
\*Beneficiary Address  
Washington, DC 20011

### Subject: Important Message About Your Medical Assistance

Dear \*Beneficiary Name

Due to eligibility system updates, we need additional information to determine if you are still eligible for medical assistance coverage under current eligibility rules. You must complete and return the attached Conversion Renewal Form by \*Due Date. After we receive your completed form and determine if you are still eligible for medical assistance coverage, you will be informed of the decision in a separate notice.

### How Soon We Need Your Documents

We need your completed form by \*Due Date in order to make a decision about your eligibility for Medicaid. If you do not provide the form, your Medicaid will end. **You will receive a separate termination in the mail.**

### How to Submit Your Documents

You can send the necessary documents either through fax, U.S. Postal mail, online or in-person. Please refer to the attached information sheet.

Questions? Call District Direct Customer Service at 1-202-727-5355 or go online to [www.districtdirect.dc.gov](http://www.districtdirect.dc.gov).



# GOVERNMENT OF THE DISTRICT OF COLUMBIA



## Creating and Accessing Your Online Account

### Your Secure User Account

**\*How to access and create an account for District Direct. Mobile app and online applications are available.**

District Direct is a place where important information about your account is stored ([www.districtdirect.dc.gov](http://www.districtdirect.dc.gov) or download the District Direct Mobile Application from the Google Play or Apple App Stores). You can also submit documents and report changes through District Direct.

- ***If you do not have an account***, you can create one at [www.districtdirect.dc.gov](http://www.districtdirect.dc.gov) or through the District Direct Mobile Application (available on the Google Play or Apple App Stores). On the main page, click on “Login” and then click “Create Account”. On the next page, enter the information required to create your account (e.g., username, password). Once complete, click “Create Account”. Once your account is created, you must connect your account by clicking “Connect Your Account” on the homepage and entering the required information to connect your account. Once your account is connected, navigate back to the homepage to see your information.

### **How to Submit Your Documents** \*These are ways to submit verification documents.

You can submit documents either through online, fax, U.S. Postal mail, or in-person.

- **Online:** Log into District Direct at [www.districtdirect.dc.gov](http://www.districtdirect.dc.gov) or through the Mobile Application and view outstanding verifications. You can upload scanned copies of documents.
- **Fax** your change form and all supporting documents to: 202-698-6405
- **U.S. Postal Mail:**  
District Direct  
DC Department of Human Services  
P.O. Box 91560  
Washington, DC 20090

*Be sure to write your account number (25909333) on your submission.*

- **In-Person:** Take the document(s) to any Economic Security Administration Office (see insert for list of service center locations).

## How to Report Changes \*These are methods in which to report changes to a case.

You can report changes either through online, fax, U.S. Postal mail, phone, or in-person. A Medicaid Change Report Form is attached for you to complete and submit when reporting changes in your household.

- **Online:** Log in to District Direct at [www.districtdirect.dc.gov](http://www.districtdirect.dc.gov) or through the Mobile Application and submit a change report. You can upload scanned copies of supporting documents.
- **Fax** your change form and all supporting documents to: 202-698-6405
- **U.S. Postal Mail:**
  - District Direct
  - DC Department of Human Services
  - P.O. Box 91560
  - Washington, DC 20090

*Be sure to write your account number (25909333) on your submission.*

- **Phone:** Call District Direct at 1-202-727-5355
- **In-Person:** Go to any Economic Security Administration Office (see insert for list of service center locations).



## Conversion Renewal Form

This is a supplemental form for medical assistance. A friend, relative, or anyone that you wish, may help you complete this application.



### Medical

**(Doctors, hospitals, prescriptions, labs, and x-rays)**

- free or low-cost insurance from Medicaid
- free or low-cost insurance from the D.C. Healthcare Alliance or Immigrant Children’s Program
- affordable, private health insurance plans through the Marketplace
- a tax credit that can immediately help pay your premiums for health coverage.

**\*Included services.**

 **Service Center Locations** Monday – Friday | 7:30am – 4:45pm

**Anacostia Service Center**

2100 Martin Luther King Jr. Ave., SE  
Washington, DC 20020  
Fax: (202) 727-3527

**Taylor Street Service Center**

1207 Taylor St., NW  
Washington, DC 20011  
Fax: (202) 576-8740

**H Street Service Center**


645 H St., NE  
Washington, DC 20002  
Fax: (202) 724-8964

**Congress Heights Service Center**

4049 South Capitol St., SW  
Washington, DC 20032  
Fax: (202) 645-4524

**Fort Davis Service Center**

3851 Alabama Ave., SE  
Washington, DC 20020  
Fax: (202) 645-6205

 Customers may call the ESA Call Center at (202) 727-5355 to learn which Service Center serves their address



**NEW MOBILE APPLICATION:**

You can now apply for Medical assistance programs online by downloading the DC First app from the Apple App Store or the Google Play Store on your smartphone. Check the App for more information about the scope of Medical program applications available.

<b>FOR AGENCY USE ONLY</b>	<b>Date Received:</b>	<b>Date Disposed:</b>	<b>Case Number:</b>
<b>Programs Applied For:</b>			<b>Application Type</b>
<input type="checkbox"/> Medical	<input type="checkbox"/> Approved	<input type="checkbox"/> Pending	<input type="checkbox"/> Denied
			<input type="checkbox"/> Renewal

Do Not Use.  
For Agency Only.

# Language Access Support

If you speak another language, you have the right to free language assistance services. Call (202) 727-5355 or TTY/TDD 711 (855) 532-5465. District law requires that agencies provide you with information and assistance in your language for free. If you do not receive help in your language, please call the DC Office of Human Rights at (202) 727-4559 and press 0.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶቻችን በነጻ ሊያግዝዎት ተዘጋጅተዎልዎልዎልዎልዎልዎልዎልዎል (202) 727-5355 (መስማት ለተሳናቸው: TTY/TDD 711 (855) 532-5465).

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(202) 727-5355 (TTY/TDD 711 (855) 532-5465)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (202) 727-5355 (ATS : TTY/TDD 711 (855) 532-5465).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

Dè dè nà ke dyédé gbo: Ǿ jù ké m̄ [Bàsóò-wùdù-po-nyò] jù ní, ní, à wuḍu kà kò dọ po-poò b̄éin m̄ gbo kpáa. Ǿ́ (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নি:খরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-(202) 727-5355 (TTY/TDD 711 (855) 532-5465)।

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。(202) 727-5355 (TTY/TDD 711 (855) 532-5465)

まで、お電話にてご連絡ください。  
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (202) 727-5355 (TTY/TDD 711 (855) 532-5465)번으로 전화해 주십시오.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

What is the Language that you need to read?	<input checked="" type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> French	<input type="checkbox"/> Korean	<input type="checkbox"/> Amharic	<input type="checkbox"/> Chinese (Mandarin)	<input type="checkbox"/> Chinese (Cantonese)	<input type="checkbox"/> Other
What Language do you need to speak to get ESA services?	<input checked="" type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> French	<input type="checkbox"/> Korean	<input type="checkbox"/> Amharic	<input type="checkbox"/> Chinese (Mandarin)	<input type="checkbox"/> Chinese (Cantonese)	<input type="checkbox"/> Other
If you need an interpreter, what language do you need interpreted?	<input checked="" type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> French	<input type="checkbox"/> Korean	<input type="checkbox"/> Amharic	<input type="checkbox"/> Chinese (Mandarin)	<input type="checkbox"/> Chinese (Cantonese)	<input type="checkbox"/> Other

**\*Please complete the above section with the appropriate language needed.**

Do you want free language interpretation?

\*Check "Yes" if a language interpreter is needed. If not, check "No" and sign below.

Yes (a case worker will assist you)       No (complete and sign waiver below)

I, Beneficiary Full Name, acknowledge that The Department of Human Services (DHS) has notified me of my right to a professional and trained interpreter as required by the D.C. Language Access Act of 2004 at no cost to me. By signing below, I agree that I have refused this service and opted to rely on interpreter assistance by someone I have identified. I am aware that this individual was not identified by or vetted through DHS and that DHS is neither responsible for the provision of these services nor does DHS incur any liability that may result from these services. I am also aware that this waiver only applies to this one instance. If I require interpreter assistance from DHS in the future, I will notify the agency directly to request this service.

Sign here

Signature

Applicant or Representative Signature

Date

Today's Date

OFFICIAL USE: This statement was orally translated into (language) \_\_\_\_\_ by (name)

\_\_\_\_\_, who is a language line interpreter, professional in-person interpreter, or multilingual DHS employee because a written translation was not available in that language or the customer was unable to read in his/her spoken language.

**Do Not Use.  
For Translator Only.**

\*Complete this document entirely, to the best of your ability.

## STEP 1 Tell us about the person completing this application.



What type of assistance is your household applying for? (check all that apply)

Medical

First Name

First Name

Last Name

Last Name

Middle Name

Middle Name

Suffix (Jr., III., etc.)

Residential Address (where you live)

123 Street Name

Unit

Apt 1

City

Washington

State

DC

ZIP

200XX

Mailing Address (If different)

City

State

ZIP

Preferred Phone (please note, only mobile phones may receive text messages) (\_\_\_000\_\_\_) 000 - 0000

Is your Preferred Phone a mobile or landline phone? Mobile  Landline

Email

Name@email.com

By checking this box, I consent to receive text messages, email messages, and pre-recorded calls related to my ESA case(s). Consent to these terms is not a condition of the receipt of benefits or services. Message and data rates may apply. **\*Check this box to receive electronic notification regarding your case**

Would you like to name people who can act on your behalf?

Yes  Make sure to complete Appendix C (page 38)

No

# STEP 2

## Tell us about everyone in your household, even if you are not requesting benefits for them.



\*\* If you have more than 5 applicants in your household, please use a separate sheet of paper to include their information

\*\* List everyone who will be included on your federal tax return this year (note: you do not need to file taxes to receive assistance).

*\*Fill in your household information below.*

	Example <i>*Do not copy from this column.</i>	Household Member #1 (YOU) <i>*Self or primary beneficiary</i>	Household Member #2 <i>*Add spouse and/or child</i>
<b>1. First Name</b>	Maya	First Name	Child's First Name
<b>Middle Name</b>	Michelle	Middle Name	Child's Middle Name
<b>Last Name</b>	Johnson	Last Name	Child's Last Name
<b>Suffix (Jr., Sr., IV, etc.)</b>			
<b>2. Which benefits is this person applying for with your household?</b> <small>(List all that apply. If none, write "N/A")</small>	Food, Cash, Medical	Medical	Medical
<b>3. a. Date of Birth</b>	01/23/1987	00/00/0000	00/00/0000
<b>3. b. Gender</b> (male, female)	Female	Female	Female
<b>3. c. Are you Hispanic or Latino?</b>	No	No	No
<b>4 Race/Ethnicity:</b> <small>(Hispanic/ Black/African American/ Asian/White/ Native Hawaiian or Pacific Islander/ American Indian or Alaskan Native)</small>  <small>This question is voluntary. You may list more than one race and ethnicity. This information will not affect your benefits. The District collects and uses this information to monitor and address racial and ethnic disparities in health experiences. Please consider providing this data to support these efforts</small>	African American	White	White
<b>5. Social Security Number</b> <small>(you may leave this blank if the person does not have an SSN or is not applying for benefits)</small>	555-55-5555	000-00-0000	000-00-0000
If this person does not have a Social Security and is applying for benefits, has he/she applied for a Social Security Number?  If this person has not applied for an SSN, and is applying for benefits, why has he/she not applied?	<input type="checkbox"/> Yes <input type="checkbox"/> No  Not eligible for SSN	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>6. What is this person's marital status?</b> (Never been married, married, separated, divorced, widowed)	Married	Never been married	Never been married
<b>7. Relationship to you</b>	Daughter	Self	Daughter
<b>8. Are you or your spouse the biological or adoptive parents of this person?</b>	Yes	N/A	Yes
<b>9. Is this person a U.S. citizen or U.S. national?</b> (Applicants only) Many immigrants are eligible for benefits (If you answer no, please complete <b>Step 4</b> )	Yes	Yes	Yes
<b>a.</b> Are you a naturalized or derived US citizen? (Applicants only)	No		
<b>b.</b> If you are a naturalized or derived citizen, what are the alien and certificate numbers on your citizenship document? (this question is only for persons applying for medical assistance).	Alien Number Certificate Number _____	Alien Number Certificate Number _____	Alien Number Certificate Number _____
<b>10. Is this person an American Indian or Alaska Native?</b> (If yes, complete Appendix B. You may be eligible for enhanced benefits)		No	No
<b>If yes, what is this person's Tribal Identification Number?</b> (Medical Assistance only)			
<b>11. Is this person in the Military or a U.S. Veteran?</b> If yes, please contact the District of Columbia's Office of Veteran Affairs for potential eligibility for enhanced benefits.  The District of Columbia Office of Veteran's Affairs contact information is: 441 4th Street, NW, Suite 870 North, Washington DC 20001, (202) 724-5454, <a href="mailto:ova@dc.gov">ova@dc.gov</a> .	No	No	No
<b>12. Does this person currently live in the District of Columbia?</b> (For applicants only)	Yes	Yes	Yes
If yes, do you intend to stay in the District?	No		
If you do not intend to stay in the District, when do you plan to leave?			

If you are not currently in the District, are you living outside the District of Columbia temporarily, but plan to return when the purpose of the absence has been accomplished?			
If yes, what is the reason for your absence? (School attendance, looking or receiving medical care, serving in the military, Other (specify).	School attendance		
<b>13. Are you a victim of domestic violence?</b> (For sponsored immigrants applying for medical assistance)	No	No	No

## STEP 2a Further Questions about Household members: 1 and 2



\*\* If you have more than 5 applicants in your household, please use a separate sheet of paper to include their information)

\*\* If applying for healthcare coverage, list everyone who will be included on your federal tax return this year (note: you do not need to file taxes to receive assistance).

<b>14. Is this person in this country for temporary purposes or under the jurisdiction of another country?</b> (e.g., certain embassy employees and their families).	No	No	No
<b>15. Is this person staying in an institution like a nursing home, hospital, group home, jail, halfway house, drug or alcohol treatment center, or another facility?</b>	No	No	No
If yes, what is the name of the institution?	Lakewood Nursing Home		
If yes, what is the institution's address?	123 Main St		
Were you placed in the institution by a District government agency?	Yes		
If yes, which agency?	Dept Human Svcs		
<b>16. Are you in the District of Columbia voluntarily?</b>	Yes	Yes	Yes

<b>17. Are you currently experiencing homelessness in the District?</b>	Yes	No	No
<b>18. Is this person blind?</b>	No	No	No
<b>19. Is this person disabled?</b>	No	No	No
<b>20. Does this person need with daily living activities or living in a medical institution?</b>	No	No	No
<b>21. Does this person live in foster care?</b>	No	No	No
<b>22. Was this person in foster care at age 18 or older?</b>	Yes	No	No
<b>23. Is the person emancipated?</b>	No	No	No
<b>24. Is this person currently pregnant or has been pregnant in the last 60 days?</b>	Yes	No	No
If yes, when is the baby due? (For applicants, an estimated due date is accepted and will not require verification)	mm/dd/yyyy		
If yes, how many babies are expected during this pregnancy?	1		
If this person was recently pregnant, when did the pregnancy end?	mm/dd/yyyy		
Was this person enrolled in Medicaid during their pregnancy?	Yes		
If yes, is this the person's first pregnancy?	No		
<b>25. Does this person want help paying for medical bills from the last 3 months?</b> The following questions are asked to see if we can help pay any medical bills you had in the 3 months before you applied for coverage. If you do not need help paying for medical bills for the past three months, proceed to question 13 (Medical assistance only)	Yes	N/A	N/A
If yes, which months does this person have medical bills? (Medical assistance only)	Jan and Feb		



If yes, did this person live outside of the District in the last 3 months? If you answer yes, please complete Appendix D (Medical assistance only)	No	No	
If yes, did this person have a change in U.S. citizenship or qualified immigration status in the last 3 months? If you answer yes, please complete Appendix D. (Medical assistance only)	No	No	
If yes, did this person have a change in their tax filing status in the last 3 months? If you answer yes, please complete Appendix D.	No	No	
If yes, did this person's income change in the last 3 months? If you answer yes, please complete Appendix D.	No	No	
If yes, did this person have a change in their medical coverage in the last 3 months? If you answer yes, please complete Appendix D.	No	No	
If yes, did this person become blind or disabled in the last 3 months? If you answer yes, please complete Appendix D.	No	No	
If yes, did this person's assets change in the last 3 months? If you answer yes, please complete Appendix D.	No	No	
<b>26. Has this person had insurance through a job and lost it in the past 3 months?</b>	Yes	No	No
If yes, when did the coverage end?	12/31/2020		
If yes, what is reason for the coverage ending?	Laid off		
If yes, is this person a full-time student?	Yes		
<b>27. If this person is a child, are there any parents living outside the home?</b>	No	N/A	Yes
<b>28. Has this person been screened for Breast or Cervical Cancer through Project Wish?</b>	No	No	No

\*Fill in the information for the remaining persons living the home.

## STEP 2

Tell us about everyone in your household, even if you are not requesting benefits for them - Household members: 3-5



\*\* If you have more than 5 applicants in your household, please use a separate sheet of paper to include their information

	Household Member #3	Household Member #4	Household Member #5
<b>1. First Name</b>			
<b>Middle Name</b>			
<b>Last Name</b>			
<b>Suffix (Jr., Sr., IV, etc.)</b>			
<b>2. Which benefits is this person applying for with your household?</b> (List all that apply. If none, write "N/A")			
<b>3a. Date of Birth</b>			
<b>3b. Gender</b> (male, female)			
<b>3c. Are you Hispanic or Latino?</b>			
<b>4 Race/Ethnicity:</b> (Hispanic/ Black/African American/ Asian/White/ Native Hawaiian or Pacific Islander/ American Indian or Alaskan Native)  This question is voluntary. You may list more than one race and ethnicity. This information will not affect your benefits. The District collects and uses this information to monitor and address racial and ethnic disparities in health experiences. Please consider providing this data to support these efforts	<h1>Household Members 3-5</h1>		
<b>5. Social Security Number</b> (you may leave this blank if the person does not have an SSN or is not applying for benefits)			
If this person does not have a Social Security and is applying for benefits, has he/she applied for a Social Security Number?  If this person has not applied for an SSN, and is applying for benefits, why has he/she not applied?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>6. What is this person's marital status?</b> (Never been married, married, separated, divorced, widowed)			

<p><b>7. Relationship to you</b></p>			
<p><b>8. Are you or your spouse the biological or adoptive parents of this person?</b></p>			
<p><b>9. Is this person a U.S. citizen or U.S. national?</b> (Applicants only)          Many immigrants are eligible for benefits (If you answer no, please complete <b>Step 3</b>)</p>			
<p><b>a.</b> Are you a naturalized or derived US citizen? (Applicants only)</p>			
<p><b>b. If you are a naturalized or derived citizen, what are the alien and certificate numbers on your citizenship document?</b>  (applicants only)</p>	Alien Number _____ Certificate Number _____	Alien Number _____ Certificate Number _____	Alien Number _____ Certificate Number _____
<p><b>10. Is this person an American Indian or Alaska Native?</b>          (If yes, complete Appendix B. You may be eligible for enhanced benefits)</p>			
<p>If yes, what is this person's Tribal Identification Number? (Medical Assistance only)</p>			
<p><b>11. Is this person in the Military or a U.S. Veteran?</b>           If yes, please contact the District of Columbia's Office of Veteran Affairs for potential eligibility for enhanced benefits.           The District of Columbia Office of Veteran's Affairs contact information is:          441 4th Street, NW,          Suite 870 North, Washington DC 20001,          (202) 724-5454, <a href="mailto:ova@dc.gov">ova@dc.gov</a>.</p>	<h1 style="color: red; margin: 0;">Household Members 3-5</h1>		
<p><b>12. Does this person currently live in the District of Columbia? (For applicants only)</b></p>			
<p>If yes, do you intend to stay in the District?</p>			
<p>If you do not intend to stay in the District, when do you plan to leave?</p>			
<p>If you are not currently in the District, are you living outside the District of Columbia temporarily, but plan to return when the purpose of the absence has been accomplished?</p>			

<p>If yes, what is the reason for your absence?</p> <p>(School attendance, looking or receiving medical care, serving in the military, Other (specify)).</p>			
<p><b>13. Are you a victim of domestic violence?</b> (sponsored immigrants applying for medical assistance)</p>			

## STEP 2a Further Questions about Household members: 3-5



\*\* If you have more than 5 applicants in your household, please use a separate sheet of paper to include their information)

\*\* If applying for healthcare coverage, list everyone who will be included on your federal tax return this year (note: you do not need to file taxes to receive assistance).

	Household Member #3	Household Member #4	Household Member #5
<p><b>14. Is this person in this country for temporary purposes or under the jurisdiction of another country?</b> (e.g., certain embassy employees and their families).</p>			
<p><b>15. Is this person staying in an institution like a nursing home, hospital, group home, jail, halfway house, drug or alcohol treatment center, or another facility?</b></p>			
<p>If yes, what is the name of the institution?</p>			
<p>If yes, what is the institution's address?</p>			
<p>Were you placed in the institution by a District government agency?</p>			
<p>If yes, which agency?</p>			
<p><b>16. Are you in the District of Columbia voluntarily?</b></p>			
<p><b>17. Are you currently experiencing homelessness in the District?</b></p>			
<p><b>18. Is this person blind?</b></p>			
<p><b>19. Is this person disabled?</b></p>			

Household  
Members 3-5

20. Does this person need help with daily living activities or living in a medical institution?			
21. Does this person live in foster care?			
22. Was this person in foster care at age 18 or older?			
23. Is the person emancipated?			
24. Is this person currently pregnant or has been pregnant in the last 60 days?			
If yes, when is the baby due? (For applicants only, an estimated due date is accepted and will not require verification)			
If yes, how many babies are expected during this pregnancy?			
If this person was recently pregnant, when did the pregnancy end?			
Was this person enrolled in Medicaid during their pregnancy?			
If yes, is this the person's first pregnancy?			
25. Does this person want help paying for medical bills from the last 3 months? The following questions are asked to see if we can help pay any medical bills you had in the 3 months before you applied for coverage. If you do not need help paying for medical bills for the past three months, proceed to question 13			
If yes, which months does this person have medical bills?			
If yes, did this person live outside of the District in the last 3 months? If you answer yes, please complete Appendix D			
If yes, did this person have a change in U.S. citizenship or qualified immigration status in the last 3 months? If you answer yes, please complete Appendix D.			
If yes, did this person have a change in their tax filing status in the last 3 months? If you answer yes, please complete Appendix D.			

# Household Members 3-5

<p>If yes, did this person's income change in the last 3 months? If you answer yes, please complete Appendix D.</p>			
<p>If yes, did this person have a change in their medical coverage in the last 3 months? If you answer yes, please complete Appendix D.</p>			
<p>If yes, did this person become blind or disabled in the last 3 months? If you answer yes, please complete Appendix D.</p>			
<p>If yes, did this person's assets change in the last 3 months? If you answer yes, please complete Appendix D.</p>			
<p><b>26. Has this person had insurance through a job and lost it in the past 3 months?</b></p>			
<p>If yes, when did the coverage end?</p>			
<p>If yes, what is reason for the coverage ending?</p>			
<p>If yes, is this person a full-time student?</p>			
<p><b>27. If this person is a child, are there any parents living outside the home?</b></p>			
<p><b>28. Has this person been screened for Breast or Cervical Cancer through Project Wish?</b></p>			

# Household Members 3-5



**\*Complete Step 3 for applicants who are non-US citizens.**

## **STEP 3** Are you or anyone in your household who is seeking benefits for themselves as a non-U.S. citizen?



Yes – complete below.

No – skip to step 4

Many immigrants are eligible for benefits.

If your status is not listed, please list “other” as your status in the table below.

If you are not applying for benefits for yourself, you do not have to give details about your own immigration status. Instead, you can just give immigration information for the household members who are seeking benefits.

We must ask Immigration Services (USCIS) to verify the status of anyone who is seeking benefits for themselves and is NOT listed as “OTH- ER.” This may affect your eligibility for benefits and the amount of your benefits.

### **Immigration Statuses**

- Lawful Permanent Resident
- Asylee
- Refugee
- Cuban/Haitian entrant
- Conditional Entrant Granted before 1980
- Victim of Trafficking and his/her Spouse, Child, Sibling or Parent
- Temporary Protected Status (TPS)
- Deferred Enforce Departure (DED)
- Lawful Temporary Resident
- Member of a federally recognized Indian tribe or American Indian born in Canada
- Deferred Action Status (Exception: Deferred Action for Childhood Arrivals (DACA) is not an eligible immigration status for applying for health insurance)
- Person granted withholding of deportation
- Person granted parole by the US Department of Homeland Security for a period of at least one year
- Resident of American Samoa
- Administrative order staying removal issues by the Department of Homeland Security
- Citizens of Micronesia, the Marshall Islands, and Palau
- Battered spouse or child with a pending or approved:
  - Self-petition for an immigrant visa
  - Immigrant visa filed for a spouse or child by a US citizen or Lawful Permanent Resident (LPR)
  - Application for cancellation of deportation
- Individual with Non-immigrant Status, includes worker visas (such as H1, H-2A, H-2B), student visas, U-visa, T-visa, and other visas
- Other



Household Member Name	Alien #	Immigration Status (use categories above)	Immigration Document Type	Document ID Number

**The following answers will only be used for determining Medical, Food, and Cash Assistance**

<p><b>Did anyone above move to the U.S. before August 22, 1996?</b></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><b>If yes, who?</b></p>
---	----------------------------

**If you are a Lawful Permanent Resident (LPR), do you have a sponsor?** Yes  No

Sponsor full name \_\_\_\_\_

Sponsor address	City	State	ZIP
-----------------	------	-------	-----

Sponsor's employer	Sponsor's monthly income: \$
--------------------	------------------------------

**Have you, your parents, your spouse, and/or your sponsor ever worked in the U.S.?** Yes  No

**How much support do you receive every month from your sponsor? \$**

**\*Complete Step 4 with the appropriate tax information.**

## STEP 4 Tax Filing Information



If anyone in your household files taxes, please complete this section

Tax Filer Name	Filing Status	Tax Dependents Living with the Tax Flier	Tax Dependents NOT Living with the Tax Flier
Please list each Tax Filer in your household	<p>Please tell us the Tax Filer's status:</p> <p>(Head of Household, Single, Married Filing Jointly, or Married Filing Separately)</p> <p>If filing jointly, list who you file jointly with.</p>	<p>Please list all tax dependents in the home that the tax filer is claiming.</p> <p><i>*Add spouse and/or child</i></p>	<p>Please list all tax dependents that the tax filer is claiming that are not living in the home.</p>
Tax Filer 1	Full Name (Self)	Child's Full Name	
Tax Filer 2			

If anyone in your household is a tax dependent of someone not living in your house please list below:

Tax Dependent Name	Tax Filer Name Claiming Dependent	What is the Tax Filer's relationship to the Tax Dependent?
<b>*Complete for all persons who are claimed by a tax filer not living in the home.</b>		

**\*Fill in all income information for Step 5.**

## STEP 5 Does anyone in your household (including non-applicants) have any income?



Yes – complete below

No – skip to step 6

Who in your household is employed? <small>(include yourself, spouse, and dependents (write full names)</small>	Employer's Name <small>(if self-employed, write "self-employed")</small>	Employer's Address	Employer's Phone	Employment Start Date	Paycheck Amount <small>(before taxes and deductions)</small>	How often? <small>(e.g. daily, weekly, biweekly, semi-monthly, monthly, yearly, one-time lump sum payment)</small>
Full Name	Employer	123 Work Street	(111) 111- 1111	00/00/0000	\$200	Biweekly
Who in your household is self-employed?	What type of work does the self-employed person do?	How often does the self-employed person receive pay?	How much does the self-employed person receive each time?	What business-related expenses does the self-employed person have?		What is the total of the monthly self-employment expenses?
<b>*Fill in accurate information for all applicants who are self-employed.</b>						

**\*Complete this section with all other income.**

What types of income does your household receive? For example:

(Report these for all programs)

- Unemployment/Workers' Comp
- Alimony received under agreements finalized after Dec. 31, 2018
- Taxable Annuities
- Other taxable income type: \_\_\_\_\_
- Lottery/Gambling Winnings?
- Disability benefits
- Veterans Disability
- Other VA benefit
- Net Rental/Royalty?
- Net Farming/Fishing
- Social Security (Non-SSI)
- Pensions & retirement

Income type	Who in your household receives this?  (full name)	Amount  (before taxes & deductions)	How often?  (weekly, biweekly, semi-monthly, monthly, one-time lump sum payment)
SSA	Full Name	\$220	Monthly
Has anyone in the household stopped working or reduced their working hours in the last 60 days? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	If yes, who?		
Who was the employer?	Why did this person stop working in this employment?		

**\*Complete all questions that apply.**

## Additional Income Questions

**1. Please check all that can be deducted on the household's tax return:** (Medical assistance only)

Alimony Paid \$ \_\_\_\_\_ How often? \_\_\_\_\_

(Note that alimony is only deductible if paid under an agreement finalized before Jan. 2, 2019)

Other deductions type? \_\_\_\_\_ \$ \_\_\_\_\_ How often? \_\_\_\_\_

Student loan interest \$ \_\_\_\_\_ How often? \_\_\_\_\_

If any of these are checked, please list which household member who is claiming these deductions:

\_\_\_\_\_

If anyone in your household is paying alimony, was the divorce finalized after December 31, 2018? Yes  No

**2. Has anyone in your household had their student loan(s) discharged?** Yes  No   
(Medical and DC Alliance only)

If yes, who? \_\_\_\_\_

Why was this person's student loan(s) discharged?

Total Disability  Death  Public Service  Loan Forgiveness

Is a beneficiary of the annuity a member of your household?  Yes  No

If yes, full name(s) of beneficiaries: \_\_\_\_\_

What type of annuity is it?  Deferred  Immediate  Retirement

What kind of annuity is it?  Revocable  Non-Assignable  Irrevocable

On what date was the annuity established? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Does the annuity provide a balloon or deferred payment?  No  Yes

Which entity was the annuity purchased through?  Financial  Insurance  Other:

What is the source of the annuity funds?  Annuitant  Retirement Plan  Unknown

If funds were used to purchase the annuity, were the funds from someone in the household?  Yes  No

Full name of funder: \_\_\_\_\_

\*Check "Yes", if you would like the register to vote and sign below. Check "No" and move to Step 8 if you do not want to register to vote.

## STEP 7 If you are not registered to vote where you live now, would you like to apply to register to vote here today?



- Yes – complete this step and complete the voter registration application (attached the back of this application)
- No – skip to step 8

### If you do not check either box, you will be considered to have decided not to register to vote at this time

The decision to register to vote is absolutely voluntary. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. We keep this information confidential. A decision not to apply as well as the name of the office where your application was submitted will remain confidential and will only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with The District of Columbia Board of Elections and Ethics, 441 4th Street NW, Suite 250, Washington, DC 20001; phone (202) 727-2525.

We have attached a voter registration form for you. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. If you have additional people in your household that would like a voter registration application, please let us know.

Sign here

Date

**Signature**

**Today's Date**

\_\_\_\_\_  
Applicant or Representative Signature

\_\_\_\_\_  
Date

\*Complete all sections that apply to the best of your knowledge. For renewals, please complete the box located on the top left of the chart below.

## STEP 8 Your Family's Health Coverage



(Medical Assistance ONLY)

1. Is anyone in your household enrolled in health coverage now? Yes  No

If yes, check the type of coverage below and write the person(s) name(s) next to the coverage they have:

Medicaid:

Full Name (self), Child's Full Name

CHIP:

\_\_\_\_\_

Was this coverage from the District of Columbia?

Yes  No

Was this coverage from another state?

Yes  No

If yes, which state(s)?

\_\_\_\_\_

Employer Insurance:

\_\_\_\_\_

Name of Health Insurance:

\_\_\_\_\_

Policy Number:

\_\_\_\_\_

Is this COBRA coverage? Yes  No

Is this a retiree health plan? Yes  No

**If you have insurance, you must complete Appendix A below**

CHIP:

\_\_\_\_\_

Medicare:

\_\_\_\_\_

TRICARE (Don't check if you have Direct Care or Line of Duty coverage):

\_\_\_\_\_

VA Health Care Program:

\_\_\_\_\_

Peace Corps:

\_\_\_\_\_

Other

Name of Health Insurance:

\_\_\_\_\_

Policy or Claim Number:

\_\_\_\_\_

Is this a limited-benefit plan (like a school accident policy)?

Yes  No

**\*Read carefully and sign this section of the application before continuing.**

## STEP 9 Read and Sign This Application

Sign below if you and your household are applying for Medical assistance. There will also be further questions starting in Step 10 about Medical Assistance for persons who are elderly, disabled, or blind.

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge, I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that I must tell District Direct if anything changes (and is different than) what I wrote on this application, I can visit District Direct Customer Service at 1-202-727-5355 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file).
- I know that the information I have provided on this application will be kept private as required by law.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, the following individuals are incarcerated:

**\*List all applicants who are incarcerated that the time you submit this application.**

\_\_\_\_\_, & \_\_\_\_\_

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

### Renewal of coverage for future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow District Direct to use income data, including information from tax returns. District Direct will send me a notice and let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

5 years (the maximum number of years allowed), or for a shorter number of years:

4 years  3 years  2 years  1 year  Don't use information from tax returns to renew my coverage

**\*5 years is the recommended amount of time to allow automatic renewals. Check the box for the amount of time you would like benefits automatically renewed.**

### If anyone on this application is eligible for Medicaid

I'm giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.



**\*Read carefully. Then, sign and date below.**

### **What should I do if I think my eligibility results are wrong?**

If you do not agree with our decision about your health insurance or Medical assistance, you have a right to appeal our decision and receive a Fair Hearing. You can appeal a denial, termination, or change in your eligibility for Medicaid, premium tax credits, or cost-sharing assistance. You can also appeal if you disagree with the amount of your premium tax credits or cost-sharing assistance. Once you appeal, you can go before the Administrative Law Judge and explain why you do not agree with our decision.

You have 90 days following the postmark of the notice informing you of the eligibility decision, denial, termination, or change, to appeal the decision stated in the notice you received. If you do not appeal within 90 days, you may lose your appeal right.

You may appeal through any of the following methods:

- Calling District Direct Customer Service at 1-202-727-5355.
- Completing the **Appeal Request for Individuals and Families** form and send it by fax to (202) 724-2041, by e-mail to [DC.OARA@dc.gov](mailto:DC.OARA@dc.gov), or by mail to: **Office of Administrative Review and Appeals**, 64 New York Avenue NE, 5th Floor, Washington DC 20002.
- Going to any Department of Human Services Service Center and filling out the **Appeal Request Form**
- Going to the Office of **Administrative Hearings Resource Center**, located at 441 4th Street NW, Suite 450-North, Washington, DC 20001 and filling out the **Hearing Request Form**

If you receive eligibility through the Medicaid program or DC Alliance, you can request a Fair Hearing by:

- Calling **(202) 698-4650** or (202) 727-8280

**Sign this application.** The person who filled out **Step 1** should sign this application. If you're an authorized representative, you may sign here as long as you've provided the information required in Appendix C (attached).

Sign here

Date

**Signature**

**Today's Date**

Applicant or Representative Signature

# STEP 10 Tell us about your household's assets



(If your child has Medicaid coverage through the Katie Beckett Pathway, only complete this section with your child's assets)

<b>1. Does anyone in your household have cash on hand or in the home?</b> If yes, who? _____ How much? \$ _____				Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>2. Does anyone have any financial accounts?</b> If yes, list all accounts owned by you and anyone applying with you. Some examples of financial accounts are: Checking/Savings account, 401K, IRA, Annuities, Money Market, Stocks/Bonds/Mutual Funds/etc.				Yes <input type="checkbox"/> No <input type="checkbox"/>	
Type	Account Owner(s)	Bank Name	Account Balance		
			\$		
			\$		
			\$		
<b>3. Does anyone in your household have any vehicles? (Medical Assistance Only)</b> • If yes, please list all vehicles owned by you and anyone applying with you. Some examples of vehicles are: Cars, Trucks, Boats, or Watercraft, Motorcycles, motor homes, ATVs, etc.  • If yes, is this vehicle used by someone who is sick or disabled?				Yes <input type="checkbox"/> No <input type="checkbox"/>	
Yes <input type="checkbox"/> No <input type="checkbox"/>					
Owner	Make/Model	Vehicle ID	Year	Amount Owed	
Name D/L# or Non-Driver ID#		VIN# Tag #		\$	
Name D/L# or Non-Driver ID#		VIN# Tag #		\$	
Name D/L# or Non-Driver ID#		VIN# Tag #		\$	
<b>4. Does anyone in your household have any property assets?</b> If yes, please complete the table below for you and anyone applying with you.				Yes <input type="checkbox"/> No <input type="checkbox"/>	

Do Not Use.  
Not Applicable at  
This Time.

Type	Who owns this?	Fair Market Value	Amount Owed	Date Acquired
Your Home (Medical Assistance Only)		\$		
Land		\$		
Rental Home (Medical Assistance Only)		\$		
Vacation Home		\$		
Equipment/Tools		\$		
Machinery		\$		
Trailers		\$		
Livestock		\$		
Mineral/Oil Rights		\$		
Other:		\$		
<b>5. Does anyone in your household have any of the following assets?</b> If yes, complete the table below for you and anyone applying with you.			Yes <input type="checkbox"/>	No <input type="checkbox"/>
Type	Who owns this?	Value	Date Acquired	
Life Insurance (Medical Assistance Only)		\$		
Trust		\$		
Burial Plot		\$		
Burial Plan/Contract		\$		
<b>6. Has anyone in your household sold, traded, or given away assets in the last 3 months</b> (For Food Assistance and Retroactive Medical coverage only)?			Yes <input type="checkbox"/>	No <input type="checkbox"/>
Who?	What was traded or given away?		Fair Market Value of item given away	
			\$	
			\$	

Do Not Use.  
Not Applicable at  
This Time.

# STEP 11 Transfer of Assets



**\*\* If the person completing this form is renewing Medicaid benefits for you or your spouse and you or your spouse are currently receiving Medicaid services for Long Term Care Services and Supports, please complete this step.**

**\*\* If the person completing this form is renewing Medicaid benefits for their child who is currently receiving Medicaid services through the Katie Beckett pathway, please complete this section including only your child's assets.**

If you, your spouse, or your child has sold, traded, gifted, or disposed of any assets in the last 12 months, that include those listed above, please complete the section below and attach proof. Examples of resources: Cash, Checking Account, Savings Account, Certificate of Deposit, Promissory Notes, Real Property (land, home, rental property, etc.), Trust Fund, Certificate of Deposit IRA, Promissory Note, Mutual Fund, Mortgages, Stocks or Bonds, Life Insurance, Burial Funds Insurance, Burial Plot, etc.

Transfer Date	Type of Asset	Value of Asset at Time of Transfer	Who received the Asset and the Reason for the Transfer	Amount You Received
		\$		\$
		\$		\$
		\$		\$
		\$		\$
		\$		\$

\*List all household expenses if apply for, or currently receiving, food assistance.

## STEP 12 Tell us about your household's expenses



### 1. How much does your household pay for the following per month? (Food assistance only)

Rent: \$ \_\_\_\_\_ Mortgage: \$ \$500

Property Taxes: \$ \_\_\_\_\_ Homeowners Insurance: \$ \$50 Condo Fee/HOAs: \$ \_\_\_\_\_

If you answered Question #1 - Who pays? Full Name (self)

### 2. Check all the utilities that your household pays any money for separate from your rent.

Electric  Gas  Fuel  Water  Phone (including cell)  Other:

If you answered Question #2 - Who pays? Full Name (self)

### 3. Does anyone in your household pay child support?

Yes  No

If yes, who? \_\_\_\_\_

### 4. Is the household legally obligated to pay child support?

Yes  No

If yes, how much are you required to pay each month? \$ \_\_\_\_\_

How much do you pay each month? \$ \_\_\_\_\_

### 5. Does anyone in your household pay dependent care expense?

Yes  No

If yes, who? \_\_\_\_\_

How much does this person pay? \$ \_\_\_\_\_

How often? \_\_\_\_\_ (daily, weekly, monthly, every two weeks, etc.)

To whom? \_\_\_\_\_ For whom? \_\_\_\_\_

\*Complete Step 13 if renewing Medicaid Coverage for Long-Term Care. Complete Step 14 if applying for cash assistance while awaiting SSI determination.

## STEP 13 Additional Questions Regarding Your Household Costs



(Only complete this step if you or your spouse are renewing Medicaid coverage for Long Term Care services)

1. Are you receiving any housing assistance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. If you are able, do you intend to return home within six months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Does anyone currently live in your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. If yes, are they related to you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. If yes, what is their relationship to you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## STEP 14 Medical or Interim Disability Assistance (IDA)



(Complete only if you are applying for Temporary Cash Assistance While Awaiting Supplemental Security Income (SSI) Determination)

Yes – complete below       No – skip to step 15

1. Have you ever filed a Supplemental Security Income (SSI) application with the Social Security Administration (SSA)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. If yes, when did you file your SSI application with SSA? _____		
3. Is your SSI application still in progress?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Were you previously denied SSI eligibility by SSA on a prior application? (IDA only)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, when was it filed? _____		
If there were any changes to your medical condition to report since the last time you filed an application with SSA for SSI benefits, please list them:		

\*Sign and date to allow DHS to verify the information you provided with agencies listed below.

## STEP 15 Information Exchange & Certification of Application

DHS May Need to Get Information about You

I give my permission to DHS to get information about me from other people, agencies, and businesses. I understand that DHS may contact people on the list below. I understand that DHS may contact other people not on this list. I know that DHS may contact people in the District as well as in Maryland, Virginia, and other states.

- Hospitals, clinics, and other medical and mental health providers;
- Social service agencies;
- Current and former employers;
- Rental agencies, mortgage lenders, utility companies, landlords, and resident managers;
- Schools (public, chartered, and private);
- Childcare and adult care providers;
- Parents and caretakers of children;
- Department of Behavioral Health (DBH),
- Department of Health (DOH);
- DC Housing Authority (DCHA);
- Department of Employment Services (DOES);
- Office of Tax and Revenue (OTR);
- Internal Revenue Service (IRS);
- Department of Motor Vehicles (DMV);
- Banks, credit unions, and other lending institutions;
- Credit bureaus and other reporting agencies; and
- Any other persons, agencies, and businesses as necessary

I give all these people my permission to give information about me to DHS. This includes details about my health, my income, my assets, my bills, and my family. This also includes any government, medical, and social services records about me. I know that DHS will treat all my information as confidential. I will cooperate with providing any specific written authorizations that any of these people require before they will give DHS my information.

### Illegal Use of Benefits and Penalties

The District of Columbia may pursue criminal charges against you and seek to disqualify you from receiving public assistance in the future if you break the public assistance program laws.

You must not:

- Allow someone else to use your Medicaid card/benefits;
- Continue to use your Medicaid card/benefits if no longer a resident of DC;
- Accept payment from a provider in return for receiving Medicaid covered services, unless authorized as part of an approved Department of Health Care Finance (DHCF) program;
- Give false information or withhold information to get or continue to get benefits;

**I attest and declare under penalty of perjury to the best of my knowledge and belief that the information submitted is correct and the person(s) for whom I am applying for benefits is/are U.S. citizen(s) or are lawfully present in the United States.**

Sign here

Date

**Signature**

**Today's Date**

Applicant or Representative Signature

\*Complete Appendix A if receiving, or eligible for medical benefits from an employer.

## Appendix A Health Coverage from Jobs



Form Approved  
OMB No: 0938-1191

(Please complete only if applying for Medical Assistance and someone in the household is eligible for health coverage from a job)

### Health Coverage from Jobs

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

#### Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

#### Employee Information

Employee name (First, Middle, Last)

Social Security Number (SSN)

#### Employer Information

Employer name

Employer Identification Number (EIN)

Employer address

Employer phone number

City

State

ZIP

Who can we contact about employee health coverage at this job?

Phone number (if different from above)

Email address

Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

Yes (Continue)



**If you're in a waiting or probationary period, when can you enroll in coverage?**

(mm/dd/yyyy) \_\_\_\_\_

List the names of anyone else who is eligible for coverage from this job.

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

**No** (Stop here and go to Step 5 in the application)

**Tell us about the *health plan* offered by this employer**

Does the employer offer a health plan that meets the minimum value standard\*? Yes  No

For the lowest-cost plan that meets the minimum value standard\* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

\* A health plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the minimum value standard.

How much would the employee have to pay in premiums for this plan? \$

How often? Weekly  Every two weeks  Twice a month  Once a month   
Quarterly  Yearly

What change will the employer make for the new plan year (if known)?

- Employer won't offer health coverage
- Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard\*(Premium should reflect the discount for wellness programs.)

How much will the employee have to pay in premiums for that plan? \$

How often? Weekly  Every two weeks  Twice a month  Once a month   
Quarterly  Yearly

Date of change: (mm/dd/yyyy)

\*Continued from Appendix A. Complete to the best of your ability.

## Employer Coverage Tool

Form Approved

OMB No: 0938-1191

Use this tool to help answer questions in your Medical assistance application, Appendix A. That part of the application asks about any employer health coverage that you're eligible for **\*(even if it's from another person's job like a parent or a spouse)**. The information in the boxes below match the boxes in Appendix A. For example, you can use the answer to question 14 on this page to answer question 14 on Appendix A.

**Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one for *each* employer that offers health coverage that you're eligible for.**

### Employee Information

The employee needs to fill out this section.

1. Employee name: (First, Middle, Last)

2. Employee Social Security number (SSN)

### Employer Information

Ask the employer for this information.

3. Employer name

4. Employer Identification Number (EIN)

5. Employer address (the Marketplace will send notices to this address)

6. Employer phone number

7. City

8. State

9. Zip code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)

12. Email address

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Go to question 13a).

**13a.** If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? \_\_\_\_\_ (mm/dd/yyyy) (Go to next question)

**No** (STOP and return this form to employee)

**Tell us about the *health plan* offered by this employer**

Does the employer offer a health plan that covers an employee's spouse or dependent?

**Yes, which people?**    Spouse    Dependent(s)

**No** (Go to question 14)

**14.** Does the employer offer a health plan that meets the minimum value standard\*?

**Yes** (Go to question 15)    **No** (STOP and return this form to employee)

**15.** For the lowest-cost plan that meets the minimum value standard\* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

**a.** How much will the employee have to pay in premiums for this plan?

\$

**b.** How often?

Weekly    Every two weeks    Twice a month    Once a month    Quarterly    Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return this form to employee.

**16.** What change will the employer make for the new plan year (if known)?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard\*(Premium should reflect the discount for wellness programs.)

How much will the employee have to pay in premiums for that plan?

\$

How often?   Weekly    Every two weeks    Twice a month    Once a month   
Quarterly    Yearly

Date of change: \_\_\_\_\_ (mm/dd/yyyy)

\*Complete Appendix B entirely if someone in the home identifies as American Indian or Alaskan Native.

# Appendix B American Indian/Alaska Native Identification

Form Approved

OMB No: 0938-1191

## American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Combined Application for Food, Medical, and Cash benefits.

### Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following question to make sure your family gets the most help possible.

**NOTE:** If you have more people to include, make a copy of this page and attach.

	AI/AN Person 1		AI/AN Person 2	
1. Name (First name, Middle name, Last name)	First	Middle	First	Middle
	Last		Last	
2. Member of a federally recognized tribe?	Yes <input type="checkbox"/> If yes, tribe name:		Yes <input type="checkbox"/> If yes, tribe name:	
	No <input type="checkbox"/>		No <input type="checkbox"/>	
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian Health program, or through a referral from one of these programs?	Yes <input type="checkbox"/> No <input type="checkbox"/> If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/> If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? Yes <input type="checkbox"/> No <input type="checkbox"/>	

<p>4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:</p> <ul style="list-style-type: none"><li>• Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties</li><li>• Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)</li><li>• Money from selling things that have cultural significance</li></ul>	<p>\$</p> <p>How often? _____</p>	<p>\$</p> <p>How often? _____</p>
---	-----------------------------------	-----------------------------------



\*Complete Appendix C only if beneficiary would like to appoint an authorized representative.

## Appendix C Authorized Representative Authorization



You can name people to act on your behalf in up to 3 roles. For Medicaid, you can also pick an organization.

Medical <input type="checkbox"/>	<b>REPRESENTATIVE</b> - This person/organization can apply for benefits, provide interview assistance, receive notices, report changes, and make inquiries. Your household will be held liable for any over issuance that results from the representative providing incorrect information.					
	<b>Full Name</b>			<b>If person, Date of Birth</b>		
	<b>Phone</b>			<b>Email</b>		
	<b>Address</b>		<b>Unit</b>	<b>City</b>	<b>State</b>	<b>ZIP</b>
	<b>I authorize this person to:</b> (check all that apply)					
Apply for benefits <input type="checkbox"/>		Interview Assistance <input type="checkbox"/>	Receive notices <input type="checkbox"/>	Report changes <input type="checkbox"/>	Make inquiries <input type="checkbox"/>	

By signing, I certify that the individual(s) designated above is (are) allowed to act on my behalf. I understand that anyone knowingly providing false information may be prosecuted under applicable federal and state statutes. If the District determines that an authorized representative has knowingly provided false information about the household circumstances or has made improper use of benefits, it may disqualify that person from being an authorized representative for up to one year. I understand that the power to act as an authorized representative is valid until I modify the authorization or notify the agency that the representative is no longer authorized to act on my behalf, or the authorized representative informs the agency that he or she no longer is acting in such capacity, or there is a change in the legal authority upon which the individual or organization's authority was based.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

I agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

(If authorized representative for Medicaid is a provider or staff member or volunteer of an organization) I affirm that I will adhere to the regulations in 42 CFR part 431, subpart F and at 45 CFR §155.260(f), 42 CFR §447.10, as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information.

Authorized Representative Signature \_\_\_\_\_ Date \_\_\_\_\_













# Appendix E Certification of Breast or Cervical Cancer Screening

(This Appendix is ONLY to be completed by Project Wish to be used for a Breast and Cervical Cancer Medicaid application.)

<b>Medicaid Applicant Name (first, middle, last)</b>
--

<b>Social Security Number</b>	<b>Date of Birth</b>
-------------------------------	----------------------

**Project Wish Coordinator: Please read the responses below and check YES if the applicant is enrolled in Project Wish.**

YES <input type="checkbox"/>	<p>This applicant is enrolled in Project Wish, the D.C. Center for Disease Control and Prevention’s (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and has received screening and/or diagnostic testing per the NBCCEDP guidelines. (If yes is selected, this form must be completed by the diagnosing or treating physician)</p>
------------------------------	--

YES <input type="checkbox"/>	<p>This applicant was screened by the Center for Disease Control and Prevention’s (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) _____ (list the state and program name here), and has received screening and/or diagnostic testing per the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) guidelines. (If YES is selected, this form must be completed by the diagnosing or treating physician).</p>
------------------------------	---

Do Not Use.  
For Project Wish  
Only.

<b>Diagnosis Information for the Medicaid Applicant</b>	
---	--

<b>Diagnosis:</b>	
-------------------	--

<b>Physician Comments:</b>	
----------------------------	--

<b>Diagnosis Date:</b>	
------------------------	--

<b>Physician Signature:</b>	<b>Date:</b>
-----------------------------	--------------

<b>Physician Name:</b>	
------------------------	--

<b>Facility/Hospital/Clinic Name:</b>	
---------------------------------------	--

<b>Facility/Hospital/Clinic Address:</b>	
--	--

**I am signing this form under penalty of perjury, which means I’ve provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I willfully provide false or untrue information.**

<b>NBCCEDP Coordinator Signature:</b>	<b>Date:</b>
---------------------------------------	--------------

<b>NBCCEDP Coordinator Name:</b>	
----------------------------------	--

**\*Read Carefully. Step 19 explains your right and program rules.**

## **STEP 19**    **Read about your rights and program rules.**

### **General Rules**

You must give true and complete information. If you lie or give false information, you may lose your benefits. You could also be fined and go to prison. We may verify your information to make sure it is correct. We may check on your income, your Social Security information, and your immigration information. We verify this information through computer matching programs. We may also interview you and do a home visit. Your case may be chosen for a Quality Control review. This is a detailed review of all of your information. It may include personal interviews and a review of your medical records. By applying, you agree to cooperate with the State and Federal reviewers. If you refuse to cooperate, you may lose all or part of your benefits. If you are under investigation or are fleeing to avoid the law, we may share your information with federal and local agencies. If a SNAP claim arises against you, the information on this form, including Social Security Numbers (SSNs), may be sent to Federal and State offices, or private claims collection agencies for claims collection action against all adults in the household. Under federal and District law, you must provide your Social Security Number (if you have one) to receive benefits for yourself unless you are applying for the Healthcare Alliance or Immigrant Children Program and do not declare yourself to be a U.S. Citizen or qualified alien (See 22-B DCMR §3304, §3305, and §3306, 42 CFR §435.910, 42 USCS §1320b-7(a)(1), 45 C.F.R. §155.310(a)(3), 7 CFR §273.6, DC Code §4-204.07, §4-205.05a, §4-205.72, §4-217.07, and Mayor's Order 92-49). The alien status of applicant household members shall be subject to verification by USCIS through the submission of information from the application to USCIS, and the submitted information received from USCIS may affect your household's eligibility and level of benefits.

Your SSN will be used to verify your identity and citizenship, determine eligibility and amount of benefits prevent receipt of duplicate benefits, and make required program changes. The DHS computer system uses your SSN to verify your income through the Income and eligibility verification system (IEVS) using records from federal and local sources, including the United States Internal Revenue Service (IRS), the United States Social Security Administration (SSA), DC Department of Employment Services (DOES), and the DC Child Support Services Division (CSSD). Information from IEVS will be requested, used, and may be verified through collateral contact when DHS finds discrepancies. This information may affect your household's eligibility and level of benefits. DHS also reserves the right to check your information with income verification services and other local agencies.

You must promptly report changes that may affect your eligibility for medical assistance; change in residence, income, who lives with you, change in citizen/immigration status, and incarceration. If you receive Medicaid as a person who is aged, blind, or disabled, you must report changes in assets. To report a change, call (202) 727-5355.

All information and documentation gathered for determining your Medical Assistance eligibility or other program related use is confidential. Each program provides safeguards, restricting the use and disclosure of information about you to purposes directly connected with the administration of the program. Releasing information concerning your eligibility to anyone not authorized to receive the information is a violation of Federal and D.C. law and may result in legal action. We will keep your eligibility information confidential unless you give us permission (or we are permitted by law) to release information to others.

### **Head of Household**

The head of household is the person responsible for filling out this application and the person who will be the point of contact for DHS in communicating about your household's benefits. Your household may select a new head of household at each certification action or whenever there is a change in your household's composition. To report a change to the head of household, contact DHS. If you are applying for benefits for only yourself, you are the head of household. If multiple people living in your household are seeking benefits, follow the guidelines below to select your head of household:

- If there are one or more children under the age of 18 living in your household, the head of household must be either a parent, over the age of 18, of the child(ren) or an adult, over the age of 18, who has parental control over the child(ren).
- If there are no children under the age of 18 living in your household, choose a head of household from among the adults over the age of 18 living in your household.

If your household cannot agree on a person to appoint as your head of household, DHS will designate an individual in your household as its head of household.

### **Recertification**

We will send you a recertification notice in the mail. If you get Medical Assistance and your Also, please let us know if you move. It is your responsibility to keep us informed of your current address so that we can send you important forms and notices concerning your benefits. Your address may also be used to provide your benefit card(s). Call **(202) 727-5355** to report your new address.

### **Human Rights**

In accordance with the DC Human Rights Act of 1977, as amended, DC Official Code § 2-1401.01 et seq., (Act) the District of Columbia does not discriminate on the basis of actual or perceived: race, color, religion, national origin, sex (gender or sexual harassment), age, marital status, gender identity or expression, personal appearance, sexual orientation, familial status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income, status as a victim of an intra-family offense, and place of residence or business. Sexual harassment is a form of sex discrimination, which is prohibited by the Act. In addition, harassment based on any of the above protected categories is prohibited by the Act. Discrimination in violation of the Act will not be tolerated. Violators will be subject to disciplinary action. COMPLAINTS OF POSSIBLE VIOLATIONS OF THIS LAW MAY BE FILED WITH: Government of the District of Columbia Office of Human Rights  
| 441 4th Street, N.W., 570N Washington, D.C. 20001 | Telephone: (202) 727-4559 | Fax: (202)727-9589| TTY 711

### **Fair Hearings**

If you think that DHS has made a mistake, then you can get a Fair Hearing. Call (202) 442-9094 to find out more. At a Fair Hearing, you can ask someone else to speak for you. This could be an attorney, a friend, a relative, or someone else. You can also bring witnesses. We will pay for transportation to the Fair Hearing for you and your witnesses. We may also pay for some of your other costs. You can also get free legal help for a Fair Hearing. Call one of the organizations on the Referrals page (on page 26) to get free legal help. You may request a Fair Hearing through any of the following methods:

- Calling the ESA Call Center (202) 727-5355
- Completing a Request for Hearing form and fax it to (202) 724-2041, or email to [DC.OARA@DC.GOV](mailto:DC.OARA@DC.GOV)
- Go to any Department of Human Services Service Center to fill out a Request for Hearing.
- Go to the Office of Administrative Hearings (OAH) Resource Center, located at 441 4th Street NW, Suite 450-North, Washington, DC 20001, call OAH (202) 442-9094, or complete a Request for fair hearing form and fax it to (202) 442- 4789 or email it to [oah.filing@dc.gov](mailto:oah.filing@dc.gov).
- (Medical Assistance Only) Contacting the Office of Health Care Ombudsman & Bill of Rights, located at 441 4th Street NW, Suite 250 North, Washington DC 20001, call the Ombudsman at (202) 724 -7491 or 1 (877) 685-6391, by confidential fax at (202) 478-1397, by email at [healthcareombudsman@dc.gov](mailto:healthcareombudsman@dc.gov) , or visit their website at [www.healthcareombudsman.dc.gov](http://www.healthcareombudsman.dc.gov)

You may request an expedited Fair Hearing on Medicaid when the standard time allotted for the Fair Hearings process may jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function. For Medicaid, you must receive a final decision on your Fair Hearing within 90 days, or 7 business days for an expedited Fair Hearing concerning eligibility.

### **Medical Assistance Rules**

Use this application to apply for medical assistance. After you apply, you will get a decision about your Medical Assistance within 45 days (or 60 days if DHS must determine if you are disabled). If you do not get a notice within this period, please call (202) 727-5355. If you get Medicaid, then you must recertify each year when we send you a recertification notice. There is no time limit for getting Medical Assistance. Also, if you lose TANF, you may still get Medical Assistance.

**Child Support:** You agree to cooperate fully with the DC Child Support Services Division (CSSD), unless exempt, in establishing paternity and establishing child and medical support as required by law. Pregnant women are not required to cooperate in establishing paternity and obtaining medical support. You can lose your benefits if you do not cooperate. If you have a good reason for not cooperating with CSSD, such as fear for your safety or your families' safety, you do not have to cooperate with CSSD. However, you must apply for an exception to cooperation. If you have questions, call (202) 442-9900.

**Estate Recovery:** The District will seek recovery for the bills we pay if you are in a nursing home or other medical institution. Also, if you are age 55 or older, the District will seek recovery for services that you get. This means that we may put a lien or claim on your property or estate. If you have questions, call (202)698-2000.

**Lawsuits:** If you sue or enter into settlement negotiations with a third party for a medical claim or injury, you must provide written notice of the action (either by personal service or certified mail) within 20 calendar days to the Medical Assistance Administration, Third Party Liability Section, 441 4th Street, N.W., Suite 1000-South, Washington, DC 20001. If you have questions, call (202)698-2000.

**Out of Pocket Reimbursement Information:** If you paid for drug prescriptions, doctor visits, or hospitalizations during a time that you were eligible for Medicaid, you may be able to be reimbursed for the expenses.

**Requirements:** You may be eligible for reimbursement if during a period of time you or a family member were eligible for Medicaid, and

- a. You paid for drug prescriptions, doctor visits, or hospitalizations; or
- b. You are still paying a bill or are being asked to pay a bill by a pharmacy, clinic, doctor, or hospital for drug prescriptions, doctor visits, or hospitalizations.

If you believe that you are entitled to reimbursement, you must request reimbursement within six (6) months of the date you went to the pharmacy, clinic, doctor, or hospital, or within six (6) months of the date you learned you were eligible for Medicaid, whichever is later.

You must complete and submit a Medicaid Reimbursement Request Form to the DC Department of Health Care Finance (DHCF). You can get a copy of the form at any ESA office, or you can download a copy at <https://www.dcmcaid.com/dcwebportal/nonsecure/recipientForms>

If you have questions or if you need help completing this form or obtaining requested information, contact:

- a. The Medicaid Recipient Claims Research Team of the D.C. Department of Health Care Finance (DHCF) at (202) 698- 2009.
- b. Terris Pravlik & Millian, LLP, 1816 12th Street, Suite 303, N.W., Washington, DC 20009-4422, (202) 682-2100, who will provide you with free legal assistance.

A decision on your reimbursement claim must be made within 90 days:

- a. The Medicaid Recipient Claims Research Team must make a decision on your reimbursement claim within 90 days from the time you file your claim. If no decision is made within those 90 days, your claim will be treated as valid, and you will be paid within 15 days after the end of the 90-day period.
- b. If you are not satisfied with the decision of the Medicaid Recipient Claims Research team, you have a right to a Fair Hearing. You may request a Fair Hearing by calling the District of Columbia Office of Administrative Hearings (OAH) at (202) 442-9094. OAH is located at 441 4th Street, N.W., Washington, DC 20001-2714.
- c. If you are not satisfied with the result of the fair hearing, you may appeal to the United States District Court of the District of Columbia within 30 days.

You may obtain free legal assistance to help you present your case at the fair hearing or at the appeal by contacting Terris Pravlik & Millian, LLP at 1816 12th Street, Suite 303, N.W., Washington, DC 20009-4422, (202)682-2100.

**Social Security Number:** For Medicaid, providing the Social Security Number (SSN) of non-applicants is voluntary. In connection with Medicaid, a non-applicant's SSN would be used only to determine an applicant's or beneficiary's eligibility for Medicaid or other insurance affordability program or for a purpose directly connected to the administration of the Medicaid State plan.



The Department of Human Services (DHS) complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. DHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. DHS:

- Provides free aids and services to people with disabilities to 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 OR Information written in other languages

If you need these services, contact Surobhi Rooney. If you believe that DHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Surobhi Rooney, DHCF Civil Rights Coordinator 441 4th St. NW, Washington, DC 20001 [surobhi.rooney@dc.gov](mailto:surobhi.rooney@dc.gov). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Surobhi Rooney 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 through the Office for Civil Rights Complaint Portal, available 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 <http://www.hhs.gov/ocr/office/file/index.html>. DHS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

### **Interim Disability Assistance (IDA)**

After you apply, you will get a decision about your IDA within 60 days. Applicants for IDA must also apply for Supplemental Security Income (SSI) and provide proof of the date of the SSI application. An application for IDA is considered to be filed when it is received at the designated ESA Service Center and a face-to-face interview is complete. If you do not get a notice within 60 days, you can get a Fair Hearing. Approval of IDA is contingent on the availability of funds. If funds are exhausted at the time the customer is determined to meet all eligibility requirements, the customer will be placed on a waiting list, and approved when funds become available. Also, if you do not think your benefit amount is correct, then you can get a Fair Hearing.

If you get IDA, then you must cooperate with your IDA case manager. This means:

- Give us medical reports and other materials;
- Keep your appointments with the doctor and with the Social Security Administration;
- Keep your appointments with your case manager; and
- Go to treatment programs, as required.

If you do not follow these rules, then you may lose part or all of your IDA benefits. Also, DHS will take out the amount of IDA that you got from your first "lump sum" SSI check; DHS will send the rest of your first SSI check to you. Applicants for IDA must sign a DHS 340, Authorization for Reimbursement of Interim Assistance, agreeing to reimburse ESA for the cost of their IDA payments. The IDA recipient will repay the entire amount of the IDA assistance payments received if the SSI benefits received for the same period equals or exceeds the IDA payments. If the SSI benefits are less than the IDA payments for the same period the SSI benefits were received, the recipient will repay that portion of the IDA payments that equals the amount of SSI benefits. You will be liable for the IDA received if SSA finds you disabled, but you withdraw your SSI application before back benefits are paid.

### **USDA/HHS Joint Nondiscrimination Statement**

This institution is prohibited from discriminating based on race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: <https://www.ascr.usda.gov/filing-program-discrimination-complaint-usda-customer> , and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. mail: U.S. Department of Agriculture

Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW  
Washington, D.C. 20250-9410

2. fax: (202) 690-7442; or

3. email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: <https://www.fns.usda.gov/snap/state-directory>

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (800) 368- 1019 (voice).

This institution is an equal opportunity provider.





**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
**DEPARTMENT OF HUMAN SERVICES**



**You may go to any of these Service Centers for assistance between the hours of 7:30 AM and 4:45 PM, Monday through Friday.**

**OR**

You can call the DHS Call Center for assistance. If there is heavy call volume, you will have the option to request an automated callback.

- For general questions about DHS benefits or a notice or form you have received, call (202)727-5355.

If you are Hearing Impaired, you may call TTY/TDD 711 (855) 532 5465.

Fort Davis Service Center  
3851 Alabama Avenue, SE  
Washington, DC 20020  
Fax: (202) 645-6205

Anacostia Service Center  
2100 Martin Luther King Avenue, SE  
Washington, DC 20020  
Fax: (202) 727-3527

Congress Heights Service Center  
4049 South Capitol Street, SW  
Washington, DC 20032  
Fax: (202) 645-4524

Taylor Street Service Center  
1207 Taylor Street, NW  
Washington, DC 20011  
Fax: (202) 576-8740

H Street Service Center  
645 H Street, NE  
Washington, DC 20002  
Fax: (202) 724-8964

