Retroactive Medicaid Application for Institutional Care

If you are requesting retroactive Medicaid coverage to pay for medical bills that you received in a Nursing Facility, Skilled Nursing Facility, or Intermediate Care Facility for the Developmentally Disabled 3 months prior to filing your Medicaid Long Term Care Application (retroactive months), please complete, sign and return this application form. This form will be used to determine if you qualify for retroactive Medicaid coverage. You must meet all eligibility requirements for Long Term Care Medicaid coverage during the retroactive period to qualify for Long Term Care Retroactive Medicaid coverage.

How to Submit this Retroactive Medicaid Coverage Application

Mail: Department of Human Services
Case Records Management Unit
441 4th Street, NW, Suite 1C-15
Washington, DC 20001

Email: esanursing.home@dc.gov

You may upload this application through Quickbase

Fax: (202) 535-1122

Drop Off: You may drop off the completed and signed form at any of the below service centers.

H Street Service Center
609 H Street, NE
Washington, DC 20002

Congress Heights Service Center
4001 South Capitol Street, SW
Washington, DC 20032

Fort Davis Service Center
3851 Alabama Avenue, SE
Washington, DC 20020

Anacostia Service Center
2100 Martin Luther King Avenue, SE
Washington, DC 20020

Taylor Street Service Center
1207 Taylor Street, NW
Washington, DC 20011

1 Applicant Information

Tell Us About Yourself *We will use this information to contact you, if needed.*

Your Name *(first, middle, last)*

____

____

Social Security Number **or** DC Medicaid Number *Date of Birth (mm/dd/yyyy)*

____

City State ZIP code

____

Phone number *(if you have one)*______________________________Email address *(if you have one)*___________________________

Are you applying for retroactive coverage for yourself? Yes ☐ No ☐

2 Residence History

Did you live in D.C. throughout the entire three retroactive months? Yes ☐ No ☐

If no, please tell us which months you did not live in D.C., the state where you were living, and which month you moved into the District.

At any time during the three retroactive months, was your U.S. citizenship/eligible immigration status different from your status at the time you applied for LTC Medicaid? Yes ☐ No ☐

If yes, please tell us when your citizenship/eligible immigration status changed and you became a U.S. citizen or met one of the eligible immigration status categories.

______________________________________ _______________________ _____________________

3 Citizenship/Eligible Immigration Status* Information

Please see **Attachment B for more information on what is an eligible immigration status for Medicaid.*

4 Resource History

At any time during the three retroactive months, did you or your spouse have resources different in type or value from the resources you had at the time you applied for LTC Medicaid? Yes ☐ No ☐

Did you and your spouse own the same resources such as cars, home, insurance policies and bank accounts in the three retroactive months as you owned at the time you applied for LTC Medicaid? Yes ☐ No ☐

If your resources were different please explain below.

5 Income History

At any time during the three retroactive months, did you or your spouse have income different from the income you had at the time you applied for LTC Medicaid? Yes ☐ No ☐

If yes, tell us whose (yours or your spouse's) income changed and what the gross income was for each of the three retroactive months for which coverage is requested**.**

Name (first and last)	Month Before LTC Application	Two Months Before LTC Application	Three Months Before LTC Application
____________________	$____________________	$____________________	$____________________
Name (first and last)	Month Before LTC Application	Two Months Before LTC Application	Three Months Before LTC Application
____________________	$____________________	$____________________	$____________________
Name (first and last)	Month Before LTC Application	Two Months Before LTC Application	Three Months Before LTC Application
____________________	$____________________	$____________________	$____________________

6 Signature

If we have existing records or receive information that does not reasonably match the information you provided on this retroactive Long Term Care Medicaid application form, you may be required to provide additional documentation to verify resources, income, residency or citizenship.

Sign this application. The person who filled out this retroactive Long Term Care Medicaid application should sign below. If you want an authorized representative or want to change the authorized representative you have now, fill out Attachment A on page 4.

☐ Check here if you are an authorized representative. Sign below and fill out Attachment A on page 4.

I am signing this application under penalty of perjury which means I have 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 provide false and or untrue information.

Signature____ Date____________________

Print Name____

7 Notice of Rights and Responsibilities

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.

You may designate someone as your authorized representative. This gives them the authority to file the application on your behalf. If you designate someone to be your authorized representative, the agency will send them copies of notices that they send to you. They may submit verifications on your behalf as well.

Your case may be chosen for a Quality Control review. This is a detailed review of all of your information. It may include some personal interviews and a review of your medical records. By applying, you agree to cooperate with the state or 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.

Under federal and District law, you must provide your Social Security Number (if you have one) if you are seeking Medicaid. (See 42 CFR 435.910) Your SSN will be used to verify your identity, prevent receipt of duplicate benefits, and make required program changes. The Department of Human Services (DHS) computer system uses your SSN to verify your income by using records from the Internal Revenue Service, the Social Security Administration, and the DC Child Support Services Division (CSSD).

Medical Assistance Rules After your complete application is submitted to ESA, 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 the DC Medicaid Branch on (202) 698-4220 or the Change Center on (202) 727-5355.

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.
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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. You can get a copy of the form at any ESA office, or you can download a copy at https://www.dc-medicaid.com/dcwebportal/nonsecure/recipientForms.

IF YOU HAVE QUESTIONS OR IF YOU NEED HELP COMPLETING THE 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 NW, Suite 303, Washington, DC 20009, (202) 682-0578, 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 Office of Administrative Hearings at (202) 442-9094. The Office of Administrative Hearings is located at 441 4th Street, NW; Washington, DC 20001-2714.
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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 NW; Suite 303, Washington, DC 20009 or (202) 6820578.

Estate Recovery The District may seek recovery for all the bills paid by Medicaid on your behalf, including nursing home, waiver or services provided in other medical institutions. For more information on estate recovery, contact the Department of Health Care Finance, Health Operations Administration, Third Party Liability Division at (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, NW, Suite 1000-South, Washington, DC 20001. If you have questions, call (202) 698-2000.

Reporting Changes You must report changes in your income, Medicare status, marital or institutional status, who lives with you, or if you move from D.C. You may want to report a change of District address, changes in your shelter costs and changes in medical expenses. To report a change, call (202) 727-5355. You must call us by the 10th day of the month after the change. You may also call the LTC unit at (202) 698-4220 to report changes that will affect what you need to pay for your Long-Term Care services.

Confidentiality By applying, you give DHS permission to talk with your employer, your landlord, your nursing facility, your bank, your doctor, and other people who have information about you. You also give these people your permission to give information about you to DHS. In addition, you also give DHS permission to look at your motor vehicle records, wage data, tax information, and other government records. DHS keeps all of your information confidential. DHS does not release your records without your permission, except as permitted or required by law.

Discrimination is Against the Law DHCF and DHS comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. DHCF and DHS do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Attachment A

Authorized Representative

You can choose an authorized representative.

You can give a trusted person permission to talk about this retroactive Medicaid Long Term Care application form with us, see your information, and act for you on matters related to this retroactive Medicaid Long Term Care application form, including getting information about your retroactive Medicaid Long Term Care application form and signing your retroactive Medicaid Long Term Care application form on your behalf.

This person is called an "authorized representative". If you are a legally appointed representative for someone on this retroactive Medicaid Long Term Care application form, submit proof with this application form. If you ever need to change your authorized representative, contact Department of Human Services (DHS).

Name of authorized representative:

Address:	Apartment #	City	State	ZIP code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other Number

Number:

The Medicaid member requesting retroactive coverage needs to sign below to confirm selection of an authorized representative. If the Medicaid member is unable to sign, then the authorized representative will have to provide proof of their appointment to represent the Medicaid member. By signing, you allow this person to sign and submit your retroactive Medicaid application form, get official information about this retroactive Medicaid form, receive copies of notices and other communications from DHS and DC Health Link, and act on your behalf on all future matters with DHS and DC Health Link.

Your Signature:	Date

Printed Name:

Attachment B	**Eligible Immigration Status**

Eligible Immigration Status Chart	
For all applicants, these are eligible immigration statuses:	**If the person is an individual under the age of 21 or a pregnant woman**, these are additional eligible immigration statuses:
• Lawful Permanent Resident (LPR, or "Green card" holder) • Asylee • Refugee • Cuban or Haitian entrant • Individual paroled into the U.S. for at least one year • Conditional entrant granted before 1980 • Battered spouse, child and parent • Victim of Trafficking and his/her spouse, child, sibling or parent • Individual granted Withholding of Deportation or Withholding of Removal • Amerasian Immigrant • Iraqi and Afghan Special Immigrants • Member of a federally-recognized Indian tribe or American Indian Born in Canada • Veterans or individuals on active duty in the Armed Forces and their immediate family members	• Individual with Non-immigrant Status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau) • Individual with Temporary Protected Status (TPS) or Applicant for Temporary Protected Status (TPS) (with Employment Authorization) • Individuals with Deferred Enforced Departure (DED) • Family Unity beneficiary • Individual with Deferred Action Status • (Except Individual with Deferred Action for Childhood Arrivals (DACA). DACA is not an eligible immigration status)Applicant for Special Immigrant Juvenile Status • Applicant for Adjustment to LPR Status • Applicant for Asylum • Applicant for Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) • Applicant who has filed for creation of record of lawful admission for permanent residence (Registry Applicants) (with Employment Authorization) • Individual released on an order of Supervision (with Employment Authorization) • Applicant for Cancellation of Removal or Suspension of Deportation (with Employment Authorization) • Applicant for Legalization under IRCA (with Employment Authorization) • Legalization under the LIFE Act (with Employment Authorization) • Individual Lawfully Admitted with Temporary Resident Status • Resident of American Samoa • Individual granted administrative order staying removal issued by the Department of Homeland Security