



DHS Form 1209-W: Annual POC Medicaid Waiver Recertification

(for Codes 853, 853Q, 853S)

Please complete, sign, and fax to the IMA Medicaid Branch

Last Name	First Name	Middle	Telephone (Home)	
Address Where You Live	Street	City	State	Zip
Mailing Address (if different)	Street	City	State	Zip
Social Security Number	Date of Birth	Sex	ACEDS Case # (if available)	

1. Have you completed a recent level-of-care assessment? Yes No
2. Do you currently receive SSI? (if YES, stop here, sign and return) Yes No
3. Are you still a District resident? Yes No
4. Is your income still below the special income limit* for the Waiver? Yes No
 * 300% of the SSI payment level
5. Are your countable resources still below the categorically needy level? Yes No
6. Do you receive Medicare? If so, provide Medicare # or copy of card. Yes No
7. Please describe below any changes in your household or circumstances.

Signature of Customer or Auth. Rep.

Date