GOVERNMENT OF THE DISTRICT OF COLUMBIA

SAMPLE NOTICE: Conversion Renewal Form

04/01/2023 Account ID: 999999999

JOHN DOE
441 4TH STREET, NW
WASHINGTON, DC 20001

Subject: Important Message About Your Medical Assistance
Dear JOHN DOE:

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 **6/30/2023.** 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.

This decision is supported by the following provision of the District of Columbia Municipal Regulations: 22 DCMR § B3306.4.

After your renewal form is processed, you may be required to submit additional documentation to verify information provided on your renewal form or in your face to face interview. If you are required to provide additional information then you will be sent a separate notice in the mail. If you fail to renew your eligibility for health coverage within the specified time period, **you will lose your health coverage**.

If you are hospitalized, disabled, elderly, or caring for a household member who is hospitalized, disabled, or elderly, you may be exempt from having to attend a face-to-face interview. If you feel you qualify for a face-to-face interview exemption, please contact your local Service Center. (see insert for list of service center locations.)

How Soon We Need Your Documents

We need your completed form by **6/30/2023** in order to make a decision about your eligibility for medical assistance. 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, or in-person. Please refer to the attached information sheet.

DISTRICT OF COLUMBIA

Department of Human Services (DHS)
Economic Security Administration (ESA)

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.

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

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

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

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

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

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.

FOR AGENCY USE ONLY	Date Received:	Date Disposed:	Case Number:

Programs Applied For:		Application Type
☐ Medical	☐ Approved ☐ Pended ☐ Denied	☐ Renewal

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 ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (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 dɛ nià kɛ dyédé gbo: Ɔ jǔ ké m̀ [Bàsɔ́ɔ̀-wùdù-po-nyɔ̀] jǔ ní, nìí, à wudu kà kò dò po-poɔ̀ bɛ́ìn m̀gbo kpáa. Đá (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 করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় 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: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บรการช่วยเหลือทางภาษาได้ฟรี 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?	☐ English	☐ Spanish	☐ Vietnamese	☐ French	☐ Korean	☐ Amharic	☐ Chinese (Mandarin)	☐ Chinese (Cantonese)	☐ Other
What Language do you need to speak to get ESA services?	☐ English	☐ Spanish	☐ Vietnamese	☐ French	☐ Korean	☐ Amharic	☐ Chinese (Mandarin)	☐ Chinese (Cantonese)	☐ Other
If you need an interpreter, what language do you need interpreted?	☐ English	☐ Spanish	☐ Vietnamese	☐ French	☐ Korean	☐ Amharic	☐ Chinese (Mandarin)	☐ Chinese (Cantonese)	☐ Other

Do you want free language interpretation?

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

I,_____, 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 Date

_____ _____

Applicant or Representative Signature

OFFICE 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.

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	**Last Name**	
Middle Name	**Suffix (Jr., III., etc.)**	
Residential Address (where you live)		**Unit**
City	**State**	**ZIP**
Mailing Address (If different)		
City	**State**	**ZIP**
Preferred Phone (please note, only mobile phones may receive text messages) (_____) _____ - _____		
Is your Preferred Phone a mobile or landline phone? **Mobile** ☐ **Landline** ☐		
Email		
☐ 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.		

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

Yes ☐ Make sure to complete Appendix C (page 34) No ☐

STEP 2 Tell us about everyone in your household, even if you are not requesting benefits for them - Household members 1 & 2

**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).

	Example	Household Member #1 (YOU)	Household Member #2
1. First Name	Maya		
Middle Name	Michelle		
Last Name	Johnson		
Suffix (Jr., Sr., IV, etc.)			
2. Which benefits is this person applying for with your household? (List all that apply. If none, write "N/A")	Food, Cash, Medical		
3a. Date of Birth	01/23/1987		
3b. Gender (male, female)	Female		
3c. Are you Hispanic or Latino?	No		
4. Race/Ethnicity: (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.	African America n		
5. Social Security Number *(you may leave this blank if the person does not have an SSN or is not applying for benefits)*	555-55-5555		
If this person does not have a Social Security and is applying for benefits, has he/she applied for a Social Security Number?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If this person has not applied for an SSN, and is applying for benefits, why has he/she not applied?	Not eligible for SSN		
6. What is this person's marital status? (Never been married, married, separated, divorced, widowed)	Married		
7. Relationship to you	Daughter	Self	

8. Are you or your spouse the biological or adoptive parents of this person?	Yes		
9. Is this person a U.S. citizen or U.S. national? (Applicants only) Many immigrants are eligible for benefits (If you answer no, please complete **Step 4**)	Yes		
a. Are you a naturalized or derived US citizen? (Applicants only)	No		
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
10a. Is this person an American Indian or Alaska Native? (If yes, complete Appendix B. You may be eligible for enhanced benefits)			
10b. If yes, what is this person's Tribal Identification Number? (Medical Assistance only)			
. **11. Is this person in the Military or a U.S. Veteran?** (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, ova@dc.gov.	No		
12. Does this person currently live in the District of Columbia? (For applicants only)	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		
13. Are you a victim of domestic violence? (For sponsored immigrants applying for medical assistance)	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).

14. Is this person in this country for temporary purposes or under the jurisdiction of another country? (e.g., certain embassy employees and their families).	No		
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?	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		
16. Are you in the District of Columbia voluntarily?	Yes		
17. Are you currently experiencing homelessness in the District?	Yes		
18. Is this person blind?	No		
19. Is this person disabled?	No		
20. Does this person need help with daily living activities or living in a medical institution?	No		
21. Does this person live in foster care?	No		
22. Was this person in foster care at age 18 or older?	Yes		
23. Is the person emancipated?	No		
24. Is this person currently pregnant or has been pregnant in the last 60 days?	Yes		
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		
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 (Medical assistance only)	Yes		
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		
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		
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		
If yes, did this person's income change in the last 3 months? If you answer yes, please complete Appendix D.	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		
If yes, did this person become blind or disabled in the last 3 months? If you answer yes, please complete Appendix D.	No		
If yes, did this person's assets change in the last 3 months? If you answer yes, please complete Appendix D.	No		
26. Has this person had insurance through a job and lost it in the past 3 months?	Yes		
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		
27. If this person is a child, are there any parents living outside the home?	No		
28. Has this person been screened for Breast or Cervical Cancer through Project Wish?	No		

STEP 3 **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
1. First Name			
Middle Name			
Last Name			
Suffix (Jr., Sr., IV, etc.)			
2. Which benefits is this person applying for with your household? (List all that apply. If none, write "N/A")			
3a. Date of Birth			
3b. Gender (male, female)			
3c. Are you Hispanic or Latino?			
4. Race/Ethnicity: (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			
5. Social Security Number *(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 ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6. What is this person's marital status? (Never been married, married, separated, divorced, widowed)			
7. Relationship to you			
8. Are you or your spouse the biological or adoptive parents of this person?			

9. Is this person a U.S. citizen or U.S. national? (Applicants only) Many immigrants are eligible for benefits (If you answer no, please complete **Step 3**)			
a. Are you a naturalized or derived US citizen? (Applicants only)			
b. If you are a naturalized or derived citizen, what are the alien and certificate numbers on your citizenship document? (applicants only)	Alien Number Certificate Number	Alien Number Certificate Number	Alien Number Certificate Number
10. Is this person an American Indian or Alaska Native? (If yes, complete Appendix B. You may be eligible for enhanced benefits)			
If yes, what is this person's Tribal Identification Number**?** (Medical Assistance only)			
. **11. Is this person in the Military or a U.S. Veteran?** 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, ova@dc.gov.			
12. Does this person currently live in the District of Columbia? (For applicants only)			
If yes, do you intend to stay in the District?			
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 of 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).			
13. Are you a victim of domestic violence? (sponsored immigrants applying for medical assistance)			

STEP 3a 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
14. Is this person in this country for temporary purposes or under the jurisdiction of another country? **(e.g., certain embassy employees and their families).**			
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?			
If yes, what is the name of the institution?			
If yes, what is the institution's address?			
Were you placed in the institution by a District government agency?			
If yes, which agency?			
16. Are you in the District of Columbia voluntarily?			
17. Are you currently experiencing homelessness in the District?			
18. Is this person blind?			
19. Is this person disabled?			
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.			
If yes, did this person's income change in the last 3 months? If you answer yes, please complete Appendix D.			
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.			
If yes, did this person become blind or disabled in the last 3 months? If you answer yes, please complete Appendix D.			
If yes, did this person's assets change in the last 3 months? If you answer yes, please complete Appendix D.			
26. Has this person had insurance through a job and lost it in the past 3 months?			
If yes, when did the coverage end?			
If yes, what is reason for the coverage ending?			
If yes, is this person a full-time student?			
27. If this person is a child, are there any parents living outside the home?			
28. Has this person been screened for Breast or Cervical Cancer through Project Wish?			

STEP 4 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 5

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

Did anyone above move to the U.S. before August 22, 1996? ☐ Yes ☐ No	**If yes, who?**

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? $

STEP 5 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	**Please tell us the Tax Filer's status:** (Head of Household, Single, Married Filing Jointly, or Married Filing Separately) If filing jointly, list who you file jointly with.	**Please list all tax dependents in the home that the tax filer is claiming.**	**Please list all tax dependents that the tax filer is claiming that are not living in the home.**
Tax Filer 1			
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?

STEP 6 Does anyone in your household (including non-applicants) have any income?

☐ Yes – complete below ☐ No – skip to step 7

Who in your household is employed? (include yourself, spouse, and dependents) (write full names)	**Employer's Name** (if self-employed, write "self-employed")	**Employer's Address**	**Employer's Phone**	**Employment Start Date**	**Paycheck Amount** (before taxes and deductions)	**How often?** (e.g. daily, weekly, biweekly, semi-monthly, monthly, yearly, one-time lump sum payment)

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**	**What business-related expenses does the self-employed person have?**		**What is the total of the monthly self-employment expenses?**

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)

Has anyone in the household stopped working or reduced their working hours in the last 60 days? Yes ☐ No ☐	If yes, who?
Who was the employer?	Why did this person stop working in this employment?

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? (Medical and DC Alliance only) **Yes** ☐ **No** ☐

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: _____

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 _____

Applicant or Representative Signature

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: _____

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 ☐

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 DC Health Link if anything changes (and is different than) what I wrote on this application, I can visit DCHealthlink. com or call 1-855-532-5465 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.
- 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:

_____, & _____

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 DC Health Link to use income data, including information from tax returns. DC Health Link 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

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.

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 assis- tance. 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 DC Health Link Customer Service toll-free at 1-855-532-5465 or TTY at 711.
- 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, 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 _____

Applicant or Representative Signature

STEP 10 Tell us about your household's assets

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

1. Does anyone in your household have cash on hand or in the home? **Yes ☐ No ☐**

If yes, who? _____

How much? $ _____

2. Does anyone have any financial accounts? **Yes ☐ No ☐**

If yes, list all accounts owned by your and anyone applying with you. Some examples of financial accounts are: Checking/Savings account, 401K, IRA, Annuities, Money Market, Stocks/Bonds/Mutual Funds/etc.

Type	Account Owner(s)	Bank Name	Account Balance
			$
			$
			$

3. Does anyone in your household have any vehicles? (Medical Assistance Only) **Yes ☐ No ☐**

- If yes, please list all vehicles owned by your and anyone applying with you. Some examples of vehicles are: Cars. Trucks, Boats, or Watercraft, Motorcycles, motor homes, ATV's, etc.
- If yes, is this vehicle used by someone who is sick or disabled? **Yes ☐ No ☐**

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# Tage #		$ $ VIN# Tage #
Name D/L# or Non-Driver ID#		VIN# Tage #		$ $

4. Does anyone in your household have any property assets? **Yes ☐ No ☐**

If yes, please complete the table below for you and anyone applying with you.

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:		$		
5. Does anyone in your household have any of the following assets? If yes, complete the table below for you and anyone applying with you.			**Yes** ❑	**No** ❑
Type	Who owns this?	Value	Date Acquired	
Life Insurance (Medical Assistance Only)		$		
Trust		$		
Burial Plot		$		
Burial Plan/Contract		$		
6. Has anyone in your household sold, traded, or given away assets in the last 3 months (For Food Assistance and Retroactive Medical coverage only)?			**Yes** ❑	**No** ❑

Who?	What was traded or given away?	Fair Market Value of item given away
		$
		$

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 includes those listed above, please complete the section below and attach proof. Examples of resources: Cash, Checking Account, Savings Account, Certificates 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
		$		$
		$		$
		$		$
		$		$
		$		$

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: $_____

Property Taxes: $_____ Homeowners Insurance: $_____ Condo Fee/HOAs: $_____

If you answered Question #1 - Who pays? _____

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? _____

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? _____

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? □Yes □No
2.	If you are able, do you intend to return home within six months? □Yes □No
3.	Does anyone currently live in your home? □Yes □No
4.	If yes, are they related to you? □Yes □No
5.	If yes, what is their relationship to you?

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** ☐	**No** ☐
2. If yes, when did you file your SSI application with SSA? _____		
3. Is your SSI application still in progress?	**Yes** ☐	**No** ☐
4. Were you previously denied SSI eligibility by SSA on a prior application? (IDA only)	**Yes** ☐	**No** ☐

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:

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 _____

Applicant or Representative Signature

Appendix A **Health Coverage from Jobs**

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

Form Approved OMB No: 0938-1191

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)	

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)

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 ❑ If yes, tribe name:		Yes ❑ If yes, tribe name:	
	No ❑		No ❑	
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 ❑ No ❑ 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 ❑ No ❑		Yes ❑ No ❑ 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 ❑ No ❑	

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: • Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties • 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) • Money from selling things that have cultural significance	$ How often? _____	$ How often? _____

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 ☐

REPRESENTATIVE - 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.

Full Name		**If person, Date of Birth**		
Phone		**Email**		
Address	**Unit**	**City**	**State**	**ZIP**

I authorize this person to: (check all that apply)

Apply for benefits ☐ Interview Assistance ☐ Receive notices ☐ Report changes ☐ Make inquiries ☐

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 D Retroactive Medicaid Supplemental Questions

(Please complete only if applying for Medical Assistance and you answered yes to question 25 and any yes to the sub-questions of question 25).
If you do not have this information now, you will be able to apply for these months up to 9 months after you submit this application.

- **Residence History:** If you or a member of your household were not a District resident in the 3 months prior to this application, please complete the table below for each person that was not a District resident.

First Month	Month	Year	Second Month	Month	Year	Third Month	Month	Year

Member Name	State	Member Name	State	Member Name	State

- **Citizenship/Eligible Immigration Status Information:** If you or a member of your household had a change in their citizenship/eligible immigration status in the 3 months prior to this application, please complete the table below for each person in your household that had this change.

First Month	Month	Year	Second Month	Month	Year	Third Month	Month	Year

Member Name	Immigration Status	Member Name	Immigration Status	Member Name	Immigration Status

- **Tax Information:** If you or a member of your household had a change in their tax-filing status in the 3 months prior to this application, please complete the table below for each person in your household that had this change.

First Month	Month	Year	Second Month	Month	Year	Third Month	Month	Year
Member Name	**Tax-Filing Status** (Tax Filer, Tax Dependent, Non-Filer)		**Member Name**	**Tax-Filing Status** (Tax Filer, Tax Dependent, Non-Filer)		**Member Name**	**Tax-Filing Status** (Tax Filer, Tax Dependent, Non-Filer)	

- **Income History:** If you or a member of your household had a change in their income within the 3 months prior to this application, please complete the table below for each person in your household that had this change.

First Month	Month	Year	Second Month	Month	Year	Third Month	Month	Year
Member Name	**Income Type** (Salary/Wages, Pension, Unemployment, Self-Employment Income, Social Security, etc.)		**Member Name**	**Income Type** (Salary/Wages, Pension, Unemployment, Self-Employment Income, Social Security, etc.)		**Member Name**	**Income Type** (Salary/Wages, Pension, Unemployment, Self-Employment Income, Social Security, etc.)	

- **Other Medical Coverage:** If you or a member of your household had a change in their medical coverage within the 3 months prior to this application, please complete the table below for each person in your household that had this change.

First Month	Month	Year	Second Month	Month	Year	Third Month	Month	Year
Member Name	Coverage Type	Did coverage start or end?	**Member Name**	Coverage Type	Did coverage start or end?	**Member Name**	Coverage Type	Did coverage start or end?

- **Disability:** If you or a member of your household had a change in their disability status within the 3 months prior to this application, please complete the table below for each person in your household that had this change.

First Month	**Month**	**Year**	**Second Month**	**Month**	**Year**	**Third Month**	**Month**	**Year**

Member Name	**Disability Status** (Blind or Disabled)	**Member Name**	**Disability Status** (Blind or Disabled)	**Member Name**	**Disability Status** (Blind or Disabled)

- **Assets Information:** If you or a member of your household had a change in their assets within the 3 months prior to this application, please complete the table below for each person in your household that had this change.

First Month	**Month**	**Year**	**Second Month**	**Month**	**Year**	**Third Month**	**Month**	**Year**

Member Name	**Asset Type**	**Value**	**Member Name**	**Asset Type**	**Value**	**Member Name**	**Asset Type**	**Value**

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.

Medicaid Applicant Name (first, middle, last)	
Social Security Number	**Date of Birth**

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

YES ☐	**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)**
YES ☐	**This applicant was screened by the Center for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) In this state _____(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).**

Diagnosis Information for the Medicaid Applicant

Diagnosis:		
Physician Comments:		
Diagnosis Date:		
Physician Signature:		**Date:**
Physician Name:		
Facility/Hospital/Clinic Name:		
Facility/Hospital/Clinic Address:		

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.

NBCCEDP Coordinator Signature:		**Date:**
NBCCEDP Coordinator Name:		

STEP 16 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 sub- mission 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 permit- ted 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
- 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.
- (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 , or visit their website at 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://dhcf.dc.gov/publication/medicaid-%E2%80%93-reimbursement-form

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 Humans 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. 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.

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.

Questions? Call District First Customer Service at 1-202-727-5355 or go online to www.districtfirst.com. **[If Assister/Broker Assigned]** You may also contact <assister/broker organization name> at <assister/broker organization phone>.