Department of Human Services
DCAS Business Operations
645 H Street NE
Washington DC 20002

SAMPLE NOTICE: MAGI D2 Renewal Form

John Doe

441 4th Street, NW

Washington, DC
20001

- This Notice has Important Information. This notice has important information about your application or coverage through DC Health Link. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-855-532-5465.

- Este aviso contiene información importante acerca de su solicitud o su seguro con DC Health Link. Preste atención a las fechas que aparecen en este aviso, puesto que podría ser necesaria alguna acción por su parte antes de determinada fecha a fin de mantener su seguro médico con nosotros o sus ayudas con el coste. Usted tiene derecho a recibir esta información y soporte en su idioma sin coste adicional. Llame al 1-855-532-5465.

- ይህ ማስታወቂያ አስፈልግ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም ስለ DC Health Link ሽፋን አስፈላጊ መረጃ አለው። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖችን ፈልጉ። የጤና ሽፋንዎን ለመጠበቅ እና በአከፋፈሉ እርዳታ ለማግኘት በተወሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ ለማግኘት እና ያለ ምንም ክፍያ በቋንቋዎ እርዳታ የማግኘት መብት አልዎት። በ 1-855-532-5465 ላይ ይደውሉ።

- 本通知包含重要信息。本通知包含有关您通过 DC Health Link 提交申请和保险的重要信息。请查看本通知中的关键日期。您可能需要在特定截止日期前采取行动，以便维持您的健康保险或有助于降低费用。您有权免费以自己的母语获 得本信息和帮助。请致电 1-855-532-5465。

- Cet avis contient des informations importantes. Cet avis contient des informations importantes au sujet de votre demande ou de la couverture par DC Health Link. Cherchez les dates clés dans cet avis. Vous devrez peut-être prendre des mesures en respectant certaines échéances afin de maintenir votre couverture de santé ou d'assumer des coûts. Vous avez le droit d'obtenir ces informations et d'être aidé dans votre langue sans frais. Appelez le 1-855-532-5465.

- May Importanteng Impormasyon ang abisong ito. May Importanteng Impormasyon ang abisong ito tungkol sa aplikasyon mo o proteksiyon mo sa DC Health Link. Tingnan ang mga importanteng petsa na nasa abisong ito. Maaaring may mga kailangan kang gawin bago sumapit ang ilang deadline para mapanatili ang proteksiyon mo sa kalusugan o para makatulong sa mga gastusin. Karapatan mong makuha ang impormasyon na ito at makakuha ng tulong na nasa wika mo nang walang gastos. Tumawag sa 1-855-532-5465.

- В настоящем уведомлении содержится важная информация. В этом уведомлении содержится важная информация о вашем заявлении или страховом покрытии посредством DC Health Link. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощи на вашем языке. Звоните по телефону 1-855-532-5465.

- Este aviso contém informações importantes. Este aviso contém informações importantes sobre o seu pedido ou cobertura através da DC Health Link. Procure as datas chave neste aviso. Poderá necessitar de tomar providências dentro de certos prazos para manter a sua cobertura de saúde ou para obter ajuda com custos. Tem o direito de obter estas informações e ajuda no seu idioma sem qualquer custo. Ligue 1-855-532-5465.

- Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso DC Health Link. Cerca le date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o una sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 1-855-532-5465.

- Thông báo này có Thông tin Quan trọng. Thông báo này có thông tin quan trọng về đơn hoặc hợp đồng bảo hiểm của bạn qua DC Health Link. Xin xem những ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo đúng thời hạn để duy trì bảo hiểm sức khỏe hoặc giúp đỡ chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-855-532-5465.

- Libihne lini li gwe banga bi niigana. Libihne lini li gwe banga bi niigana kolbaha ni ndjombi yoŋ tole ma teeda moŋ loŋ ni DC Health Link. Yeŋ ma kel ma tobo tobo munu libihne lini. Bebeg le u ga bana nguim mam i boŋ nwaa le guim di loo di kola i nyu I teda mateda tole nsaa u mboo woŋ. U gwee kundei kosna biniguene bini ni mahola ni hop wong ngui nsaa wogui wo. Sebel I nsinga ini 1-855-532-5465.

- Ihe Nkwupụta a were ozi di mkpa banyere ya. Ihe Nkwupụta a were ozi di mkpa banyere ya gbasara maka arịrịọ gị ma obu ọgwụgwọ site na DC Health Link. Lee anya maka ụbọchị dị-karịrị mkpa na ihe nkwupụta a. I were ike ịchọ ime ihe na ụfọdụ oge mgwucha ka idebe ọgwụgwọ ahụ ike gị ma obu enyemaka na ikwu ụgwọ. Inwere ikike inweta ozi a na enyemaka na asụsu gị n'efu. Kpọọ 1-855-532-5465.

- Àkíyesí yìí ní Ìfitoniletí Pàtàkì Nínu. Àkíyesí yìí ní ìfitoníletí pàtàkì nípa lẹta-ìsèbéèrè tàbí ìdójútòfò rẹ nípa DC Health Link nínu. Se àwárí àwọn ọjọ pàtàkì tí n bẹ nínu àkíyesí yìí. O le ní láti gbe awọn igbesẹ ní ìbámu pẹlu awọn ọjọ tó gbẹyin kan ní pàtó láti le pa ìdójútòfò ìlera rẹ tàbí iseranwọ fun ọ mọ pẹlu sísanwo. O ní ẹtọ lati rí iranwọ àti ìfitónilétí yìí gbà ní èdè rẹ láìsanwó. Pè sórí 1-855-532-5465.

- এই নোটিশটিতে গুরুত্বপূর্ণ তথ্য আছে। DC Health Link এর মাধ্যমে আপনার আবেদন পত্র বা কভারেজ সম্বন্ধে এই নোটিশে গুরুত্বপূর্ণ তথ্য আছে। মূল তারিখগুলির জন্য এই নোটিশটি দেখুন। কিছু নির্দিষ্ট সময়সীমা অনুসারে আপনার স্বাস্থ্য কভারেজ বা তার মূল্যের ক্ষেত্রে আপনার কোন কর্মপ্রক্রিয়া গ্রহণ করার প্রয়োজন হতে পারে। আপনার এই তথ্যটি বিনামূল্যে আপনার ভাষায় পাওয়ার অধিকার আছে। 1-855-532-5465 নম্বরে কল করুন।

- この通知には重要な情報が含まれています。この通知には DC Health Link の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。 1-855-532-5465 までお電話ください。

- 본 통지서는 중요한 정보를 포함하고 있습니다. 이 통지서는 DC Health Link관련 귀하 또는 귀하의 보험 적용 대상자에 대한 정보가 들어 있습니다. 이 통지서에 나와 있는 중요 날짜를 참조하시기 바랍니다. 건강 보험을 유지하거나 보험료 지원을 받으시려면 해당 만료일자까지 연장하시기 바랍니다. 이에 대한 정보를 귀하의 언어로 비용 부담없이 지원을 받으실 수 있습니다. 해당 언어의 통역사에게 문의하시려면 1-855-532-5465로 전화하십시오.

- ประกาศนี้มีข้อมูลสำคัญประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกัน สุขภาพของคุณผ่าน DC Health Link [illegible]ภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่ายคุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้ จ่ายโทร 1-855-532-5465

- Die Nachricht enthält wichtige Informationen bezüglich Ihres Antrags bei oder Ihres Versicherungsschutzes durch DC Health Link. Suchen Sie nach Schlüsseldaten in dieser Nachricht. Sie müssen eventuell vor einer bestimmten Frist reagieren, um Ihren Versicherungsschutz aufrechtzuerhalten oder um Hilfe bezüglich der Kosten zu erhalten. Sie haben das Recht, diese Information und Hilfe kostenfrei in Ihrer Sprache zu erhalten. Wählen Sie hierfür 1-855-532-5465.

- يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات هامة بخصوص طلبك أو تغطيتك من خلال DC Health Link. ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصول على هذه المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل ب1-855-532-5465.

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Medical Assistance Renewal Form D2

April 1, 2023

Integrated Case #: 99999

John Doe
441 4th Street, NW
Washington, DC 20001

It is time to renew your health coverage. Please respond by **<Date Field>** to avoid gaps in yourcoverage.

You can renew your Health Coverage inany one of these ways

- **By mail:** Complete this form and mail it in the enclosed envelope to:
  Attention:
  Department of Human Services
  Economic Security Administration
  Outstation/Medicaid Renewal Unit
  645 H Street NE
  Washington DC 20002
- **By phone:** Just call **(202)727-5355 (TTY: 711)**
- **By fax:** You can also Fax us at **(202) 535-1122.**
- **In person:** Visit any of our ESA service centers listed on the next page.
- **Online:** Go to www.dchealthlink.com/renewalD2 for instructions.

How to complete this renewal form

1. Answer all of the questions on the form. Read the information about you and each member of your household. Add any missing information. If any information has changed, write in the right information.
2. **Sign the form in Section 10.**
3. Please return this form by **<Date Field>** to avoid gaps in your health coverage. Your eligibility is set to expire **<Date Field>**Your health coverage will endif we do not receive your form by **<Date Field>**

What we need

We need information about each person living in your household or listed on your tax return, including:

- those who get health coverage now,
- those who do not get health coverage now but would like to apply, **and**
- others who live in the household and do not get Medicaid but do not want to apply.

ESA Service Centers

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

Congress Heights Service Center
4049 South Capitol Street, SW
Washington DC 20032

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

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

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

Service Center Hours of Operation:

Monday, Tuesday, Thursday, Friday
7:30 am to 4:45 pm

Wednesday
7:30 am to 8:00 pm

1 Your contact information

▼ Review your contact information here.

John Doe

Home Address
441 4th Street, NW
Washington, DC 20001

Mailing Address
441 4th Street, NW
Washington, DC 20001

Phone: 202-000-0000

▼ Correct any wrong or missing information here.

Name (first, middle, last & suffix)

Home address | Apartment #

City (home) | State | ZIP code

Mailing address | Apartment #

City (mailing) | State | ZIP code

Best phone number to reach you: ☐ Home ☐ Cell ☐ Work

Number:

Other phone number, if you have one: ☐ Home ☐ Cell ☐ Work

Number:

Do you wish to receive electronic notification? ☐ Yes ☐ No

Email address, if you have one: _____.

You can change your decision about receiving electronic notification at any time. If you let us know that you do not want to receive electronic notification, you will receive notices in the mail.

What is your preferred spoken or written language (if not English)?

2 We need information about who files tax returns.

You can still renew if you do not file tax returns.

Will anyone in the household file a **federal tax return next year** to report income earned **this year?**

☐ Yes **If yes,** answer all of the questions below. ☐ No **If no,** answer the question marked with a star ★ below

Person 1: Name *(first, middle, last & suffix):*

If this person is filing a joint return, write the name of the spouse: Name (first, middle, last & suffix):

If this person will claim dependents, write the names of the dependents (first, middle, last & suffix):

Person 2: Name *(first, middle, last & suffix):*

This is for a second tax filer in the household

If this person is filing a joint return, write the name of the spouse: Name (first, middle, last & suffix):

If this person will claim dependents, write the names of the dependents (first, middle, last & suffix):

★ If anyone will be claimed as a dependent on someone else's tax return, write the name of the tax filer and the dependents. Answer only if different than what you reported above or if you did not fill in any information above.

Name of tax filer *(first, middle, last & suffix):* _____

Name of dependents *(first, middle, last & suffix):* _____

3 Individuals in your household are listed below.

Please check Yes if any of the individuals listed below still lives with you. Check No if any of the individuals listed below no longer lives in the household.

Last Name	First Name	MI	Date of Birth	Health coverage is up for renewal	Does this person still live with you?
				☐	☐ Yes ☐ No

Please indicate if any of the individual(s) above are deceased by writing their name(s) below:

Name(s):____

4 Tell us about anybody else in your household or on your tax return.

Also fill out Attachment A for each person you have added who wants to apply for health coverage.

Last Name	First Name	MI	Date of Birth	Sex	Is applying for Medical Coverage	Does this person live with you?
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No

5 Please complete the following question.

Question	Yes	No
Is anyone who is listed in Section 4 who is applying for coverage, an immigrant?	☐	☐
If you checked "yes" to the question above, you must complete **Attachment D** for each individual in addition to **Attachment A.**		

6 Tell us about other health insurance coverage people have

► Include anyone in Sections 3 and 4 with health coverage and anyone who is applying for healthinsurance coverage.

List everyone who is on this policy (first, middle, last & suffix):

Type of insurance: ☐ Medicare Part A ☐ Medicare Part B ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance _____

List everyone who is on this policy (first, middle, last & suffix):

Type of insurance: ☐ Medicare Part A ☐ Medicare Part B ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance _____

List everyone who is on this policy (first, middle, last & suffix):

Type of insurance: ☐ Medicare Part A ☐ Medicare Part B ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance _____

► ☐ Check here if anyone on this form is offered health insurance through a job, even if they are not enrolled in it.

☐ Check here if any of the insurance plans you listed is a state employee benefit plan.

7 Tell us more about the people listed on this renewal form

- If anyone who is renewing or applying for health insurance coverage has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or lives in a medical facility or nursing home write his or her name here.

- If anyone who is renewing or applying for health insurance coverage is blind or terminally ill, write his or her name here.

- If anyone who is renewing or applying for health insurance coverage has a child in the home who is 18 and a full time student, write his or her name here.

- If anyone who is renewing or applying for health insurance coverage is under age 26 and exited DC foster care at age 18 or older, write his or her name here.

- If anyone listed on this form (whether renewing or applying for health insurance coverage or not) is pregnant, write her information below.

- If anyone listed on this form (whether renewing or applying for health insurance coverage or not) is incarcerated, write his or her information below.

- ☐ Check here if anyone who is renewing or applying for health insurance coverage is an American Indian or Alaska Native, and fill out Attachment B.

8 Tell us about work

► Fill in the information below for everyone in your household or on your tax return who has income from a job whether or not they are renewing or applying for coverage. You can tell us about self-employment on the next page. Also include here income for persons you are adding to the household in Section 4. If someone has more than one job, tell us about all jobs. Make a copy of this page if you need space for more jobs or people. **Cross out any information that is not correct about members of your household. Write in any new information.**

Please use the following Income Frequencies:

- Weekly
- Every two weeks
- Monthly
- Yearly
- Other (write in monthly amount)

Last Name	First Name	MI	Income Amount (Before Taxes)	Income Frequency	Employer Name

Section 8 continued on next page ►►►

8 Tell us about work (continued)

► List anyone in your household who has **changed jobs** or has **worked fewer hours** in the past four months.

1. Name (first, middle, last & suffix):

☐ This person stopped working ☐ This person is now working fewer hours ☐ This person changed jobs

2. Name (first, middle, last & suffix):

☐ This person stopped working ☐ This person is now working fewer hours ☐ This person changed jobs

► If anyone in your household is **self-employed,** we need to know about their work.
See the instructions for more information about deductions.

1. Name (first, middle, last & suffix):

How much net income will this person get from self-employment this month? Amount: $_____

2. Name (first, middle, last & suffix):

How much net income will this person get from self-employment this month? Amount: $_____

► Subtract the expenses below from your gross income to get an amount for your net self-employment income.

- Car and truck expenses (for travel during the workday, not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or business interruption insurance
- Interest (including mortgage interest paid to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals
- Deductible self-employment taxes
- Cost of self-employed health insurance
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan

► If anyone in your household has **deductions,** tells us what kind.

Alimony paid to someone else	**How much?**	**How often?**
Name (first, middle, last & suffix):	**$**	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Other (write in monthly amount)_____.
Student loan interest paid	**How much?**	**How often?**
Name (first, middle, last & suffix):	**$**	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Other (write in monthly amount)_____.
Other deductions	**How much?**	**How often?**
Name (first, middle, last & suffix):	**$**	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Other (write in monthly amount)_____.

9 Tell us about other income

Use the tables below to specify other income types and how often the payments are received.
Cross out any information that is not correct. Write in any new information.

Other Income Types:
-Unemployment
-Social Security
-Pensions
-Retirement accounts
-Alimony received
-Farming or fishing (profit after business expenses)
-Rental income or royalties (profit after business expenses)
-Other (please specify)

How often?
-Weekly
-Every two weeks
-Monthly
-Yearly
- Other (write in monthly amount)

Name (First, Middle, Last, Suffix)	Other Income Type	How much?	How Often?

10 Read and sign this renewal form

Privacy Act Statement (Effective 03/04/2014)

We are authorized to collect the information on this form and any supporting documentation, including social security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), the Tax Code, and the Social Security Act.

We need the information provided about you and the other individuals listed on this form to determine eligibility for: (1) Medicaid, Alliance, and ICP (2) enrollment in a qualified health plan through DC Health Link, (3) insurance affordability programs (such as advanced payment of the premium tax credits and cost sharing reductions), and (4) certifications of exemption from the individual responsibility requirement. As part of that process, we will verify the information provided on the form, communicate with you or your authorized representative, and if applicable, eventually provide the information to the health plan you select so that they can enroll any eligible individuals in a qualified health plan or insurance affordability program. We will also use the information provided as
part of the ongoing operation of DHS, including activities such as verifying continued eligibility for all programs, processing appeals, reporting on and managing the insurance affordability programs for eligible individuals, performing oversight and quality control activities, combatting fraud, and responding to any concerns about the security or confidentiality of the information.

In order to verify and process renewals, applications, determine eligibility, and operate, we will need to share selected information that we receive outside of DHS, including to:

1. Federal agencies, (such as the Internal Revenue Service, Social Security Administration and Department of Homeland Security), State agencies or local government agencies. We may use the information you provide in computer matching programs with any of these groups to make eligibility determinations, to verify continued eligibility for enrollment in Medicaid, Alliance, and ICP, a qualified health plan or Federal benefit programs, or to process appeals of eligibility determinations;
2. Other verification sources including consumer reporting agencies;
3. Employers identified on applications for eligibility determinations;
4. Applicants/enrollees, and authorized representatives of applicants/enrollees;
5. Agents, Brokers, and issuers of Qualified Health Plans, as applicable, who are certified by DC Health Link to assist applicants/enrollees;
6. Contractors engaged to perform a function for DHS or DC Health Link and
7. Anyone else as required by law.

While providing the requested information (including social security numbers) is voluntary, failing to provide it may delay or prevent your ability to obtain Medicaid, Alliance, and ICP, health coverage through DC Health Link, advanced payment of the premium tax credits, cost sharing reductions, or an exemption from the shared responsibility payment. If you don't have an exemption from the shared responsibility payment and you don't maintain qualifying health coverage for three months or longer duringthe year, you may be subject to a penalty. If you don't provide correct information on this form or knowingly and willfully provide false or fraudulent information, you may be subject to a penalty and other law enforcement action.

This statement provides the notice required by the Privacy Act of 1974 (5 U.S.C. § 552a(e)(3))

To obtain information about how your health information is kept private and protected by Medicaid, visit http:// dhcf.dc.gov/publication/hipaa-notice-privacy-practice.

Renewal of coverage in future years

► Read the statement below and check **one** box.

To make it easier to check my income at renewal time, I agree to allow DHS and DC Health Link to use income information from my tax returns for the number of years I checked below. I can also choose to not allow DHS and DC Health Link to check this information. If I do not give permission for DHS and DC Health Link to check my income using my tax returns, I understand that I may be required to submit other documentation of my income to DHS and DC Health Link.

Yes, I give permission to check my income on tax returns for (check one box):

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

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Do not use information from tax returns to renew my coverage.

10 Read and sign this renewal form (continued)

Your rights and responsibilities

I am signing this renewal 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 District and federal law if I willfully provide false or untrue information.

I know that I must tell DHS if anything changes (and is different than) what I wrote on this renewal form. I understand that a change in my information could affect the eligibility for member(s) of my household.

I know that under District and federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination with the D.C. Office of Human Rights or the Federal Department of Health and Human Services Office of Civil Rights.

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
OCRComplaint@hhs.gov
Or online at:
https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

DC Office of Human Rights
441 4th Street NW
Suite 570 North
Washington, DC 20001
Phone: (202) 727-4559 TTY: 711
Fax: (202) 727-9589

I know that my information on this renewal form will be used only to determine eligibility for health coverage and will be kept private as required by law.

We need this information to check your eligibility for help paying for health coverage. We will 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 from these electronic data bases does not match the information you provided in this renewal form, we may ask you to send us additional documentation.

<u>If anyone on this renewal form is eligible for health coverage</u>

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties, I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- If any child on this renewal form has a parent living outside of the home, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

<u>What should I do if I think my eligibility results are wrong?</u>

If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household, including how many days you have to request an appeal. Below is important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- If you request an appeal, you may be able to keep your eligibility while your appeal is pending.
- The outcome of your appeal could change the eligibility of other members of your household.

To appeal your eligibility results, log into your "MyAccount" at **www.dchealthlink.com** or call **(855) 532-5465 (TTY: 711).** You can also mail an appeal request form or your own letter requesting an appeal to Office of Administrative Hearings ResourceCenter, 441 4th Street NW, Suite 450-North, Washington, DC 20001. You can appeal eligibility for Medicaid, Alliance, and ICP, purchasing health coverage through DCHealth Link, enrollment periods, tax credits, or cost sharing reductions if you were denied these. If you qualify for tax credits or cost-sharing reductions, you can appeal the amount we determined you are eligible for.

By signing this renewal form, you represent that you have permission from all of the people whose information is on the renewal form to both submit their information to DHS and DC Health Link, and receive any communications about their eligibility and enrollment.

► **Sign and date below.**

If you want an authorized representative or want to change the authorized representative you have now, fill out Attachment C.

☐ Check here if you are an authorized representative. Sign below and fill out Attachment C.

Signature of household contact or authorized representative:	Date:
X	

Please do not forget to sign the Renewal Form on the previous page.

Attachment A

Additional People applying for Medicaid and Health Insurance Coverage *For people listed in Section 4*

Tell us about anyone in your household who wants to apply for health coverage. **Do not answer** these questions for people **who already have health coverage.** *If more than one person is applying, make a copy of this page.*

Name of person applying: Name (first, middle, last & suffix)

► Tell us about citizenship

Is this person a U.S. citizen or U.S. national?

☐ Yes ***If yes,*** go to "Tell us about this person's Social Security Number (SSN)"

☐ No ***If no,*** please answer all of the questions below and also fill out Attachment D

☐ Check here, if this person has lived in the U.S. since 1996.

☐ Check here, if this person, his or her spouse, or a parent is a veteran or an active duty member in the U.S. military.

► Tell us about this person's Social Security Number (SSN)

Please write this person's SSN here if this person is applying for health insurance coverage:

_____ - _____ - _____

The SSN will be used to determine eligibility including verifying income, eligibility, and amount of medical assistance payments.

► Tell us more about this person

☐ Check here, if this person lives with at least one child under the age of 18, or with an 18 year old who is a full time student, and is the main person taking care of this child.

☐ Check here, if this person is a resident of the District.

☐ Check here, if this person wants help paying for medical bills from the last three months.

How is this person related to you? _____

► Tell us about race and ethnicity. *You may choose not to answer these questions.*

If this person is Hispanic/Latino, check all that apply:

☐ Mexican ☐ Mexican American

☐ Chicano/a ☐ Puerto Rican

☐ Cuban ☐ Other____.

What is this person's race? Check all that apply:

☐ White ☐ Asian Indian ☐ Korean ☐ Guamanian or Chamorro

☐ Black or African American ☐ Chinese ☐ Vietnamese ☐ Samoan

☐ American Indian or Alaska Native ☐ Filipino ☐ Other Asian ☐ Other Pacific Islander

☐ Japanese ☐ Native Hawaiian ☐ Other_____.

★ If anyone applying for Medicaid has medical bills from the last three months, send the medical bills with the form.

Attachment B

American Indian or Alaska Native family member (AI/AN) *To help you fill out Section 7*

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 may not have to pay co-pays and may get special monthly enrollment periods.

If more than two people are American Indian or Alaska Native, make a copy of this page.

1. Name (first, middle, last & suffix):

Is this person a member of federally recognized tribe? ☐ Yes ☐ No

If yes, tribe name?

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program? ☐ Yes ☐ No

If no, does this person qualify to get these services? ☐ Yes ☐ No

List any income that includes money from these sources:

. Payments from a tribe for 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 much income? $

How often?

☐ Weekly ☐ Monthly

☐ Every two weeks ☐ Yearly

☐ Other (write in monthly amount)

2. Name (first, middle, last & suffix):

Is this person a member of federally recognized tribe? ☐ Yes ☐ No

If yes, tribe name?

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program? ☐ Yes ☐ No

If no, does this person qualify to get these services? ☐ Yes ☐ No

List any income that includes money from these sources:

. Payments from a tribe for 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 much income? $

How often?

☐ Weekly ☐ Monthly

☐ Every two weeks ☐ Yearly

☐ Other (write in monthly amount)

Attachment C Assistance with completing this renewal form

You can choose an authorized representative.

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

This person is called an "authorized representative". If you ever need to change your authorized representative, contact DHS. If you are a legally appointed representative for someone on this renewal form, submit proof with the renewal form.

Name of authorized representative:

Address: Apartment # City State ZIP code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other

Number:

By signing, you allow this person to sign and submit your renewal form, get official information about this renewal form, receive copies of notices and other communications from DHS and DC Health Link, and act for you on all future matters with DHS and DC Health Link

Your signature: Date:

X

► If anyone helped you complete this renewal form, please fill out the section below.

The person who helped you complete this renewal form should sign below. If you are an authorized representative, you may sign here as long as you have provided the information required above and signed Section 10 of this renewal form as applicable.

Name of person who helped you complete the renewal form:

Phone: Email:

Signature of the person who helped you complete the renewal form: Date:

X

Attachment D

Helpful information about immigration status and document types. *To help you fill out Section 5*

Eligible immigration status list

► If you see the person's status below, **please complete the next page about immigration documents.**

For all, these are 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

If the person is an individual under the age of 21 or a pregnant woman, these are additional eligible immigration statuses:

- 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 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

Please see next page for Immigration Document Form ►►►

Attachment D

Please complete this form if you or someone in your household is renewing or applying for health coverage and is an immigrant.

Immigration document form.

If you are adding a person at renewal, you must also complete Attachment A.

Please make a copy this page if you need more space.

► People who are applying for health insurance coverage and are immigrants must put their immigration documents and ID numbers below. A list of documents is at the end of this section. If your document type is not listed, you can write its name. To be eligible for Medicaid, a person must have an eligible immigration status. A list of eligible immigration statuses is on the previous page. If you do not see the immigration status on the previous page, you or your household member(s) may qualify for DC Health Care Alliance (Alliance) or Immigrant Children's Program (ICP). If you have questions, or are eligible but have no document, call **1-855-532-5465 (TTY:711)**

If you have a:

Permanent Resident Card (1-551, also known as Green card) or Employment Authorization Card (EAD or I-766)

First, Middle, Last Name	Alien Registration Number	Card Number	Expiration Date (required only for EAD or I-766)

If you have a:

Temporary I-551 Stamp (on passport or I-94, I-94A) or Immigrant Visa (with Temporary I-551 language)

First, Middle, Last Name	Alien Registration Number (required only for Temporary I-551 Stamp)	Passport Number	Country of Issuance	Expiration Date

If you have a:

Country of Issuance Reentry Permit (I-327), Refugee Travel Document (I-571), or Notice of Action (I-797)

First, Middle, Last Name	Alien Registration Number

If you have a:

Arrival/Departure Record (I-94 or I-94A)

First, Middle, Last Name	Alien Registration Number

If you have a:

Foreign Passport or Arrival/Departure Record in Foreign Passport (I-94)

First, Middle, Last Name	I-94 Number (required only for I-94)	Passport Number	Expiration Date	Country of Issuance

If you have a:

Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) or (I-20) Certificate of Eligibility for Nonimmigrant (F-1) Student Status

First, Middle, Last Name	SEVIS ID

If you have a document that is not listed above:

Other

First, Middle, Last Name	Alien Registration Number (or I-94 Number)	Description of the type or name of the document

You can also list these documents or statuses:

- Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of Homeland Security (DHS)
- Certification from US Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Cuban/Haitian entrant
- Resident of American Samoa

First, Middle, Last Name	Type of Document or Statuses and Document Number

Attachment D

Helpful information about immigration document types.

► If you have questions, or are eligible but have no document, call **1-855-532-5465 (TTY:711)**

Permanent Resident Card (I-551, also known as Green Card)

- Alien registration number
- Card number

Temporary I-551 Stamp (on passport or I-94, I-94A)

- Alien registration number

Immigrant Visa (with temporary I-551 language)

- Alien registration number
- Passport number

Employment Authorization Card (EAD or I-766)

- Alien registration number
- Card number
- Expiration date
- Category code

Arrival/Departure Record (I-94 or I-94A)

- I-94 number

Arrival/Departure Record in foreign passport (I-94)

- I-94 number
- Passport number
- Expiration date
- Country of issuance

Foreign passport

- Passport number
- Expiration date

Country of issuance Reentry Permit (I-327)

- Alien registration number

Refugee travel document (I-571)

- Alien registration number

Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)

- Alien registration number or an I-94 number
- Description of the type or name of the document

Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)

- SEVIS ID

Notice of Action (I-797)

- Alien registration number or an I-94 number

Other

- Alien registration number or an I-94 number
- Description of the type or name of the document

You can also list these documents or statuses:

- Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada This is considered an eligible immigration status for Medicaid, but not for a Qualified Health Plan [QHP]
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of Homeland Security (DHS)
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Cuban/Haitian entrant
- Resident of American Samoa

Notice Regarding Nondiscrimination, Disability, and Language Access Services

The D.C. Health Benefit Exchange Authority and the D.C. Department of Human Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. These agencies do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

These agencies:

- Provide free support 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)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

Exchange (Private Insurance) Customers: If you need these services, contact:

DC Health Link Contact Center
Phone: (855) 532-5465/ TTY: 711
Email: info@dchealthlink.com

Medicaid Customers: If you need these services, contact:

Department of Health Care Finance, Office of the Ombudsman
441 4th Street, NW
900 South
Washington, DC 20001
Phone: (202) 724-7491/ TTY: 711
Email: healthcareombudsman@dc.gov

Exchange (Private Insurance) Customers: If you believe that the D.C. Health Benefit Exchange Authority 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 in person or by mail, fax, or email with:

Jennifer Libster, Associate General Counsel
D.C. Health Benefit Exchange Authority
1225 Eye Street NW, Suite 400
Washington, DC 20005
Phone: (202) 715-7576/ TTY: 711
Email: 1557.grievance@dc.gov
Fax: (202) 730-1658

You must file a grievance within 60 days of the date you became aware of the alleged discriminatory action. Jennifer Libster is available to help you with the grievance filing process.

Medicaid Customers: If you believe that the Department of Human Services 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 in person or by mail, fax, or email with:

Surobhi M. Rooney, Chief Compliance Officer
DC Department of Health Care Finance, Office of the Senior Deputy Director
441 4th Street NW, Suite 900 South
Washington, DC 20001
Phone: (202) 442-5916/ TTY: 711

Surobhi Rooney is also available to help you with the grievance filing process.

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, DC 20201
Phone: (800) 868–1019/ TDD: (800)537–7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.