GOVERNMENT OF THE DISTRICT OF COLUMBIA

SAMPLE NOTICE: Long Term Care Renewal Form

Notice Date: 04/01/2023 Account ID: 999999999

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

Subject: Important Message About Determining Your Medical Assistance Coverage

Dear JOHN DOE:

It is time to renew your **long term care** medical assistance coverage. You must renew your medical assistance coverage at least once a year. You must complete and return the attached renewal form and copies of all required documents by **6/30/2023** to keep your long term care medical assistance coverage.

Please read and answer all of the questions on the form. Read the information about you and each person in your household. Add any missing information. If any information has changed, write in the right information. Sign the form and return your completed form and all required documents to the District of Columbia (District) Department of Human Services (DHS), Economic Security Administration (ESA), Medicaid Branch, 5th FL, 645 H Street, NE, Washington, DC 20077-0555 through mail, phone, fax, or in-person.

If you do not return a completed renewal form and copies of all required documents by **6/30/2023,** you will lose your medical assistance coverage.

How to Submit Your Documents

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

Your Secure User Account

You can access/create an account with District Direct. Please refer to the attached information sheet.

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

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Renewal Form for Long Term Care Services and Supports

Please complete the following sections to give us your updated information.

As you complete this form, please tell us any changes that have occurred.

If there is a change in your benefits, you will get a notice explaining the change. You will not be required to visit a Service Center. However, you may be contacted by phone or mail if additional information is needed to determine your eligibility.

Household Member(s)

Listed below are the people we have on record as living with you. Check yes or no to indicate whether the member still lives with you. If any person listed is no longer a household member, enter the date the person left.

First name	Last Name	Date of Birth	Still lives in your household?	Date left, if known
Mickey	Mouse	1/1/1960	✓ Yes ☐ No	

Do you have new household members not listed above? ☐ Yes ✓No

Would the new member(s) like to apply for coverage? ☐ Yes ✓ No

If yes, an application will be mailed to the address on file so that the new household member(s) can apply for coverage.

Contact Information

Listed below is the contact information we have on file for you.

Cell: 202-000-0000	Home:	Work:
Is this number correct? ✓Yes ☐N	Is this number correct? ☐Yes ☐N	Is this number correct? ☐Yes ☐N
If you answered no, please update your contact information below:		
Cell:	Home:	Work:

Address we have on file for you and your household:		
Address: <Address>		
City: <City>	State: <State>	Zip Code: <Zip Code>

Do you have a new address? ☐Yes ☐N	If yes, what is your new address?	
Address:		
City:	State:	Zip Code:

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Facility Information

Listed below is the information we have on file for the institution where you or your spouse are living.

Name of Facility: ABC Nursing Care		
Address we have on file for your facility:		
Address: 441 4th Street, NW		
City: Washington	State: MD	Zip Code: 20001
Do you still live in this institution? ✓Yes ☐No If no, please complete the table below:		

New Address		
Address:		
City:	State:	Zip Code:
Is your new address a facility? ☐Yes ☐No. If yes, please provide the facility's name below.		
Facility Name:		

General Household Questions

Do you own your home? ☐Yes ✓No		
If yes, what is the address (if different from address provided above)?		
Address:		
City:	State:	Zip Code:

Tax-Filing Status

Please verify the tax-filing status for each member of your household below.

Full name	Will this person file Income taxes next year?		Please list the name of the spouse if filing jointly.	Please list anyone who may claim you as dependent.	Please list any dependents you may claim.
John Doe	✓Yes	☐No			

Income

Please verify the income sources below and provide an end date if this income has ended.
Please attach proof, such as letter from income source.

Source of Income	Who Receives Income	Specific Type of Income	Amount before taxes	How often Received	Income End Date
Annuity	John Doe	Unearned	$1000	Monthly	

Please list any additional income sources not listed above with an end date if this income has ended. Attach a sheet of paper, if more space is needed. Examples of Income Sources: Retirement, Social Security, Supplemental Security Income (SSI), Veterans Benefits, Railroad Retirement, Civil Service Benefits, Interest/Dividends, Insurance, Mineral Rights/Oil Leases, Unemployment Benefits, Worker's Compensation, Employment/Work, Farm Income, Self-employment, Rental Income, Contributions from Family/Friends, Income from Trusts or Annuities.

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Source of income	Who receives income	Amount before taxes	How often received	Income start date	Income end date
		$			
		$			
		$			
		$			
		$			

Assets

Listed below are the assets we have on record for you.

Type of resource	Owner(s)	$ Value
Checking Account	John Doe	$985.00

If you or your spouse obtained any other assets that are not listed above, please complete the table 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.

Type of resource	Date Obtained	Location (address, bank, insurance co., brokerage firm, etc.)?	Owner(s)	$ Value
				$
				$
				$

Transfer of Assets

If you or your spouse 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
		$		$
		$		$
		$		$

Vehicles

Listed below are the vehicles we have on record for you.

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Make	Model	Year	Value	Amount owed	Owner(s)
Toyota	Corolla	2015	$15,000	$0	John Doe

If you or your spouse own a car, truck, motorcycle, boat, trailer, or other vehicle not listed above, please complete the following information about each vehicle (attach additional pages as needed).

Make	Model	Year	Value	Amount owed	Owner(s)
			$	$	
			$	$	

Health Insurance

Listed below are the Health Insurance details we have on record for you.

Health insurance company name	Who is insured?	Type of insurance	Start and End date MM/DD/YY – MM/DD/YY	Amount
United Health Care	John Doe	Health	1/1/2023-12/31/2023	$155.00

Do you have Medicare? □Yes ✓No Medicare □A □B

Does your spouse have Medicare? □Yes ✓No Medicare □A □B

Do you have other health insurance? □Yes ✓No

Does your spouse have other health insurance? □Yes ✓No

If you, your spouse, or anyone in your home, have other health insurance besides Medicare, please provide the following information and attach copies (front and back) of Medicare and insurance cards.

Health insurance company name	Who is insured?	Type of insurance	Start and End date MM/DD/YY – MM/DD/YY	Policy or Claim #	Amount
					$
					$
					$
					$

Housing Costs

Listed below are the housing costs we have on record for you.

Person who pays this cost	Type of housing costs	Amount	Frequency

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		($)	(yearly, monthly, weekly, etc.)

a) Are you receiving any housing assistance? □Yes □No
b) If you are able, do you intend to return home within six months? □Yes □No
c) Does anyone currently live in your home? □Yes □No
d) If yes, are they related to you? □Yes □No
e) If yes, what is their relationship to you? _____

If you or your spouse have housing costs, please complete the following information about each housing cost.

Person who pays this cost	Type of housing costs	Amount ($)	Frequency (yearly, monthly, weekly, etc.)
	Rent/Mortgage	$	
	Property Taxes	$	
	Utilities	$	
	Condo Fees	$	
	Heat (if separate)	$	
	Home Insurance	$	
	Other Shelter Costs (Specify):	$	

Medical Expenses

Listed below are the medical expenses we have on record for you.

Name of person who pays this cost	Type of Expense	Start date of the expense	Amount paid	How often paid?

If you have new medical expenses not reported above, please complete the following information about each medical expense.

Name of person who pays this cost	Type of Expense	Start date of the expense	Amount paid	How often paid?
			$	
			$	
			$	

Cost to Take Care of Others

Listed below are the costs to take care of others that we have on record for you.

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Amount paid	How often paid?

Dependent care costs are payments for the care of someone in your household who depends on your income, like a child or an adult age 60 or older, or an individual with a disability. Paying this cost allows someone in the household to work, look for work, or attend school or a training course. You are allowed, but not required, to report changes in your costs to take care of others.

Example: child support, alimony, childcare, or adult care costs.

Name of person who pays this cost	Name of person who is paid	Amount paid	How often paid?
		$	
		$	

READ THE FOLLOWING INFORMATION CAREFULLY BEFORE YOU SIGN THIS APPLICATION

- **By signing below, I give my permission to the DC Department of Human Services (DHS) to get information about me and my spouse. DHS can get this information from those officials or institutions that have knowledge of my situation. I give all of these parties my permission to give information about me to DHS. I have reviewed the information in my application, and I believe that all of the information on this entire application is true and correct. I know if I give false information, I may be breaking the law and I could be at risk of criminal prosecution and penalties. I know that state and federal officials will check this information. I agree to help and cooperate with their potential investigations.**
- **By signing below, I understand that the District of Columbia government (District) may seek recovery for all the bills paid by Medicaid on my behalf, including nursing home, waiver, or services provided in other medical institutions.**
- **By signing below, I have reviewed my Rights and Responsibilities attached to this Renewal Form. I understand my responsibilities and agree to cooperate as required.**
- **By signing below, I understand that if I, or my spouse, purchased an annuity on or after February 8, 2006, and I receive long term care services, the District of Columbia must be named a remainder beneficiary of the annuity by virtue of the provision of medical assistance relating to long-term care services.**

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- **Authorized Representative(s): If the applicant cannot sign this form, you may sign it for them. By signing, you certify that this person wants to renew for benefits and agrees to the conditions above.**
- **Nursing Facility and Intermediate Care Facility Applicants/Beneficiaries Only**
  By signing below, I understand that if I am determined ineligible for Medicaid Long Term Care Services due to excess income and placed on a spend-down, the nursing facility or intermediate care facility may use the projected Medicaid reimbursement rate for medical institution expenses to help me meet my spend-down. If the projected medical expenses are used to meet my spend-down amount and I am determined eligible for Medicaid long term care coverage, I understand that I am still responsible for paying the medical institution the projected medical institution expenses.

Signature:_____ **Date:** _____

Representative Signature: _____ **Date:** _____

Appendix A: Notice of Rights and Responsibilities

General Rules

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

You must give true and complete information. If you lie or give false information, you may lose your benefits. You could also be fined and go to prison. We may verify your information to make sure it is correct. We may check on your income, your Social Security information, and your immigration information. We verify this information through computer matching programs. We may also interview you and do a home visit.
You may designate someone as your authorized representative. This gives them the authority to file the application on your behalf. If you designate someone to be your authorized representative, the agency will send them copies of notices that they send to you. They may submit verifications on your behalf as well.

Your case may be chosen for a Quality Control review. This is a detailed review of all of your information. It may include some personal interviews and a review of your medical records. By applying, you agree to cooperate with the state or federal reviewers. If you refuse to cooperate, you may lose all or part of your benefits. If you are under investigation or are fleeing to avoid the law, we may share your information with federal and local agencies.

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

Medical Assistance Rules
After your complete application is submitted to the District of Columbia Department of Human Services (DHS) Economic Security Administration (ESA), you will get a decision about your Medical Assistance within 45 days (or 60 days if DHS must determine if you are disabled). If you do not get a notice within this period, please call the DC Medicaid Branch on (202) 698-4220 or the Change Center on (202) 727-5355.

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

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.

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You must complete and submit a Medicaid Reimbursement Request Form to the DC Department of Health Care Finance. You can get a copy of the form at any ESA office, or you can download a copy at https://dhcf.dc.gov/publication/medicaid-%E2%80%93-reimbursement-form.

IF YOU HAVE QUESTIONS OR IF YOU NEED HELP COMPLETING THE FORM OR OBTAINING REQUESTED INFORMATION CONTACT:
a. The Medicaid Recipient Claims Research Team of the D.C. Department of Health Care Finance (DHCF) at (202) 698-2009.
b. Terris Pravlik & Millian, LLP, 1816 12th Street NW, Suite 303, Washington, DC 20009, (202) 682-0578, who will provide you with free legal assistance.

A DECISION ON YOUR REIMBURSEMENT CLAIM MUST BE MADE WITHIN 90 DAYS:
a. The Medicaid Recipient Claims Research Team must make a decision on your reimbursement claim within 90 days from the time you file your claim. If no decision is made within those 90 days, your claim will be treated as valid, and you will be paid within 15 days after the end of the 90-day period.
b. If you are not satisfied with the decision of the Medicaid Recipient Claims Research team, you have a right to a fair hearing. You may request a fair hearing by calling the Office of Administrative Hearings at (202) 442-9094. The Office of Administrative Hearings is located at 441 4th Street, NW; Washington, DC 20001-2714.
c. If you are not satisfied with the result of the fair hearing, you may appeal to the DC Court of Appeals within 30 days.

You may be able to obtain free legal assistance to help you present your case at the hearing or on appeal. If you are a member of the class certified by the court in Salazar v. District of Columbia, Civil Action No. 93-452 (TSC) (D.D.C.), you may contact Terris, Pravlik & Millian, LLP at 1816 12th Street, NW, Suite 303 Washington, DC 20009 or (202) 682-0578.

Free legal assistance for beneficiaries who are not members of the Salazar class may be available from the following organizations:

Bread for the City Legal Clinic, (202) 480-8950 or (202) 791-3982 Legal Aid Society, (202) 628-1161

Legal Counsel for the Elderly, (202) 434-2120

Neighborhood Legal Services, (202) 832-6577

University Legal Services, (202) 547-4747

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

Lawsuits
If you sue or enter into settlement negotiations with a third party for a medical claim or injury, you must provide written notice of the action (either by personal service or certified mail) within 20 calendar days to the

Department of Health Care Finance, Health Care Operations Administration, , Third Party Liability Division, 441 4th Street, NW, Suite 1000-South, Washington, DC 20001. If you have questions, call (202) 698-2000.

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

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

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

The Department of Health Care Finance (DHCF) and the Department of Human Services (DHS):
• Provide 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)
• Provide free language services to people whose primary language is not English, such as: ○ Qualified interpreters
○ Information written in other languages
If you need these services, contact Ms. Surobhi Rooney at (202) 442-5916.
If you believe that the either DHCF or 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:

Ms. Surobhi Rooney, DHCF Civil Rights Coordinator 441 4th Street, NW
Washington DC, 20001
Phone: (202) 442-5916
Email: surobhi.rooney@dc.gov

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ms. 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

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https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by phone 1-800- 368-1019 or mail at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Washington, DC 20201

Fair Hearings

If you think that DHS has made a mistake, then you can get a Fair Hearing. Call 202-698-4650 to find out more. You can also call (202) 727-8280. 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 agencies below to talk to a lawyer or counselor.

Free Legal Help

Neighborhood Legal Services

680 Rhode Island Avenue, NE (202) 832-6577

4609 Polk Street, NE (Ward 7)

(202) 832-6577

2811 Pennsylvania Avenue, SE (Ward 8)

(202) 832-6577

Terris Pravlik & Millian, LLP

1816 12th Street NW, Suite 303, Washington, DC 20009

(202) 682-0578

Legal Counsel for the Elderly (60 years or older)

601 E Street, NW (202)434-2120

Legal Aid Society 666 11th Street, NW Suite 800

(202) 628-1161

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

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