GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES
ECONOMIC SECURITY ADMINISTRATION
Request for Action Form

Section 1-Provider Section:

Facility/Provider Name: Provider Number:

Address: Telephone #: Fax #:

Provider Type: ☐ LTC Institution: NF/ICF/CHS ☐ EPD ☐ IDD ☐ PACE

Name of Patient	SSN	Medicaid Number

◯ New Admit ◯ Re-Admit ◯ Discharge ◯ Payment Change

New Admission/Readmission:
Date of Admission: _____
Admitted From:
- ◯ Hospital
  Hospital Name: _____
- ◯ Nursing Home
  Facility Name: _____
- ◯ Residence/Home
  Address: _____
- ◯ PACE : PACE4DC

Discharged:
Date of Discharged: _____
Reason for Discharged:
- ◯ Discharged to Community
  Address: _____
- ◯ Another Nursing Facility
  Facility Name: _____
- ◯ Hospital
  Hospital Name: _____
- ◯ Death
  Date of Death: _____
- ◯ Other : _____

Medicare Coverage:
The patient has Medicare coverage. ○ YES ○ NO If yes, Medicare ID #: _____
Request Date for Medicaid LTC payment to begin: _____
(**Date Medicare no longer serves as the primary payer for care. This is for LTC only, not short term stay).**

Conservator/Authorized Representative
Name _____ Contact Number _____
Address _____ Relationship _____

Authorized Provider Signature:
Name: _____ Contact Number _____
Signature: _____ Date _____

Section 2-Economic Security Administration Section:

◯ **Approved** ◯ **Denied** **Medicaid Eligibility Period: From:** _____ **To:** _____

Patient Payability

Initial month: _____
This is what you owe for the **first month**. This is based on the date that you were admitted through the last day of the first month or from the date your Medicare covered days ended through the last day of the month. **$**_____
Monthly Amount:
This is what you owe **monthly**. You owe this amount for the entire month as a patient. You must pay this amount for each full month of your stay in the facility. **$**_____

Discharge date: _____
This is what you owe for the month that you were discharged. It is based on the first of the month through your discharged date. **$**_____
Comment: _____

Social Service Representative Section

Printed Name: _____ Contact Number _____
Signature: _____ Date _____

DISTRIBUTION:

ORIGINAL TO FACILITY 2nd COPY TO FISCAL AGENT 3rd COPY TO CONSERVATOR/REPRESENTATIVE PAYEE 4th COPY TO PATIENT 5th COPY TO CASE RECORD

WHAT TO DO IF YOU DON'T AGREE WITH THIS DECISION

If you are not satisfied with the Agency's action on your eligibility or the reason for this action, you may request a fair hearing. You have up to 90 days from the date of this notice to request a hearing. A hearing decision will be rendered within 60 days of your request. You may make the request in writing, by talking with your worker in the office, or by telephone. You may also request a fair hearing by calling DHS Customer Service at 724-5506, or the Office of Administrative Hearings at 727-8280. You may also take or mail your request to the Office of Administrative Hearings at 441 4th Street, NW, Suite 540-South, Washington, D.C. 20001-2714. You may also contact one of the free legal services listed below. Your worker will gladly answer questions about your case, including information about hearings and how you may obtain free legal counsel from any of the organizations listed below.

The law provides: (1) that you have a "right to be represented by legal counsel or by a lay person who is not an employee of the District of Columbia Government; (2) that you may bring witnesses in your behalf; (3) that reasonable expenses relating to the hearing, such as an interpreter and transportation costs for you and your witnesses, will be paid for by the agency; and (4) that free legal services are available to you."

Neighborhood Legal Services

680 Rhode Island Ave., NE
(202) 832-6577

4609 Polk St., NE (Ward 7)
(202) 832-6577

2811 Pennsylvania Ave., SE (Ward 8)
(202) 832-6577

Legal Counsel for the Elderly
601 E Street, NW
(202) 434-2120
for persons age 60 and older)

Bread for the City Legal Clinics

1525 7th Street, NW
(202) 265-2400

1640 Good Hope Rd., SE
(202) 561-8587

Legal Aid Society
666 11th Street, NW, Suite 800
(202) 628-1161

Legal Clinic for the Homeless
1200 U St., NW
(202) 328-5500

If you believe you have been discriminated against because of race, color, sex, national origin or handicap, you may file a complaint with the D.C. Department of Human Services or the Federal Department of Health and Human services within 180 days from the date of this notice.

In accordance with the D.C. Human Rights Act of 1977, as amended, D.C. Official Code § 2-1402 et seq., (Act) the District of Columbia does not discriminate on the basis of actual or perceived: race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, family status, family responsibilities, matriculation, political affiliation, disability, source of income, place of residence or business, genetic information, or gender identity and expression. 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 this Act will not be tolerated. Violators will be subject to disciplinary action.