Government of the District of Columbia
Department of Health Care Finance
Office of Chronic & Long-Term Care

Beneficiary Agreement

The Medicaid beneficiary, a family member, or responsible party may complete this form, as appropriate.

Name of Beneficiary

_____

Last First Middle Initial

_____ is responsible for making medical decisions.
Print Name Clearly

Please check the appropriate box:

1. I agree to out-of-state nursing facility placement……..…. ❑ Yes ❑ No
2. I understand DC Medicaid benefits end with death……... ❑ Yes ❑ No
3. I understand DC Medicaid does not pay for funeral or burial expenses…… ❑ Yes ❑ No
4. I understand that I/_____ may be eligible to
   Name of Medicaid Beneficiary
   receive care in the community and choose to receive care in a nursing facility…… ❑ Yes ❑ No

Signature _____ Date _____ / _____ / _____