



## DECLINING YOUR MEDICAID HEALTH COVERAGE



If you and/or other members of your family have been determined eligible for Medicaid health coverage through DC Health Link, you have the right to decline your Medicaid health coverage. You must complete, sign, and return the Request to Decline Medicaid Health Coverage to DC Health Link.

**Review the information on this form carefully.** If you have any questions, please call DC Health Link Customer Service at (855) 532-5465/TTY (855) 532-5465 or go online to [www.DCHealthLink.com](http://www.DCHealthLink.com). You may also contact an In-Person Assister (listings at [www.DCHealthLink.com](http://www.DCHealthLink.com) or by calling DC Health Link Customer Service) to discuss your options.

### IMPORTANT INFORMATION ABOUT DECLINING MEDICAID HEALTH COVERAGE

Starting January 1, 2014, you are required to have minimum essential health coverage each month if you do not qualify for an exemption. If you do not meet an exemption to have minimum essential health coverage you will be required to pay a tax penalty when filing your federal income tax return. If you decline Medicaid health coverage, and do not qualify for an exemption, you are still responsible for obtaining minimum essential health insurance coverage for yourself and your dependents.

You have the right to 15 days advance notice before the DC Department of Health Care Finance terminates your Medicaid coverage. Waiving the 15 day notice means your Medicaid coverage will terminate on the last day of the month in which DC Health Link receives your request.

### CHOOSING PRIVATE DC HEALTH LINK COVERAGE

You have the right to enroll in a private insurance plan through DC Health Link without financial assistance and you do not have to decline your Medicaid in order to do so. **However, enrollment in private insurance through DC Health Link can only occur during Annual Open Enrollment or during a Special Enrollment Period.** For 2014, Annual Open Enrollment lasts from October 1, 2013 through March 31, 2014. In all other years, Annual Open Enrollment occurs October 15 through December 7 of each year. Special Enrollment Periods are based on circumstances that prevented the customer from enrolling during the Annual Open Enrollment.

If you are eligible for Medicaid but choose to enroll in a private health insurance plan through DC Health Link instead, you will NOT be eligible for help paying for health coverage (Premium Tax Credits and Cost Sharing Reductions). If you are able to pick a plan during an enrollment period, you must make your selection by the 15th day of the month, and pay the monthly premium by the date indicated by your carrier, for your health coverage to take effect the first day of the following month. In order to avoid a gap in coverage, you will have to pay for your private insurance plan before your Medicaid coverage ends.

## REQUEST TO DECLINE MEDICAID COVERAGE FORM

*Return the completed Request to Decline Medicaid Coverage form by mail, online, or in-person:*

**Mail:** Department of Human Services  
Case Records Management Unit  
441 4<sup>th</sup> Street, NW, Suite 1C-15  
Washington, DC 20001

**Email:** [Medicaid@dc.gov](mailto:Medicaid@dc.gov)

**Fax:** 202.535.1122

**In Person:** Take this form to one of our Service Centers. Call DC Health Link Customer Service at (855) 532-5465/TTY (855) 532-5465 for Service Center locations.

**Name:** \_\_\_\_\_

**DC Medicaid Number or Social Security Number (SSN):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_ **Email:** \_\_\_\_\_

*I am declining Medicaid health coverage for (please list name(s) below):*

☐ **Myself:** \_\_\_\_\_ **DC Medicaid# or SSN** \_\_\_\_\_

☐ **Spouse:** \_\_\_\_\_ **DC Medicaid# or SSN** \_\_\_\_\_

☐ **Dependent(s):** \_\_\_\_\_ **DC Medicaid# or SSN** \_\_\_\_\_

\_\_\_\_\_ **DC Medicaid# or SSN** \_\_\_\_\_

\_\_\_\_\_ **DC Medicaid# or SSN** \_\_\_\_\_

\_\_\_\_\_ **DC Medicaid# or SSN** \_\_\_\_\_

*By signing below, you acknowledge that you have read and understand the following:*

- **I understand** that I am required by law to have minimum essential health coverage for myself and my dependents each month unless I qualify for an exemption. I know that if I decline my Medicaid

health coverage, I am still responsible for obtaining minimum essential health insurance coverage, or obtaining an exemption, for myself and my dependents. If I do not maintain minimum essential health coverage or qualify for an exemption, I will have to pay a tax penalty when I file my federal income tax return.

- **I understand** that if I am eligible for Medicaid but choose instead to enroll in a private health insurance plan through DC Health Link; I will not be eligible for help paying for health coverage (Premium Tax Credits and Cost Sharing Reductions). I understand that enrollment in private plans is only available during certain enrollment periods and that declining Medicaid does not qualify me for a Special Enrollment Period. I understand that if I purchase a private insurance plan through DC Health Link, I must select a plan by the 15<sup>th</sup> day of the month, and pay the monthly premium by the date indicated by my carrier, for my health coverage to take effect the first day of the following month.
- **I understand** that I have the right to 15 days advance notice before the DC Department of Health Care Finance terminates my Medicaid coverage. I understand that if I waive my 15 day right to advanced notice and choose to enroll in a DC Health Link private insurance plan, there may not be enough time to select a plan and pay my monthly premium before my Medicaid coverage ends. This may lead to a gap in health coverage.

☐ Check here if you want to waive your 15 day advanced notice and have your coverage end on the last day of the month that we receive this form.

I am signing this Request to Decline Medicaid Coverage under penalty of perjury, which means I have provided true answers to all of 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.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_