

Application for Retroactive Medicaid Coverage

If you and/or a household member requests retroactive Medicaid coverage to pay for medical bills from the past 3 months, please complete, sign and return this application form. This form will be used to determine if you and or a household member qualifies for retroactive Medicaid coverage. You and/or a household member must meet all eligibility requirements for Medicaid during the retroactive period to qualify for Retroactive Medicaid coverage.

**How to submit
this retroactive
Medicaid
coverage
application**

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

Email: Medicaid@dc.gov

Fax: (202) 535-1122

In Person: Take this completed and signed form to one of the Service Centers listed below. If you have any questions, please Call DC Health Link Customer Service at (855) 532-5465/TTY (855) 532-5465.

ESA Service Centers: You may drop off the completed and signed form at any of the below service centers.

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

Congress Heights Service Center
4001 South Capitol Street, SW
Washington, DC 20032

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

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

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

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Tell Us About Yourself and Any Household Members Applying for Retroactive Medicaid Coverage

We will use this information to contact you, if needed.

Your Name (first, middle, last) _____

Social Security Number or DC Medicaid Number _____

Date of Birth (mm/dd/yyyy) _____

Home address (Check here if you are homeless) _____

City _____

State _____

ZIP code _____

Phone number (if you have one) _____ Email address (if you have one) _____

Are you applying for retroactive coverage for yourself? Yes No

If additional household members are applying for Retroactive Coverage, please list them here. Tell us the name (first and last), Social Security Number (SSN) or Medicaid ID#, and Date of Birth (DOB) of those household members.

Name _____ SSN or DC Medicaid ID# _____ DOB _____

Name _____ SSN or DC Medicaid ID# _____ DOB _____

Name _____ SSN or DC Medicaid ID# _____ DOB _____

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Residence History

Did you or the household member(s) applying for retroactive coverage live in D.C. throughout the last 3 months?

Yes No

If no, please tell us which household member(s) did not live in D.C., the state where they used to live, and which month they moved into the District.

Name (first and last) _____ State _____ Month (MM/YYYY) _____

Name (first and last) _____ State _____ Month (MM/YYYY) _____

Name (first and last) _____ State _____ Month (MM/YYYY) _____

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Citizenship/Eligible Immigration Status* Information

Did you or the household member(s) applying for retroactive coverage have a change in U.S. citizenship/eligible immigration status in the last three months? Yes No

If yes, please tell us the name of the person(s) whose citizenship/eligible immigration status has changed in the last three months and the month the person became a U.S. citizen or met one of the eligible immigration status categories.

Name (first and last) _____ Month (MM/YYYY) _____

Name (first and last) _____ Month (MM/YYYY) _____

Name (first and last) _____ Month (MM/YYYY) _____

**Please see Attachment B for more information on what is an eligible immigration status for Medicaid.*

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Income History

Did you or a household member(s) income change in the past three months? Yes No

If yes, tell us the name of the person whose income changed and what that person's gross income is for each month retroactive coverage is requested.

Name (first and last)	Last Month	Two Months Ago	Three Months Ago
_____	\$ _____	\$ _____	\$ _____

Name (first and last)	Last Month	Two Months Ago	Three Months Ago
_____	\$ _____	\$ _____	\$ _____

Name (first and last)	Last Month	Two Months Ago	Three Months Ago
_____	\$ _____	\$ _____	\$ _____

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Signature

If we have existing records or receive information that does not reasonably match the information you provided on this retroactive Medicaid application form, you may be required to provide additional documentation to verify income, residency or citizenship.

Sign this application. The person who filled out this retroactive Medicaid application should sign below. If you want an authorized representative or want to change the authorized representative you have now, fill out Attachment A on page 4.

Check here if you are an authorized representative. Sign below and fill out Attachment A on page 4.

I am signing this application under penalty of perjury which means I have 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 federal law if I provide false and or untrue information.

Signature _____ Date _____

Print Name _____