DISTRICT OF COLUMBIA LONG-TERM CARE/WAIVER MEDICAID APPLICATION

Instructions

This application is for individuals who would like to apply for Medicaid assistance to pay for Long-Term Care services and supports to include assistance with paying for a nursing home or an intermediate care facility for the Developmentally Disabled (ICF/DD) and the Home and Community-Based Services (HCBS) Waiver Program. ***Go to page 6 to start the application.***

The HCBS Waiver Program serves:

- *The Elderly and Individuals with Physical Disabilities (EPD), and*
- *Individuals with Intellectual or Developmental Disabilities (IDD).*

Program Overview

The Elderly and Individuals with Physical Disabilities (EPD) Waiver Program

The EPD Waiver Program provides a range of services to assist adults age 65 and older and individuals with physical disabilities to live as independently as possible in their homes and communities. These services are provided in addition to other services offered through DC Medicaid.

Institutional Transition

Institutional Transition status provides a range of services for individuals receiving care in a nursing facility who are transitioning to the community to receive services under the EPD Waiver Program. It is limited to the transition period before discharge from the nursing facility.

Intellectual and Developmental Disabilities (IDD) Waiver Program

The IDD Waiver provides a range of services for individuals with intellectual or developmental disabilities who want to live as independently as possible in their homes or communities. These services are provided, according to a person's need, in addition to other services offered by DC Medicaid.

Institutional Care Program (Nursing Facility and ICF/DD Facility)

The Institutional Care Program provides coverage to people receiving institutionalized level of care in a nursing facility or in an Intermediate Care Facility for the developmentally disabled.

(Revised April 1, 2018)

Individuals may not be eligible for the Institutional Care Program or the Waiver Programs because they transferred assets for less than fair market value within the 60 month (5 year) look-back period. They may be eligible for other Medicaid services.

This is NOT an application for Cash Assistance or Food Stamps. Applications for Cash Assistance and Food Stamps are available online at *http://dcdhs.dc.gov/publication/combined-application-benefits*, at the Department of Human Services Economic Security Administration Service Centers located at:

Anacostia Service Center
2100 Martin Luther King Avenue, SE
Washington, DC 20020
Phone: (202) 645-4614 Fax: (202) 727-3527

Congress Heights Service Center
4001 South Capitol Street, SW
Washington, DC 20032
Phone: (202) 645-4525 Fax: (202) 645-4524

H Street Service Center
645 H Street, NE
Washington, DC 20002
Phone: (202) 698-4350 Fax: (202) 724-8964

Fort Davis Service Center
3851 Alabama Avenue, SE
Washington, DC 20020
Phone: (202) 645-4500 Fax: (202) 645-6205

Taylor Street Service Center
1207 Taylor Street, NW
Washington, DC 20011
Phone: (202) 576-8000 Fax: (202) 576-8740,

Or call (202)727-5355 to have one mailed to you. If you are interested in obtaining Food Stamps or are concerned about food security, you are encouraged to submit a Food Stamp application to the Department of Human Services Economic Security Administration.

If you want to apply for EPD services, you must first contact the DC Office of Aging, Aging and Disabilities Resource Center (ADRC) at (202)724- 5626 Monday thru Friday, from 8:00 A.M. to 5:00 P.M. If you want to apply for IDD, you must contact the Department on Disability Services (DDS) Intake & Eligibility Office at (202) 730-1745 Monday thru Friday, from 8:00 A.M. to 5:00 P.M.

You or someone you have chosen to act on your behalf will need to complete and submit this application.

When filling out the application, please be sure to:

- Answer all the questions and fill out all the sections correctly and completely.
- Sign and date the application.
- Send proof of all documentation that applies to you. Please review "Checklist of Needed Documentation for your Long- Term Care/Waiver Application" on **page 5**.

If you are not applying for EPD services or IDD, you can:

1. Mail this application to: Long-Term Care Unit
   645 H Street, NE
   5th Floor
   Washington, DC 20002
2. You can also bring this application to the 645 H Street, NE Service Center.
3. You can email this application to esanursing.home@dc.gov
4. You can also fax this application to (202)724-8963

If you are applying for EPD services or IDD, you will submit your application to ADRC or DDS and they will submit the complete application package to the Economic Security Administration on your behalf.

Important Notice:

All Long-Term Care applicants are required to submit a complete application. If you are applying for **EPD waiver**, a complete application must include;

- A completed and signed Long-Term Care Medicaid Application
- A completed and approved Level of Care by DHCF or its agent.

Once all the information above is provided, the application is considered complete. The Aging and Disability Resource Center (ADRC) will then submit your complete application to the Economic Security Administration (ESA) for processing. Once ADRC submits the complete application to ESA, ESA will make an eligibility determination within 45 calendar days.

If you are applying for the **IDD waiver**, a complete application must include:

- A completed and signed Long-Term Care/Waiver Medicaid Application
- A completed Level of Care Form

If you are applying for Medicaid coverage in a N**ursing Facility or ICF/DD facility**, a complete application must include:

- A completed and signed Long-Term Care/Waiver Medicaid Application
- A completed and signed Start of Care Form
- For nursing facility, a completed and approved LOC by DHCF or its agent
- Please Note: For ICF/DD facility, a completed and approved Level of Care

Please note that the clinician (Doctor or APRN) that completes your LOC Form MUST be a Medicaid provider.

If the clinician who completes your LOC is not an enrolled Medicaid provider, they MUST complete a Provider Application. Your clinician may contact the Provider Enrollment Unit at 202.698.2000 or download a streamline application at https://www.dc-medicaid.com/dcwebal/documentInformation/getDocument/14934.

To find a clinician who is a Medicaid Provider, please visit our website at www.dc-medicaid.com and click "Search for Provider" on the left hand corner.

Your application will be submitted for processing when all the required documents, including the LOC Form, are received.

Please note that your application for the EPD Waiver, the IDD waiver, Nursing facility coverage or coverage in an ICF/DD facility must be complete with the documents described above. If the application is not signed and complete and the required signed documents are not provided with the application to the ESA, the application will not be registered and processed. ESA will only begin processing the application when all of the required documentation is signed and completed and submitted to ESA.

The information you give us on this application is kept confidential as required by the Federal and District law.

To start the application, go to page 6.

Checklist of Needed Documentation for your Long-Term Care/Waiver Application

You may need to provide the item(s) listed below to process your application. Do not send originals; send in copies of the documentation with your application. In some cases, you may need to provide additional documentation. If additional documents are needed they will be requested and you will be given additional time to submit these forms.

- ☐ Current bank statements on all accounts owned and co-owned (e.g., checking, savings, credit union, etc.)
- ☐ Power of Attorney or Legal Guardianship
- ☐ Current statement of retirement accounts (e.g., IRA, Keogh Accounts, etc.)
- ☐ Current financial statements on all accounts owned and co-owned
    - ☐ Stocks
    - ☐ Bonds
    - ☐ Money market accounts
    - ☐ Certificate of deposits
    - ☐ Mutual funds
- ☐ Face and current cash value of life insurance policies
- ☐ Current statements of burial accounts
- ☐ Burial plots certificate/deed
- ☐ Life estates deeds
- ☐ Mortgage notes and mortgage deeds
- ☐ Health insurance premium amounts (copy of the bill)
- ☐ Current gross monthly income (award letters) from all sources including:
    - ☐ VA benefits
    - ☐ Railroad retirement
    - ☐ Pensions
    - ☐ Annuities

*** Current documentation cannot be older than 30 days from the month of application. ***

If you want to find out if your spouse can keep some of your monthly income, you must provide

- ☐ Spouse's monthly gross monthly income
- ☐ Rent or Mortgage statement, condo fee statement, property tax bill
- ☐ Utility bills (e.g., electric, gas, etc.)

Additional documentation for applicants who do not have Active DC Medicaid or QMB coverage

- ☐ Proof of District of Columbia residency (e.g. DC driver's license, lease agreement, rent receipt, written statement from the landlord, utility bill)

Date Application Received by ESA:		*Stamp Required
Worker Name:		
Case Number:		

*** ALL FIELDS MUST BE ANSWERED** **Initial Application ☐** **Renewal/Recertification ☐**

Section 1: Application Information	
I am applying for Long-Term Care Medicaid: <u>Institutional Care</u> ☐ Nursing Facility or Skilled Nursing Facility ☐ Intermediate Care Facilities for Persons with Intellectual and Developmental Disabilities (ICF/IDD)	<u>Home and Community-Based Waiver</u> ☐ Elderly and Individuals with Physical Disabilities (EPD) ☐ Institutional Transition ☐ Intellectual and Developmental Disabilities (IDD) ☐ Money Follows the Person (ends 12/31/18)

Section 2: Applicant Information ***Please tell us about yourself.***		
First Name:	Middle Name:	Last Name, Suffix (Jr, Sr. etc.):
Maiden Name:		
Social Security Number:	Date of Birth: (Month, Day, Year)	Gender: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
Voluntary Questions:		
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino		
Race: ☐ Black/ African American ☐ Asian ☐ American Indian or Alaskan Native ☐ White ☐ Native Hawaiian or Other Pacific Islander		
What is your primary Language?	Do you need an interpreter? ☐ YES ☐ NO	

Section 2: Applicant Information (Continued)
Please tell us about yourself.

Are you a United States citizen or U.S. national? *If yes, continue to Section 3.
☐ YES ☐ NO

If you aren't a US citizen or US national, do you have eligible immigration status?
☐ YES ☐ NO

If yes, then fill in your document type and ID number below.

a. Immigration document type:
_____

b. Document ID Number
_____

c. Have you lived in the U.S. since 1996?
☐ YES ☐ NO

d. Are you a veteran or an active duty member of the U.S. military?
☐ YES ☐ NO

Is anyone in your household pregnant? (Including self) ☐ YES ☐ NO Expected due date:_____	Have you had a child within the last 60 days? ☐ YES ☐ NO Child's Date of Birth: _____

Are you the parent or caretaker relative of a child under age 18? ☐ Yes ☐ No

Tax Information

1. Do you plan to file a federal income tax return next year? ☐ YES ☐ NO ***(If yes, please answer the following Tax Information questions please continue to question #2.)***	2. Will you file jointly with a spouse? ☐ YES ☐ NO **(If yes,** name of spouse) _____
3. Will you claim any dependents on your tax return? ☐ YES ☐ NO (**If yes,** list name(s) of dependents) _____ _____ _____ _____	4a. Will you be claimed as a dependent on someone's tax return? ☐ YES ☐ NO (**If yes,** please list the name of the tax filer) _____ 4b. How are you related to the tax filer? _____

Section 3: Applicants' Address ***Please tell us your current and/or prior address.***			
What is your home address or the address of your nursing facility? Street:	City:	State:	Zip:
Contact Telephone Number:		Is this your mailing address? ☐ YES ☐ NO (If no, provide your mailing address information below)	
What is your mailing address? Street:	City:	State:	Zip:
Are you homeless? ☐ YES ☐ NO		Do you plan to stay in the District of Columbia? ☐ YES ☐ NO	
If you are in a nursing facility, what is your previous address prior to entering the facility? Street:	City:	State:	Zip:
Did you or your spouse own this home? ☐ YES ☐ NO			

Section 4: Benefit Status ***Please tell us about any medical assistance you receive.***
Are you currently receiving Medicaid from the District of Columbia? ☐ YES ☐ NO
If yes, provide your Medicaid ID number:
Are you receiving Medicaid (Medical Assistance) benefits from another State? ☐ YES ☐ NO
If yes, list the state:

Section 4A: Retroactive Coverage-Medical Expenses ***Please complete only if you are applying for Institutional Care (Skilled Nursing Facility, Nursing Facility, and Intermediate Care Facilities for Individuals with Intellectual Disabilities) Medicaid and have any paid or unpaid medical bills from the last three months. Retroactive Coverage Only Applies to Institutional Care (Skilled Nursing Facility, Nursing Facility, and Intermediate Care Facilities for Individuals with Intellectual Disabilities) and does not apply to individuals applying for HCBS Waiver programs. If you are applying for an HCBS Waiver program, please skip this section.***	
Did the applicant applying for retroactive coverage live in D.C. throughout the last 3 months?	Yes ☐ No ☐
Did the applicant applying for retroactive coverage have a change in U.S. citizenship/eligible immigration status in the last three months?	Yes ☐ No ☐
Did you or your spouse's income change in the past three months?	Yes ☐ No ☐
Did you or your spouse's assets change in the past three months?	Yes ☐ No ☐
If yes to any of the questions above, describe the change: _____	

Section 5: Spouse Information *If married, please tell us about your spouse. Skip this section if you are not married.*		
First Name:	Middle Name:	Last Name, Suffix (Jr, Sr. etc.):
Maiden Name:		
Spouse's Social Security Number: Note: You do not need to provide your Spouse's SSN if she/he is not applying for Medicaid. We may need your spouse's SSN to verify their resources and income		
Spouse's Address: Street: City: State: Zip:		
Do you or your spouse own this home? ☐ YES ☐ NO		

Section 6: Authorized Representative *If you wish to choose someone to act on your behalf, please tell us about the individual.*		
First Name:	Middle Name:	Last Name, Suffix (Jr., Sr., etc.):
Other Name:		
Mailing Address: Street: City: State: Zip:		
Contact Telephone Number:		Relationship to you:

Section 7: Veteran's Information *Please complete this section if you are a veteran, a disabled widow(er), or a disabled child of a deceased veteran.* **(Provide a copy of your military service card.)**			
Veteran's Name:	Relationship:	Veteran's Status:	Military Service Number:

Section 8: Medical Insurance *Please complete this section if you are insured. If you have more than one, use Section 19 on page 16 or use additional sheets.*		
Policy Holder's Name:	Policy Number:	Group Number:
Relationship to Policy Holder:	Policy Effective Date:	
Insurance Company Name:		
Address: Street: City: State: Zip:		

Section 9: Income of Applicant and/or Spouse

Please tell us about any income or benefits that you and/or your spouse are currently receiving, have applied for, or have been denied. Check all that apply. If you check a benefit or income, complete the details in the boxes below.

☐ Supplemental Security Income (SSI) ☐ Social Security Disability Income (SSDI) ☐ Social Security Retirement Income ☐ Alimony ☐ Worker's Compensation ☐ Unemployment Benefits ☐ Business Income ☐ Rental Income	☐ Lump Sum Payment ☐ Black Lung Benefits ☐ Veteran's Pension/Benefits ☐ Pension or Retirement ☐ Disability/Sick ☐ Civil Service ☐ Union Benefits ☐ Other (describe):

Type of Benefit/Income	Receiving Income or Benefits	Person(s) Receiving Income or Benefits	Amount	Application Status	If applied, Application or Denial Date
	☐ YES ☐ NO	☐ Self ☐ Spouse	$	☐ Receiving ☐ Applied For ☐ Denied	
	☐ YES ☐ NO	☐ Self ☐ Spouse	$	☐ Receiving ☐ Applied For ☐ Denied	
	☐ YES ☐ NO	☐ Self ☐ Spouse	$	☐ Receiving ☐ Applied For ☐ Denied	

Section 10: Income from Working ***Please tell us about any income/money you or your spouse is currently receiving from working, including any sick leave payments.***	
Employer Name:	Type of Job:
Employer Address: Street: City: State: Zip:	
Start Date:	End Date (if you stopped working):
Gross Wages per Pay Period, include tips and commissions: $ per	
Hours of work per pay period:	How often do you get paid? ☐ Weekly ☐ Biweekly ☐ Twice a Month ☐ Monthly

Section 11: Assets ***Please tell us about your assets as of the first of the month. Check all that apply. Then complete the chart for each asset on the list that you and your spouse own individually, jointly, or with other persons. Assets added under "other" should be included in the chart in Section 12.***	
☐ Cash on hand ☐ Checking account ☐ Savings account ☐ Credit Union Account ☐ Trust Account ☐ IRA or Keogh Account	☐ Other Retirement Account ☐ Stocks and Bonds ☐ Treasury Notes or Other Notes ☐ Annuity ☐ Patient Fund Account ☐ Funds or Deposits Held in a Continuing Care Retirement Community ☐ Other (describe):

Section 11: Assets (Continued)				
Asset Type	**Owner(s)**	**Amount/Value**	**Account Number**	**Financial Institution Name**
		$		
		$		
		$		
		$		
		$		
		$		

Are any of your bank accounts set aside solely for your burial expenses? ☐ Yes ☐ No

What is the account number? _____

What is the name of the Financial Institution? _____

Section 12: Other Assets ***Please tell us about other assets that you or your spouse own individually, jointly, and with other individual(s). Include vehicles, recreational vehicles, home property, land and other personal property.***			
Asset Type	**Current Fair Market Value**	**Current Amount owed, if any**	**Owner(s)**
		$	
		$	
		$	

☐ **Note** – If you need Additional space to list assets list them in section 19.

Section 13: Transfer of Assets

Please tell us about assets that you sold, traded, gifted, or disposed of for the last 60 months (5 years). Include personal property, real property (home), motor vehicles (cars, trucks), stocks, bonds, cash, or any other assets.

Have you or your spouse sold, traded, gifted, or disposed of any assets in the last 5 years? ☐ YES ☐ NO
If yes, complete the boxes below.

Transfer Date	Type of Asset	Value of Asset at the Time of Transfer	Who received the Asset and Reason for the Transfer	Amount You Received
		$		$
		$		$
		$		$

Have you sold your home within the past twelve months? ☐ Yes ☐ No
If you sold your home within the past twelve months, do you plan on purchasing a new home? ☐ Yes ☐ No
If you placed the proceeds from the sale of your home in a bank account please provide the account number _____
and name of the financial institution _____

Section 14: Life Insurance, Long-Term Care (LTC) Insurance, and Funeral Plans

Please tell us about all the policies you owned regardless of who pays the premium.

Do you or your spouse have any life insurance policies, LTC insurance, or pre-paid burial funds? ☐ YES ☐ NO
If yes, complete the boxes below.

Original Face Value or Value of the Plan	Cash Value	Type of Plan	Policy Number or Account Number	Policy Owner(s)	Company, Funeral Home or Bank Name
$	$	☐ Life Insurance ☐ LTC Insurance ☐ Burial Plan			
$	$	☐ Life Insurance ☐ LTC Insurance ☐ Burial Plan			

☐ **Note** – If you need additional space to list assets list them in section 19.

Section 15: Spousal Impoverishment ***If you have a spouse, please complete the section below. List all the assets you and your spouse owned individually or jointly and with other individual(s).***				
☐ Cash on Hand ☐ Checking Account ☐ Savings Account ☐ Credit Union Account ☐ Retirement Account			☐ Annuity ☐ Trust Funds ☐ Stocks, Bonds ☐ Other:	
Asset Type	**Owner(s)**	**Amount/Value**	**Account Number**	**Institution Name**
		$		
		$		
		$		

Section 16: Potential Assets or Income ***Please tell us about any accident settlement, trust fund, inheritance, or any money, property, or assistance that you expect to receive.***	
Do you or your spouse expect to receive any assets, income, or other money? ☐ YES ☐ NO If yes, complete the boxes below.	
Asset Type(s)	Lawyer Name (if any)
Anticipated Date of Receipt	Lawyer Contact Number

Section 17: Residential, Spousal, and Dependent Allowance

You may qualify for certain allowances that can be deducted from your income. You may qualify for allowances if you are in a nursing facility, if you have any dependent, and if you need money to help your spouse. If you would like to be evaluated for these allowances, please complete the section below.

Have you or your spouse been in a nursing facility? ☐ YES ☐ NO If so, who? Me ☐ My Spouse ☐ Both ☐

If yes, provide the following:

Name of the Facility:	Date Entered:

Is there a spouse, child under 21, or any disabled child in the home? ☐ YES ☐ NO

If yes, complete the section below.

Name	Relationship to Applicant	Age	Gross Monthly Income (if any)	Type of Income (if any)	Value of Asset (if any)	Asset Type (if any)

For nursing facility applicants: Do you intend to return home within six months? ☐ YES ☐ NO

If you intend to return home within six months and if there is no spouse, child under 21, or a disabled child in the home, complete the section below.

Rent/Mortgage $	Utilities $	Heat (if separate) $
Property Taxes $	Condo Fees $	Home Insurance $
Other Shelter Costs (Specify) $		

<table>
<tr><th colspan="2">Section 18: For Immigrants (Non-Citizens) Applying for Benefits
Many immigrants are eligible for benefits. For any non-citizen applying for benefits, please provide the immigration information below. We use this information for the purpose of determining your eligibility for Medicaid.</th></tr>
<tr><td>Please use the categories for “Current Status” in the table below:</td><td></td></tr>
<tr><td>Lawful Permanent Resident (LPR)
Refugee or Asylee
Cuban or Haitian entrant
Person who has been granted withholding of deportation (removal)
Parolee admitted for at least on year
Alien who has been present before April 1, 1980 as a “Conditional Entrant”
Hmong/Laotian
Person on active duty in U.S. Armed Forces (or veteran)</td><td>Spouse, widow, or dependent of an American Soldier or veteran
Victim of domestic violence
Victim of a severe form of human trafficking
Native American/Inuit born outside of the United States
Amerasians who came to the U.S. due to the Vietnam War
Other (your status does not match one of those listed above)</td></tr>
<tr><td>Name of Immigrant:</td><td>Alien ID#:</td></tr>
<tr><td>Current Status:</td><td>Date You Moved to the U.S.:</td></tr>
<tr><td>Were you ever a Refugee or Asylee? ☐ YES ☐ NO</td><td>Are you Cuban/Haitian? ☐ YES ☐ NO</td></tr>
<tr><td colspan="2">Did you move to the United States before August 22, 1996? ☐ YES ☐ NO</td></tr>
<tr><td colspan="2">For Lawful Permanent Residents (LPRs) only:</td></tr>
<tr><td colspan="2">Do you have a sponsor? ☐YES ☐NO</td></tr>
<tr><td colspan="2">Have you, your spouse, and/or sponsor ever worked in the U.S.? ☐ YES ☐ NO</td></tr>
</table>

Section 19: Additional Information ***Use this area for any additional information or any other items that you would like us to know. You may attach additional sheets, if needed.***

Section 20: Signature	
▪ By signing below, I give my permission to 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 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 the Notice of My Rights and Responsibilities as outlined in Appendix B of the application. 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 and will become a remainder beneficiary of the annuity by virtue of the provision of medical assistance relating to long-term care services. ▪ 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 apply for LTC benefits and agrees to the conditions above. **<u>Nursing Facility and Intermediate Care Facility Applicants/Beneficiaries Only</u>** ▪ **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:
Authorized Representative:	Date:

Appendix A:

Information on Past Medical Bills/Expenses

If you have medical bills for services that you received before the month of this application, we may be able to help you pay some or all those bills. If you don't want us to pay those bills, or Medicaid rules do not allow us to pay the bills, we may be able to reduce what you will need to pay for your long term care services.

You can ask for Medicaid to cover your medical bills for up to three months prior to the month of this application. We call this the retroactive period. For District of Columbia (DC) Medicaid to pay for those months, you must have met the Medicaid eligibility requirements during those months and incurred expenses that would have been covered by Medicaid. If you are eligible for the retroactive period, we will reimburse you for the bills you already paid for those months. Retroactive Medicaid may cover prior Skilled Nursing Facility, Nursing Facility, and Intermediate Care Facilities for Individuals with Intellectual Disabilities expenses, but may not cover other long term care services.

If you do not want retroactive benefits, you can ask us to use your unpaid medical bills to help you qualify for Long-Term Care/Home and Community-Based Services (LTC/HCBS) if you are over the income limit or to reduce the amount that you will need to pay for your long term care services for this month and future months if you meet the LTC/HCBS income limits. You can use any unpaid medical bills no matter how old they are. This includes unpaid bills for long-term care services. If you want us to apply your past bills to your future long term care costs, then you will still be responsible for paying those past bills.

If your income is over the Long-Term Care /Home and Community-Based Services (LTC/HCBS) income limit, you may still be able to get LTC/HCBS Services by showing that you have high medical expenses. This is called Medicaid “Spend down.” To get Medicaid under Spend down, you must have a certain amount of medical bills. The total amount of medical bills you need is your “deductible.” When you have enough bills, including some past bills, you will meet your deductible and you may be eligible under Spend down. Medicaid will not pay the bills you count towards your deductible. After you meet your deductible, Medicaid may pay for some or all of your other medical bills. If you are over-income for LTC/HCBS services, you can use past medical bills to meet your Spend down deductible.

Under Spend down rules for LTC, you can also qualify based on the projected Medicaid reimbursement rate cost of the institutional care you expect to receive during a six month Spend down period. If we approve LTC based on the projected Medicaid reimbursement rate costs, you are still responsible for paying these projected costs. If we use your projected LTC costs to Spend down to Medicaid, you can still use your past medical bills to reduce the remaining amount you will need to pay for your LTC. You can use paid and unpaid bills from the current and past three months for Spend down. You can also use unpaid bills that are more

than three months old and old bills that were just paid during the past three months. If you are found to be over-income and need to use Spend down to get LTC/HCBS services, we will send you a notice telling you the amount of your deductible. If you provide bills with your application that you ask us to use for Spend down for LTC/HCBS services, we will send you an additional notice saying how much you still owe. We will use the projected Medicaid reimbursement rate cost of institutional care towards your Spend down. You can also provide any other bills you want to use.

If a third party insurance, like Medicare or other health insurance paid or is responsible for paying your medical bill, or if the bill was previously counted for Medicaid Spend down eligibility, we cannot use the bill to reduce the amount you will need to pay for your LTC/HCBS services. For more information, ask your Medicaid worker.

Appendix B:

Notice of Rights and Responsibilities

General Rules

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 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.

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://www.dc-medicaid.com/dcwebportal/nonsecure/recipientForms.

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 United States District Court of the District of Columbia within 30 days. You may obtain free legal assistance to help you present your case at the fair hearing or at the appeal by contacting Terris Pravlik & Millian, LLP at 1816 12th Street NW; Suite 303, Washington, DC 20009 or (202) 682-0578.

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 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 Medical Assistance Administration, Third Party Liability Section, 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 Healthcare 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 North 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 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 above 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 (for persons age 60 or older)
601 E Street, NW
(202)434-2120

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