Long Term Care Program Medical Assistance Application

Instructions:

This is an application for Medical Assistance that will cover some or all of the costs of persons who stay in approved Long Term Care Facilities, or who want to receive services under the Home and Community Based (HCBS) Waiver Program. The HCBS Waiver Program includes: Persons Who Are Elderly or Physically Disabled (EPD), and
Persons with Intellectual and/or Developmental Disabilities (IDD).

You, or someone you have chosen to act for you, need to complete this application only if you are about to enter, or are staying in a Long Term Care Facility, or are applying for the Home and Community Based Waiver Program. If you want EPD services, you must first contact the DC Office of Aging's Aging and Disabilities Resource Center (ADRC). You can call the ADRC on (202) 724-5626 on weekdays from 8:00 a.m. to 5:00 p.m.

This is **NOT** an application for Cash Assistance, Food Stamps or other types of Medical Assistance.

You must be a resident of the District of Columbia or if you just started staying in a Long Term Facility in D.C., you must plan to remain in D.C. after your discharge from the facility.

You can mail this application to: **Long Term Care Unit**
645 H Street N.E. 5th Floor
Washington, D.C. 20002

You can also bring in this application to the 645 H Street, N.E. Service Center. If you mail this application, please enclose a copy of the following documents:

- Proof of Residency- Mortgage/Rent Statement, utility bill etc., or
  Start Of Care Notice from the Long Term Care Facility if you currently stay in a Facility
- Proof of Income for the past 30 days for self and spouse
- Proof of any Assets that you (or spouse) own such as Bank Accounts,
  Stocks, Bonds, Life Insurance, Real Property, etc.
- Health Insurance Cards
- Copies of all paid or unpaid Medical expenses for applicant
- Documents of any assets you transferred in the last five (5) years

Upon your request, an assessment of assets can be completed when you provide proof of all of your assets.
(Combined assets for yourself and spouse).

If you have any questions, you can call 202-698-4220. Revised May 2015

1. PERSONAL INFORMATION

Name:		Social Security Number:
Date of Birth:	Sex: O Male O Female	Marital Status: O Single O Married O Divorced O Widowed O Separated

Current Address or your address prior to entering the Long Term Care Facility:	Do you plan on returning to this residence upon discharge? O Yes O No
Name and Address of the Long Term Care Facility:	Date you entered Facility:

Do you plan to stay in the District of Columbia? O Yes O No

Have you ever received Medicaid in another state? O Yes O No

If yes, list the state and the date that your Medicaid was terminated.

State: Date Medicaid was terminated:

2. INFORMATION ON SPOUSE: Complete this information even if you are not applying for your spouse.

Name:	Date of Birth:
Address:	Social Security Number:

Under Long Term Care rules, you can transfer a portion of your income to your community spouse, if his/her income is below about $2000 a month, or more when he/she has high shelter costs. The income you can transfer is called a Spousal Allowance.

If your spouse qualifies for a Spousal Allowance, would you like to transfer a portion of your income to your spouse?
O Yes O No

If you agreed to transfer a portion of your income to your spouse, you need to tell us how much your income you want to keep and how much you would like to transfer. Please mark your choice below.

I want to transfer the maximum amount. O Yes O No If you answered no, tell us how much you want to keep.
I want to keep O $70 O $100 O $125 O $150 If you want to keep another amount, record the amount here. $_____

Are you responsible to pay Court Ordered Spousal Support (Alimony)? O Yes O No	If yes, the amount of monthly support:

3. INCOME: List below the types and amounts of unearned income and earnings you and/or your spouse receive. List the gross amount of income (before taxes and deductions are taken out).

Unearned Income - such as SSI, Social Security Benefits, Pensions and/or Annuities

Type of Unearned Income	Person Receiving Payment	Amount of Payment (before taxes and deductions)	How often is it received? (monthly, weekly, every two weeks, twice a month, etc.)

Earned Income

Person who is working	Employer's Name and Telephone Number	Amount of earnings before taxes and deductions	How often is it received? (monthly, weekly, every two weeks, twice a month, etc.)

4. Please list your spouse and any dependent children, dependent parents and dependent siblings that live in your home.

	Last Name	First Name	Middle Initial	Sex	Date of Birth	Social Security Number	Relation to You	Do you claim this person as a dependent on your tax return?	Gross Monthly Income
1									
2									
3									
4									
5									

5. Legal Representation - Do you have one of the following acting on your behalf? Please answer here. O Yes O No

If you checked "yes" please provide the following information.

Conservator: O Yes O No	NAME:	ADDRESS:
	Do you pay a monthly Conservator fee? O Yes O No	
	If yes, the Fee Amount:	Telephone Number:
Representative Payee: O Yes O No	NAME:	ADDRESS:
	Do you pay a monthly Rep. Payee fee? O Yes O No	
	If yes, the Fee Amount:	Telephone Number:
Authorized Representative: O Yes O No	NAME:	ADDRESS:
	Do you pay a monthly fee? O Yes O No	
	If yes, the Fee Amount:	Telephone Number:

6A. Past Medical 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 of 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 D.C. Medicaid to pay for those months, you must have lived in D.C., met income requirements, and met the resource limit for Medicaid of $4,000 for one person, or $6,000 for a couple. If you are eligible for the **retroactive** period, we will reimburse you for the bills you already paid for those months. **Retroactve** Medicaid may cover prior nursing home 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 reduce the amount that you will need to pay for your long term care services for this month and future months. 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 monthly income is more than $2,200, you may be over-income for LTC/HCBS services. Even if your income is over the 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 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/HCBS services, you can also qualify based on the cost of the LTC/HCBS Services that you **expect** to pay during a six month Spend-Down period. If we approve LTC/HCBS services based on your **expected** costs, you are still responsible for paying these **projected** costs. If we use your projected LTC/HCBS costs to Spend Down to Medicaid, you can still use your past medical bills to reduce the amount you will need to pay for your LTC/HCBS services. 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. Since Medicaid cannot pay the bills that you use for Spend Down, it is usually best to use bills that you already paid. If you are found to be over-income and need to use Spend Down to get LTC 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, we will send you an additioinal notice saying how much you still owe. In the over-income notice we send to you we will ask you if you want us to use your expected expenses. If you want us to use expected expenses, you will need to sign a statement saying you want to do that and return the signed statement to us. You can also provide any other bills you want to use.

If a third party insurance, like Medicare or other health insurance paid your medical bill, or if the bill was previously counted for Medicaid Spenddown eligibility, we cannot use the bill to reduce the amount you will need to pay for yout LTC/HCBS services.

In the boxes on the next page, please let us know if you want Medicaid coverage for the **retroactive** period, or if you want to use your past medical bills to reduce the amount you will need to pay for your future long term care services, or to determine your eligibility through Spend-Down, or if you want us to do a combination of these. For more information, ask your Medicaid worker.

6B. Listing of Past Medical Expenses

Do you need retroactive Medicaid coverage for paid or unpaid medical bills incurred during the past three months, including nursing home bills? O Yes O No	**Do you have any past paid or unpaid medical bills, not being used to determine retroactive Medicaid coverage? (examples include Nursing Home expenses, Prescription drugs, Dental bills. Home Health Care costs, etc.) O Yes O No**

If you answered "yes" to either, or both of the above questions, list the type and amount of these past medical bills that may be used to determine eligiblity for **retroactive** coverage, to qualify through Spend Down, and/or to calculate your share of the monthly costs for care in a Long Term Facility.

Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**
Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**
Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**
Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**
Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**
Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**
Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**
Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**
Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**

Attach another page if you have additional medical bills.

7. Health Insurance Information

Medicare Information (from your Medicare Card)

Do you have Medicare?	Type of Coverage:	Medicare Claim Number:	Effective Date
O Yes O No	O Part A O Part B		Part A:
			Part B:
Does your spouse have Medicare?	**Type of Coverage:**	**Medicare Claim Number:**	**Effective Date**
O Yes O No	O Part A O Part B		Part A:
			Part B:

Other Health Insurance

Do you have other health insurance?	O Yes O No	Amount of Monthly Premium: $
Does your spouse have other health insurance?	O Yes O No	Amount of Monthly Premium: $

If you or your spouse have other health insurance, including a Medicare supplement policy, please complete the boxes below and attach a copy (front and back) of the insurance cards.

	Health Insurance Company- Name and Address	Monthly Premium	Policy Number	Type of Coverage (Medigap, Retiree, RX, etc.)
Self				
Spouse				

8A. Current Assets

Do you or your spouse currently own any of the following assets? O Yes O No

If you answered "yes", please list the type and amount of assets you or your spouse currently own.

Asset Type	Value	Asset Type	Value
Bank or Credit Union Account	$	2nd Bank or Credit Union Account	$
Stocks/Bonds/Mutual Funds	$	Real Property including your Home	$
Certificates of Deposit	$	Boats/Recreational Vehicles/Motor Homes	$
Annuity/Trust Funds/Trust Accounts	$	Cash- Including Cash Surrender Value of any Life Insurance Policies	$

Do you or your spouse, own any other assets of value? O Yes O No

Description of Asset:	Asset Value:

8B. Assets when you entered the Long Term Care Facility

If you have a spouse who lived with you before you entered the Long Term Care Facility, you need to list below the amount of assets you or your spouse had when you entered the facility. You can skip this section if this situation does not apply to you.

Asset Type	Value	Asset Type	Value
Bank or Credit Union Account	$	2nd Bank or Credit Union Account	$
Stocks/Bonds/Mutual Funds	$	Real Property including your Home	$
Certificates of Deposit	$	Boats/Recreational Vehicles/Motor Homes	$
Annuity/Trust Funds/Trust Accounts	$	Cash- Including Cash Surrender Value of any Life Insurance Policies	$

Did you or your spouse own any other assets of value? O Yes O No

Description of Asset:	Asset Value:

8C. Transfer of Assets

Have you or your spouse given away or transferred anything of value in the last five years? This would include money in bank accounts, stocks, bonds, real estate or other possessions of value, or creation of an annuity. O Yes O No

If yes, complete the following:

Date of Transfer:	Who received the transferred asset?	Description of Asset:	Value of Asset at Transfer:	Amount received for Asset:
Date of Transfer:	Who received the transferred asset?	Description of Asset:	Value of Asset at Transfer:	Amount received for Asset:
Date of Transfer:	Who received the transferred asset?	Description of Asset:	Value of Asset at Transfer:	Amount received for Asset:
Date of Transfer:	Who received the transferred asset?	Description of Asset:	Value of Asset at Transfer:	Amount received for Asset:

Attach another page if you transferred additional assets

9. Additional Questions to See How Much You May Need To Pay for Your Care

Do you own or rent a home? O Yes O No

Do you expect to return to this home within six (6) months? O Yes O No

If you expect to return, will your spouse or any of your dependents continue to stay in your home? O Yes O No

If your home will be unoccupied, you may qualify for a Home Maintenance Allowance that will reduce the amount you have to pay for your Long Term Care costs. If your home will be ocupied by your spouse, his/her Spousal Allowance may be increased becasue of high shelter expenses. Please list the amount you pay for the following:

Rent/Mortgage: _____	**Real Estate Taxes: _____**	**Home Insurance: _____**
Home Association Fees: _____	**Condo/Co-op Maintenance Fees: _____**	

10. Signature	
•	**By signing below, I give my permission to 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.**
•	**I understand that the District of Columbia will seek recovery of the bills it pays for me when I am in a nursing home or other medical institution. This means that the District of Columbia may put a lien or claim on my property or estate.**
•	**I have received a copy of my rights and responsibilities. I understand my responsibilities and agree to cooperate as required.**
•	**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 a remainder beneficiary of the annuity.**
•	**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.**

SIGNATURE: _____ **DATE:** _____

REPRESENTATIVE SIGNATURE: _____ **DATE:** _____

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.

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 in the assistance unit. (See 42 CFR 435.910, 7 CFR 273.6, DC Code §4-204.07, §4-205.05a, and §4-217.07) Your SSN will be used to verify your identity, prevent receipt of duplicate benefits, and make required program changes. The 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 you apply, 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. To get free legal help with Medicaid, call Terris, Pravlik, and Millian on (202) 682-0578 or write to them at 1121 12th Street, NW, Washington, DC 20005. If you get Medical Assistance, then you must recertify each year when we send you a recertification notice. There is no time limit for getting Medical Assistance.

Estate Recovery: The District will seek recovery for the bills we pay for you if you are in a nursing home or other medical institution. Also, if you are age 55 or older, the District will seek recovery for services that you get. This means that we may put a lien or claim on your property or estate. This does not apply to any Qualified Medicare Beneficiary (QMB) benefits you get. Effective January 1, 2010, Section 115 of the Medicare Improvement for Patients and Provider Act (MIPPA) prohibits states from recovering Medicaid payments for Medicare cost sharing expenses made on behalf of Qualified Medicare Beneficiaries. The District cannot seek recovery of payments for Medicare cost sharing.If you have questions, call (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.

Recertification

We will send you a recertification notice in the mail. You will need to work with your Waiver services case manager, or nursing facility, to get the information you need to give us to continue getting your Medical Assistance. Please contact them right away to make sure that you can complete your recertification on time. If you do not recertify, then you will lose your benefits. Also, please let us know if you move. Just call **(202) 727-5355** to report your new address.

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. Of course, DHS keeps all of your information confidential. DHS does not release your records without your permission (except when required by law).

Equality and Non-Discrimination

In accordance with Federal law and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Ave., SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

In accordance with the DC Human Rights Act of 1977, as amended, DC Official Code § 2-1401.01 et seq., (Act) the District of Columbia does not discriminate on the basis of actual or perceived: race, color, religion, national origin, sex (gender or sexual harassment), age, marital status, personal appearance, sexual orientation, gender identity or expression, familial status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income, status as a victim of an intra-family offense, and place of residence or business. 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 the Act will not be tolerated. Violators will be subject to disciplinary action. Complaints of possible violations of this law may be filed with the Government of the District of Columbia, Office of Human Rights, 441 4th Street NW, Suite 570-North, Washington, DC 20001. Telephone: (202) 727-4559. Fax: (202) 727-9589.

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
4609 Polk St., NE
(for Ward 7 only)
680 Rhode Island Ave., NE
2811 Pennsylvania Ave, SE
(for Ward 8 only)
(202) 832-6577

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

University Legal Services
220 I Street, NE, Suite 130
(202) 547-0198

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