0020120101

ACEDS CASE # *123456*

District of Columbia

Department of Human Services (DHS)

Medicaid Renewal Form M1

November 1 2014

John Smith
3900 Washington Ave NE
Washington DC 20002

It is time to renew your Medicaid coverage. Please respond by **November 30 2014**

Renewal Code: 12M00123456

MAGI-RENEWAL-ENG-VER1.0

You can renew your Medicaid in any one of these ways	• **Online:** Go to **www.DCHealthLink.com/renewalM1** for instructions. • **By mail:** Complete this form and mail it in the enclosed envelope to: *Department of Human Services* *Economic Security Administration* *Outstation/Medicaid Renewal Unit* *609 H st NE* *Washington DC 20077-0554* • **In person:** Visit any of our ESA service centers listed on the next page. • **By phone:** Just call **(855) 532-5465 (TTY: 711)** • **By Fax:** You can also Fax us at 202-671-4400.
How to complete this renewal form	1. Answer all of the questions on the form. Read the information about you and each member of your household. Add any missing information. If any information has changed, write in the right information. **2. Sign the form on page 13.** 3. Please return this form by **November 30 2014**, to avoid gaps in your Medicaid coverage. Your Medicaid eligibility is set to expire **December 31 2014**. 4. A checklist of the sections that need to be completed is included in the next page.
What we need	We need information about each person living in your household or listed on your tax return, including: • those who get Medicaid now, • those who do not get Medicaid now but would like to apply, **and** • others who live in the household and do not get Medicaid but do not want to apply. We will check your answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration, the Department of Homeland Security and others. If the information does not match, we may ask you to send more information.
If you do not qualify	If you do not qualify for Medicaid, we will check to see if you qualify for other kinds of health coverage. We may send your information to another program so they can see if you qualify.

Checklist for completion of this form

The checklist below provides a summary of the information needed to complete each section of the renewal form.

	Section	
☐	1	Verify and update your **contact information**
☐	2	Provide information about **who files tax returns**
☐	3	Update the information on those **who get Medicaid now**
☐	4	Provide information on those **who do not get Medicaid now but would like to apply, and others who live in the household but do not want to apply**
☐	5	Tell us about **other health insurance coverage**
☐	6	Provide **additional information** about all the people listed in this renewal form
☐	7	Provide information on **income from employment**
☐	8	Provide information on **other sources of income**
☐	9	Read this section and **sign the form on page 13**
☐	A	Fill this attachment for **new individuals in Section 4 who want to apply for Medicaid and Health Insurance Coverage**
☐	B	Fill this attachment for any individual who is **American Indian or Alaska Native**
☐	C	Fill this section if you want to choose an **authorized representative or if anyone helped you complete the renewal form**
☐	D	This attachment is provided to help you fill section 3 on **immigration status and document types**

ESA Service Centers

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

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

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

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

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

Service Center Hours of Operation:

Monday, Tuesday, Thursday, Friday
7:30 AM to 4:45 PM

Wednesday
7:30 AM to 8:00 PM

1 Your contact information

▼ Review your contact information here.

John Smith

Home Address
1234 New York Ave NE
Washington DC 20004

Mailing Address
3900 Washington Ave NE
Washington DC 20002

Phone:
202-345-8907

▼ Correct any wrong or missing information here.

Name *(first, middle, last & suffix)*

Home address | Apartment #

City *(home)* | State | ZIP code

Mailing address | Apartment #

City *(mailing)* | State | ZIP code

Best phone number to reach you: ☐ Home ☐ Cell ☐ Work

Number:

Other phone number, if you have one: ☐ Home ☐ Cell ☐ Work

Number:

Do you wish to receive electronic notification? ☐ Yes ☐ No

Email address, if you have one:_____

You can change your decision about receiving electronic notification at any time. If you let us know that you do not want to receive electronic notification, you will receive notices in the mail.

What is your preferred spoken or written language (if not English)?

2 We need information about who files tax returns.

You can still renew if you do not file tax returns.

Will anyone in the household file a **federal tax return *next year*** to report income earned ***this year***?

☐ Yes ***If yes,*** answer all of the questions below. ☐ No ***If no,*** answer the question marked with a star ★ below

Person 1: Name *(first, middle, last & suffix)*

If this person is filing a joint return, write the name of the spouse: Name *(first, middle, last & suffix)*

If this person will claim dependents, write the names of the dependents *(first, middle, last & suffix)*:

Person 2: Name *(first, middle, last & suffix)*

This is for a second tax filer in the household

If this person is filing a joint return, write the name of the spouse: Name *(first, middle, last & suffix)*

If this person will claim dependents, write the names of the dependents *(first, middle, last & suffix)*:

★ If anyone will be claimed as a dependent on someone else's tax return, write the name of the tax filer and the dependents. Answer only if different than what you reported above or if you did not fill in any information above.

Name of tax filer *(first, middle, last & suffix)*:_____

Name of dependents *(first, middle, last & suffix)*: _____

_____

3 These are the people in your household who get Medicaid and need to renew now

Person 1 **John Smith**

☑ The District **has** this person's Social Security number. You do not need to fill in the Social Security Number below.

☐ The District **does not** have this person's Social Security number. ***Write it in the spaces below.***

__ __ __ – __ __ – __ __ __ __

Does this person still live with you?

☐ Yes ☐ No

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because the District has it.

☐ Check here if this person has eligible immigration status and fill in the document type: _____

and ID number: _____ . See Attachment D on page 18 for more information about eligible immigration status and document types.

Person 2 **Jane Smith**

☑ The District **has** this person's Social Security number. You do not need to fill in the Social Security Number below.

☐ The District **does not** have this person's Social Security number. ***Write it in the spaces below.***

__ __ __ – __ __ – __ __ __ __

Does this person still live with you?

☐ Yes ☐ No

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because the District has it.

☐ Check here if this person has eligible immigration status and fill in the document type: _____

and ID number: _____ . See Attachment D on page 18 for more information about eligible immigration status and document types.

Person 3 **John Smith Jr**

☐ The District **has** this person's Social Security number. You do not need to fill in the Social Security Number below.

☑ The District **does not** have this person's Social Security number. ***Write it in the spaces below.***

__ __ __ – __ __ – __ __ __ __

Does this person still live with you?

☐ Yes ☐ No

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because the District has it.

☐ Check here if this person has eligible immigration status and fill in the document type: _____

and ID number: _____ . See Attachment D on page 18 for more information about eligible immigration status and document types.

Person 4 Skip and go to Page 6

☐ The District **has** this person's Social Security number. You do not need to fill in the Social Security Number below.

☐ The District **does not** have this person's Social Security number. ***Write it in the spaces below.***

__ __ __ – __ __ – __ __ __ __

Does this person still live with you?

☐ Yes ☐ No

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because the District has it.

☐ Check here if this person has eligible immigration status and fill in the document type: _____

and ID number: _____ . See Attachment D on page 18 for more information about eligible immigration status and document types.

Person 5 Skip and go to Page 6

☐ The District **has** this person's Social Security number. You do not need to fill in the Social Security Number below.

☐ The District **does not** have this person's Social Security number. ***Write it in the spaces below.***

__ __ __ – __ __ – __ __ __ __

Does this person still live with you?

☐ Yes ☐ No

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because the District has it.

☐ Check here if this person has eligible immigration status and fill in the document type: _____

and ID number: _____ . See Attachment D on page 18 for more information about eligible immigration status and document types.

3 These are the people in your household who get Medicaid and need to renew now (continued)

Person 6 Skip and go to Page 6

☐ The District **has** this person's Social Security number. You do not need to fill in the Social Security Number below.

☐ The District **does not** have this person's Social Security number. ***Write it in the spaces below.***

__ __ __ – __ __ – __ __ __ __

Does this person still live with you?

☐ Yes ☐ No

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because the District has it.

☐ Check here if this person has eligible immigration status and fill in the document type: _____

and ID number: _____ . See Attachment D on page 18 for more information about eligible immigration status and document types.

Person 7 Skip and go to Page 6

☐ The District **has** this person's Social Security number. You do not need to fill in the Social Security Number below.

☐ The District **does not** have this person's Social Security number. ***Write it in the spaces below.***

__ __ __ – __ __ – __ __ __ __

Does this person still live with you?

☐ Yes ☐ No

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because the District has it.

☐ Check here if this person has eligible immigration status and fill in the document type: _____

and ID number: _____ . See Attachment D on page 18 for more information about eligible immigration status and document types.

Person 8 Skip and go to Page 6

☐ The District **has** this person's Social Security number. You do not need to fill in the Social Security Number below.

☐ The District **does not** have this person's Social Security number. ***Write it in the spaces below.***

__ __ __ – __ __ – __ __ __ __

Does this person still live with you?

☐ Yes ☐ No

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because the District has it.

☐ Check here if this person has eligible immigration status and fill in the document type: _____

and ID number: _____ . See Attachment D on page 18 for more information about eligible immigration status and document types.

Person 9 Skip and go to Page 6

☐ The District **has** this person's Social Security number. You do not need to fill in the Social Security Number below.

☐ The District **does not** have this person's Social Security number. ***Write it in the spaces below.***

__ __ __ – __ __ – __ __ __ __

Does this person still live with you?

☐ Yes ☐ No

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because the District has it.

☐ Check here if this person has eligible immigration status and fill in the document type: _____

and ID number: _____ . See Attachment D on page 18 for more information about eligible immigration status and document types.

Person 10 Skip and go to Page 6

☐ The District **has** this person's Social Security number. You do not need to fill in the Social Security Number below.

☐ The District **does not** have this person's Social Security number. ***Write it in the spaces below.***

__ __ __ – __ __ – __ __ __ __

Does this person still live with you?

☐ Yes ☐ No

If this person is an immigrant, for their immigration status:

☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because the District has it.

☐ Check here if this person has eligible immigration status and fill in the document type: _____

and ID number: _____ . See Attachment D on page 18 for more information about eligible immigration status and document types.

4 We need more information about people not listed in Section 3 *(Page 4/5)*

▶ Tell us about anybody else in your household or on your tax return.

Other person 1: Name (*first, middle, last & suffix):* **Martha Smith**

☑ The District **has** this person's Social Security number (SSN).
☐ The District **does not** have this person's Social Security number (SSN).
Write it here if this person is applying for health insurance coverage:
— — — – — — – — — — —
This person may choose not to give the SSN if he or she is not applying, but it helps us to have it. The SSN will be used to determine eligibility.

☐ Check here if this person lives with you.
Date of birth (month/day/year):
This person is: ☐ Male ☐ Female
How is this person related to you?

☐ Check here if this person **has** Medicaid. ☐ Check here if this person does not want to apply for Medicaid or assistance paying for health coverage.
☐ Check here if this person **does not** have Medicaid and wants health insurance coverage, and fill out Attachment A on page 15.

Other person 2: Name (*first, middle, last & suffix):*

☐ The District **has** this person's Social Security number (SSN).
☐ The District **does not** have this person's Social Security number (SSN).
Write it here if this person is applying for health insurance coverage:
— — — – — — – — — — —
This person may choose not to give the SSN if he or she is not applying, but it helps us to have it. The SSN will be used to determine eligibility.

☐ Check here if this person lives with you.
Date of birth (month/day/year):
This person is: ☐ Male ☐ Female
How is this person related to you?

☐ Check here if this person **has** Medicaid. ☐ Check here if this person does not want to apply for Medicaid or assistance paying for health coverage.
☐ Check here if this person **does not** have Medicaid and wants health insurance coverage, and fill out Attachment A on page 15.

Other person 3: Name (*first, middle, last & suffix):*

☐ The District **has** this person's Social Security number (SSN).
☐ The District **does not** have this person's Social Security number (SSN).
Write it here if this person is applying for health insurance coverage:
— — — – — — – — — — —
This person may choose not to give the SSN if he or she is not applying, but it helps us to have it. The SSN will be used to determine eligibility.

☐ Check here if this person lives with you.
Date of birth (month/day/year):
This person is: ☐ Male ☐ Female
How is this person related to you?

☐ Check here if this person **has** Medicaid. ☐ Check here if this person does not want to apply for Medicaid or assistance paying for health coverage.
☐ Check here if this person **does not** have Medicaid and wants health insurance coverage, and fill out Attachment A on page 15.

Other person 4: Name (*first, middle, last & suffix):*

☐ The District **has** this person's Social Security number (SSN).
☐ The District **does not** have this person's Social Security number (SSN).
Write it here if this person is applying for health insurance coverage:
— — — – — — – — — — —
This person may choose not to give the SSN if he or she is not applying, but it helps us to have it. The SSN will be used to determine eligibility.

☐ Check here if this person lives with you.
Date of birth (month/day/year):
This person is: ☐ Male ☐ Female
How is this person related to you?

☐ Check here if this person **has** Medicaid. ☐ Check here if this person does not want to apply for Medicaid or assistance paying for health coverage.
☐ Check here if this person **does not** have Medicaid and wants health insurance coverage, and fill out Attachment A on page 15.

Other person 5: Name (*first, middle, last & suffix):*

☐ The District **has** this person's Social Security number (SSN).
☐ The District **does not** have this person's Social Security number (SSN).
Write it here if this person is applying for health insurance coverage:
— — — – — — – — — — —
This person may choose not to give the SSN if he or she is not applying, but it helps us to have it. The SSN will be used to determine eligibility.

☐ Check here if this person lives with you.
Date of birth (month/day/year):
This person is: ☐ Male ☐ Female
How is this person related to you?

☐ Check here if this person **has** Medicaid. ☐ Check here if this person does not want to apply for Medicaid or assistance paying for health coverage.
☐ Check here if this person **does not** have Medicaid and wants health insurance coverage, and fill out Attachment A on page 15.

4 We need more information about people not listed in Section 3 *(Page 4/5)*

▶ Tell us about anybody else in your household or on your tax return.

Other person 6: Name (*first, middle, last & suffix):*

☐ The District **has** this person's Social Security number (SSN).
☐ The District **does not** have this person's Social Security number (SSN).
Write it here if this person is applying for health insurance coverage:
__ __ __ – __ __ – __ __ __ __
This person may choose not to give the SSN if he or she is not applying, but it helps us to have it. The SSN will be used to determine eligibility.

☐ Check here if this person lives with you.
Date of birth (month/day/year):
This person is: ☐ Male ☐ Female
How is this person related to you?

☐ Check here if this person **has** Medicaid. ☐ Check here if this person does not want to apply for Medicaid or assistance paying for health coverage.
☐ Check here if this person **does not** have Medicaid and wants health insurance coverage, and fill out Attachment A on page 15.

Other person 7: Name (*first, middle, last & suffix):*

☐ The District **has** this person's Social Security number (SSN).
☐ The District **does not** have this person's Social Security number (SSN).
Write it here if this person is applying for health insurance coverage:
__ __ __ – __ __ – __ __ __ __
This person may choose not to give the SSN if he or she is not applying, but it helps us to have it. The SSN will be used to determine eligibility.

☐ Check here if this person lives with you.
Date of birth (month/day/year):
This person is: ☐ Male ☐ Female
How is this person related to you?

☐ Check here if this person **has** Medicaid. ☐ Check here if this person does not want to apply for Medicaid or assistance paying for health coverage.
☐ Check here if this person **does not** have Medicaid and wants health insurance coverage, and fill out Attachment A on page 15.

Other person 8: Name (*first, middle, last & suffix):*

☐ The District **has** this person's Social Security number (SSN).
☐ The District **does not** have this person's Social Security number (SSN).
Write it here if this person is applying for health insurance coverage:
__ __ __ – __ __ – __ __ __ __
This person may choose not to give the SSN if he or she is not applying, but it helps us to have it. The SSN will be used to determine eligibility.

☐ Check here if this person lives with you.
Date of birth (month/day/year):
This person is: ☐ Male ☐ Female
How is this person related to you?

☐ Check here if this person **has** Medicaid. ☐ Check here if this person does not want to apply for Medicaid or assistance paying for health coverage.
☐ Check here if this person **does not** have Medicaid and wants health insurance coverage, and fill out Attachment A on page 15.

5 Tell us about *other* health insurance coverage people have

▶ Include anyone in Sections 3 and 4 with Medicaid and anyone who is applying for health insurance coverage.

List everyone who is on this policy (first, middle, last & suffix):

Type of insurance: ☐ Medicare Part A ☐ Medicare Part B ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance_____

List everyone who is on this policy (first, middle, last & suffix):

Type of insurance: ☐ Medicare Part A ☐ Medicare Part B ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance_____

List everyone who is on this policy (first, middle, last & suffix):

Type of insurance: ☐ Medicare Part A ☐ Medicare Part B ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance_____

▶ ☐ Check here if anyone on this form is offered health insurance through a job, even if they are not enrolled in it.
☐ Check here if any of the insurance plans you listed is a state employee benefit plan.

6 Tell us more about the people listed on this renewal form

▶ If anyone who is renewing or applying for health insurance coverage has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or lives in a medical facility or nursing home write his or her name here.

Name (*first, middle, last & suffix):*

Name (*first, middle, last & suffix):*

▶ If anyone who is renewing or applying for health insurance coverage is blind or terminally ill, write his or her name here.

Name (*first, middle, last & suffix):*

Name (*first, middle, last & suffix):*

▶ If anyone who is renewing or applying for health insurance coverage has a child in the home who is 18 and a full time student, write his or her name here.

Parent/Caretaker's Name (*first, last):*	**Full time Student's Name (first, last):**
Full time Student's Name (first, last):	**Full time Student's Name (first, last):**

▶ If anyone who is renewing or applying for health insurance coverage is under age 26 and exited DC foster care at age 18 or older, write his or her name here.

Name (*first, middle, last & suffix):*

Name (*first, middle, last & suffix):*

▶ If anyone listed on this form (whether renewing or applying for health insurance coverage or not) is pregnant, write her information below.

Name (*first, middle, last & suffix):*	How many babies are expected?
Name (*first, middle, last & suffix):*	How many babies are expected?

▶ If anyone listed on this form (whether renewing or applying for health insurance coverage or not) is incarcerated, write his or her information below

Name (*first, middle, last & suffix):*	**Name of facility (if known):**	**Location of facility (state)**
Name (*first, middle, last & suffix):*	**Name of facility (if known):**	**Location of facility (state)**

▶☐ Check here if anyone who is renewing or applying for health insurance coverage is an American Indian or Alaska Native, and fill out Attachment B on page 16.

7 Tell us about work

▶ Fill in the information below for everyone in your household or on your tax return who has income from a job whether or not they are renewing or applying for coverage. You can tell us about self-employment on the next page. Also include here income for persons you are adding to the household in Section 4. If someone has more than one job, tell us about all jobs. Make a copy of this page if you need space for more jobs or people. **Cross out any information that is not correct about members of your household. Write in any new information.**

Job 1: Name of the person who is working (*first, middle, last & suffix):* **John Smith**

Employer name: XYZ Computers | **Employer** phone number: 202-100-1050

Employer address: 300 M St SE # 500 City: Washington State: DC ZIP code: 20003

How often are wages or tips paid? ☐ Weekly ☐ Every two weeks ☑ Monthly ☐ Yearly ☐ Other

How much does this person get paid (before taxes)? **$** 1200.00 (if other, write in monthly amount)

Average hours worked each week:

Job 2: Name of the person who is working (*first, middle, last & suffix):*

Employer name: | **Employer** phone number:

Employer address: City: State: ZIP code:

How often are wages or tips paid? ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Yearly ☐ Other

How much does this person get paid (before taxes)? **$** _____ (if other, write in monthly amount)

Average hours worked each week:

Job 3: Name of the person who is working (*first, middle, last & suffix):*

Employer name: | **Employer** phone number:

Employer address: City: State: ZIP code:

How often are wages or tips paid? ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Yearly ☐ Other

How much does this person get paid (before taxes)? **$** _____ (if other, write in monthly amount)

Average hours worked each week:

Job 4: Name of the person who is working (*first, middle, last & suffix):*

Employer name: | **Employer** phone number:

Employer address: City: State: ZIP code:

How often are wages or tips paid? ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Yearly ☐ Other

How much does this person get paid (before taxes)? **$** _____ (if other, write in monthly amount)

Average hours worked each week:

Job 5: Name of the person who is working (*first, middle, last & suffix):*

Employer name: | **Employer** phone number:

Employer address: City: State: ZIP code:

How often are wages or tips paid? ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Yearly ☐ Other

How much does this person get paid (before taxes)? **$** _____ (if other, write in monthly amount)

Average hours worked each week:

Section 7 *continued on next page* ▶▶▶

7 Tell us about work *(continued)*

▶ List anyone in your household who has **changed jobs** or has **worked fewer hours** in the past four months.

1. Name (*first, middle, last & suffix*):

☐ This person stopped working ☐ This person is now working fewer hours ☐ This person changed jobs

2. Name (*first, middle, last & suffix*):

☐ This person stopped working ☐ This person is now working fewer hours ☐ This person changed jobs

▶ If anyone in your household is **self-employed**, we need to know about their work.
See the instructions for more information about deductions.

1. Name (*first, middle, last & suffix*):

How much *net income* will this person get from self-employment this month? Amount: **$** _____

2. Name (*first, middle, last & suffix*):

How much *net income* will this person get from self-employment this month? Amount: **$** _____

3. Name (*first, middle, last & suffix*):

How much *net income* will this person get from self-employment this month? Amount: **$** _____

▶ Subtract the expenses below from your gross income to get an amount for your net self-employment income.

- Car and truck expenses (for travel during the workday, not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or business interruption insurance
- Interest (including mortgage interest paid to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals
- Deductible self-employment taxes
- Cost of self-employed health insurance
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan

▶ If anyone in your household has **deductions**, tell us what kind.

Alimony paid to someone else	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	**$**	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Other (write in monthly amount)_____
Student loan interest paid	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	**$**	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Other (write in monthly amount)_____
Other deductions	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	**$**	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Other (write in monthly amount)_____

8 Tell us about other income

Use the tables below to specify other income types and how often the payments are received.
Cross out any information that is not correct. Write in any new information.

Other Income Types:
- Unemployment
- Social Security
- Pensions
- Retirement accounts
- Alimony received
- Farming or fishing (profit after business expenses)
- Rental income or royalties (profit after business expenses)
- Other (please specify)

How often?
- Weekly
- Every two weeks
- Monthly
- Yearly
- Other (write in monthly amount)

Name (First, Middle, Last, Suffix)	Other Income Type	How much?	How Often?
Martha Smith	Rent	$600	Monthly

9 Read and sign this renewal form

Privacy Act Statement (Effective 03/04/2014)

We are authorized to collect the information on this form and any supporting documentation, including social security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), the Tax Code, and the Social Security Act.

We need the information provided about you and the other individuals listed on this form to determine eligibility for: (1) Medicaid, (2) enrollment in a qualified health plan through DC Health Link, (3) insurance affordability programs (such as advanced payment of the premium tax credits and cost sharing reductions), and (4) certifications of exemption from the individual responsibility requirement. As part of that process, we will verify the information provided on the form, communicate with you or your authorized representative, and if applicable, eventually provide the information to the health plan you select so that they can enroll any eligible individuals in a qualified health plan or insurance affordability program. We will also use the information provided as part of the ongoing operation of DHS, including activities such as verifying continued eligibility for all programs, processing appeals, reporting on and managing the insurance affordability programs for eligible individuals, performing oversight and quality control activities, combatting fraud, and responding to any concerns about the security or confidentiality of the information.

In order to verify and process renewals, applications, determine eligibility, and operate, we will need to share selected information that we receive outside of DHS, including to:

1. Federal agencies, (such as the Internal Revenue Service, Social Security Administration and Department of Homeland Security), State agencies or local government agencies. We may use the information you provide in computer matching programs with any of these groups to make eligibility determinations, to verify continued eligibility for enrollment in Medicaid, a qualified health plan or Federal benefit programs, or to process appeals of eligibility determinations;
2. Other verification sources including consumer reporting agencies;
3. Employers identified on applications for eligibility determinations;
4. Applicants/enrollees, and authorized representatives of applicants/enrollees;
5. Agents, Brokers, and issuers of Qualified Health Plans, as applicable, who are certified by DC Health Link to assist applicants/enrollees;
6. Contractors engaged to perform a function for DHS or DC Health Link and
7. Anyone else as required by law.

While providing the requested information (including social security numbers) is voluntary, failing to provide it may delay or prevent your ability to obtain Medicaid, health coverage through DC Health Link, advanced payment of the premium tax credits, cost sharing reductions, or an exemption from the shared responsibility payment. If you don't have an exemption from the shared responsibility payment and you don't maintain qualifying health coverage for three months or longer during the year, you may be subject to a penalty. If you don't provide correct information on this form or knowingly and willfully provide false or fraudulent information, you may be subject to a penalty and other law enforcement action.

This statement provides the notice required by the Privacy Act of 1974 (5 U.S.C. § 552a(e)(4))

To obtain information about how your health information is kept private and protected by Medicaid, visit http://dhcf.dc.gov/publication/hipaa-notice-privacy-practice.

Renewal of coverage in future years

▶ Read the statement below and check **one** box.

To make it easier to check my income at renewal time, I agree to allow DHS and DC Health Link to use income information from my tax returns for the number of years I checked below. I can also choose to not allow DHS and DC Health Link to check this information. If I do not give permission for DHS and DC Health Link to check my income using my tax returns, I understand that I may be required to submit other documentation of my income to DHS and DC Health Link.

Yes, I give permission to check my income on tax returns for (check one box):

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Do not use information from tax returns to renew my coverage.

9 Read and sign this renewal form (continued)

Your rights and responsibilities

I am signing this renewal form under penalty of perjury, which means I've 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 District and federal law if I willfully provide false or untrue information.

I know that I must tell DHS if anything changes (and is different than) what I wrote on this renewal form.
I can call (855) 532-5465 (TTY:711) or go in person to any of the ESA service centers listed on Page 2 to report any changes.
I understand that a change in my information could affect the eligibility for member(s) of my household.

I know that under District and federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination with the D.C Office of Human Rights or the Federal Equal Employment Opportunity Commission (EEOC).

EEOC Washington Field Office
131 M Street, NE
Fourth Floor, Suite 4NWO2F
Washington, DC 20507-0100
Phone: 1-800-669-4000
Fax: 202-419-0740
TTY: 1-800-669-6820

DC Office of Human Rights
441 4th Street NW
Suite 570 North
Washington, DC 20001
Phone: (202) 727-4559 TTY: 711
Fax: (202) 727-9589

I know that my information on this renewal form will be used only to determine eligibility for health coverage and will be kept private as required by law.

We need this information to check your eligibility for help paying for health coverage. We will check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information from these electronic data bases does not match the information you provided in this renewal form, we may ask you to send us additional documentation.

If anyone on this renewal form is eligible for Medicaid
•I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties, I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
•If any child on this renewal form has a parent living outside of the home, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

What should I do if I think my eligibility results are wrong?
If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household, including how many days you have to request an appeal. Below is important information to consider when requesting an appeal:
•You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
•If you request an appeal, you may be able to keep you eligibility while your appeal is pending.
•The outcome of your appeal could change the eligibility of other members of your household.

To appeal your eligibility results, log into your "MyAccount" at **www.DCHealthLink.com/renewals** or call **(855) 532-5465 (TTY: 711)**. You can also mail an appeal request form or your own letter requesting an appeal to Office of Administrative Hearings Resource Center, 441 4th Street NW, Suite 450-North, Washington, DC 20001. You can appeal eligibility for Medicaid, purchasing health coverage through DCHealth Link, enrollment periods, tax credits, or cost sharing reductions if you were denied these. If you qualify for tax credits or cost-sharing reductions, you can appeal the amount we determined you are eligible for.

By signing this renewal form, you represent that you have permission from all of the people whose information is on the renewal form to both submit their information to DHS and DC Health Link, and receive any communications about their eligibility and enrollment.

▸ **Sign and date below.**
If you want an authorized representative or want to change the authorized representative you have now, fill out Attachment C on page 17.
☐ Check here if you are an authorized representative. Sign below and fill out Attachment C on page 17.

Signature of household contact or authorized representative:	Date:
X	

Please do not forget to sign the Renewal Form on the previous page.

Attachment A

Additional People applying for Medicaid and Health Insurance Coverage *For people listed in Section 4, Page 6/7*

Tell us about anyone in your household who wants to apply for Medicaid. **Do not answer** these questions for people **who already have Medicaid**. *If more than two people are applying, make a copy of this page.*

Name of person applying: Name (*first, middle, last & suffix)*

▶ Tell us about citizenship

Is this person a U.S. citizen or U.S. national? ☐ Yes ***If yes,*** go to "Tell us more information about this person"
☐ No ***If no,*** answer all of the questions below.

☐ Check here, if this person has eligible immigration status and fill in the document type: _____
and ID number: _____. See Attachment D on page 18 for more information about eligible immigration status and document types.

☐ Check here, if this person has lived in the U.S. since 1996.
☐ Check here, if this person, his or her spouse, or a parent is a veteran or an active duty member in the U.S. military.

▶ Tell us more about this person

☐ Check here, if this person lives with at least one child under the age of 18, or with an 18 year old who is a full time student, and is the main person taking care of this child.
☐ Check here, if this person is a resident of the District. ☐ Check here, if this person wants help paying for medical bills from the last three months.

▶ Tell us about race and ethnicity. *You may choose not to answer these questions.*

If this person is Hispanic/Latino, check all that apply:
☐ Mexican ☐ Mexican American
☐ Chicano/a ☐ Puerto Rican
☐ Cuban ☐ Other _____

What is this person's race? Check all that apply:
☐ White ☐ Asian Indian ☐ Korean ☐ Guamanian or Chamorro
☐ Black or African American ☐ Chinese ☐ Vietnamese ☐ Samoan
☐ Filipino ☐ Other Asian ☐ Other Pacific Islander
☐ American Indian or Alaska Native ☐ Japanese ☐ Native Hawaiian ☐ Other _____

Name of person applying: Name (*first, middle, last & suffix)*

▶ Tell us about citizenship

Is this person a U.S. citizen or U.S. national? ☐ Yes ***If yes,*** go to "Tell us more information about this person"
☐ No ***If no,*** answer all of the questions below.

☐ Check here, if this person has eligible immigration status and fill in the document type: _____
and ID number: _____. See Attachment D on page 18 for more information about eligible immigration status and document types.

☐ Check here, if this person has lived in the U.S. since 1996.
☐ Check here, if this person, his or her spouse, or a parent is a veteran or an active duty member in the U.S. military.

▶ Tell us more about this person

☐ Check here, if this person lives with at least one child under the age of 18, or with an 18 year old who is a full time student, and is the main person taking care of this child.
☐ Check here, if this person is a resident of the District. ☐ Check here, if this person wants help paying for medical bills from the last three months.

▶ Tell us about race and ethnicity. *You may choose not to answer these questions.*

If this person is Hispanic/Latino, check all that apply:
☐ Mexican ☐ Mexican American
☐ Chicano/a ☐ Puerto Rican
☐ Cuban ☐ Other _____

What is this person's race? Check all that apply:
☐ White ☐ Asian Indian ☐ Korean ☐ Guamanian or Chamorro
☐ Black or African American ☐ Chinese ☐ Vietnamese ☐ Samoan
☐ Filipino ☐ Other Asian ☐ Other Pacific Islander
☐ American Indian or Alaska Native ☐ Japanese ☐ Native Hawaiian ☐ Other _____

★ If anyone applying for Medicaid has medical bills from the last three months, send the medical bills with this form.

Attachment B

American Indian or Alaska Native family member (AI/AN) *To help you fill out Section 6, Page 8*

Tell us about your American Indian or Alaska Native family member(s)

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They may not have to pay co-pays and may get special monthly enrollment periods.

If more than two people are American Indian or Alaska Native, make a copy of this page.

1. Name (*first, middle, last & suffix):*

Is this person a member of federally recognized tribe? ☐ Yes ☐ No

If yes, tribe name?

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program? ☐ Yes ☐ No

If no, does this person qualify to get these services? ☐ Yes ☐ No

List any income that includes money from these sources:

- Payments from a tribe for natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

How much income? **$**

How often?

☐ Weekly ☐ Monthly
☐ Every two weeks ☐ Yearly
☐ Other (write in monthly amount)

2. Name (*first, middle, last & suffix):*

Is this person a member of federally recognized tribe? ☐ Yes ☐ No

If yes, tribe name?

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program? ☐ Yes ☐ No

If no, does this person qualify to get these services? ☐ Yes ☐ No

List any income that includes money from these sources:

- Payments from a tribe for natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

How much income? **$**

How often?

☐ Weekly ☐ Monthly
☐ Every two weeks ☐ Yearly
☐ Other (write in monthly amount)

Attachment C — Assistance with completing this renewal form

You can choose an authorized representative.

You can give a trusted person permission to talk about this renewal form with us, see your information, and act for you on matters related to this renewal form, including getting information about your renewal form and signing your renewal form on your behalf.

This person is called an "authorized representative". If you ever need to change your authorized representative, contact DHS. If you are a legally appointed representative for someone on this renewal form, submit proof with the renewal form.

Name of authorized representative:

Address: | Apartment # | City | State | ZIP code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other

Number:

By signing, you allow this person to sign and submit your renewal form, get official information about this renewal form, receive copies of notices and other communications from DHS and DC Health Link, and act for you on all future matters with DHS and DC Health Link

Your signature:
X

Date:

▶ If anyone helped you complete this renewal form, please fill out the section below

The person who helped you complete this renewal form should sign below. If you are an authorized representative, you may sign here as long as you have provided the information required above and signed page 13 of this renewal form as applicable.

Name of person who helped you complete the renewal form:

Phone: **Email:**

Signature of the person who helped you complete the renewal form:
X

Date:

Attachment D

Helpful information about immigration status and document types. *To help you fill out Section 3, Page 4/5*

Eligible immigration status list

▶ If you see the person's status below, go back to Section 3, page 4/5 and check the Yes box.

For all, these are eligible immigration statuses:

- Lawful Permanent Resident (LPR, or "Green card" holder)
- Asylee
- Refugee
- Cuban or Haitian entrant
- Individual paroled into the U.S. for at least one year
- Conditional entrant granted before 1980
- Battered spouse, child and parent
- Victim of Trafficking and his/her spouse, child, sibling or parent
- Individual granted Withholding of Deportation or Withholding of Removal
- Amerasian Immigrant
- Iraqi and Afghan Special Immigrants
- Member of a federally-recognized Indian tribe or American Indian Born in Canada

If the person is an individual under the age of 21 or a pregnant woman, these are additional eligible immigration statuses:

- Individual with Non-immigrant Status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Individual with Temporary Protected Status (TPS) or Applicant for Temporary Protected Status (TPS) (with Employment Authorization)
- Individuals with Deferred Enforced Departure (DED)
- Family Unity beneficiary
- Individual with Deferred Action Status (Except Individual with Deferred Action for Childhood Arrivals (DACA). DACA is not an eligible immigration status)
- Applicant for Special Immigrant Juvenile Status
- Applicant for Adjustment to LPR Status
- Applicant for Asylum
- Applicant for Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
- Applicant who has filed for creation of record of lawful admission for permanent residence (Registry Applicants) (with Employment Authorization)
- Individual released on an order of Supervision (with Employment Authorization)
- Applicant for Cancellation of Removal or Suspension of Deportation (with Employment Authorization)
- Applicant for Legalization under IRCA (with Employment Authorization)
- Legalization under the LIFE Act (with Employment Authorization)
- Individual Lawfully Admitted with Temporary Resident Status
- Resident of American Samoa
- Individual granted administrative order staying removal issued by the Department of Homeland Security

Please see next page for Immigration Document List ▶▶▶

Attachment D

Helpful information about immigration status and document types. *To help you fill out Section 3, Page 4/5*

Immigration document types

▶ People who are not citizens, but who are eligible to apply for health insurance coverage, must put their immigration documents and ID numbers on Section 3, page 4/5. A list of documents and ID numbers is below. If your document type is not listed, you can write its name. If you have questions, or are eligible but have no document, call **(855) 532-5465 (TTY:711)**

Permanent Resident Card (I-551, also known as Green Card)
- Alien registration number
- Card number

Temporary I-551 Stamp (on passport or I-94, I-94A)
- Alien registration number

Immigrant Visa (with temporary I-551 language)
- Alien registration number
- Passport number

Employment Authorization Card (EAD or I-766)
- Alien registration number
- Card number
- Expiration date
- Category code

Arrival/Departure Record (I-94 or I-94A)
- I-94 number

Arrival/Departure Record in foreign passport (I-94)
- I-94 number
- Passport number
- Expiration date
- Country of issuance

Foreign passport
- Passport number
- Expiration date

Country of issuance Reentry Permit (I-327)
- Alien registration number

Refugee travel document (I-571)
- Alien registration number

Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- Alien registration number or an I-94 number
- Description of the type or name of the document

Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- SEVIS ID

Notice of Action (I-797)
- Alien registration number or an I-94 number

Other
- Alien registration number or an I-94 number
- Description of the type or name of the document

You can also list these documents or statuses:
- Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada. This is considered an eligible immigration status for Medicaid, but not for a Qualified Health Plan [QHP]
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of Homeland Security (DHS)
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Cuban/Haitian entrant
- Resident of American Samoa