THE ELDERLY AND PERSONS WITH PHYSICAL DISABILITIES WAIVER

What is the Elderly and Persons with Physical Disabilities (EPD) Waiver Program?

The EPD Waiver Program allows D.C. residents, who would otherwise require nursing home care, to receive services and supports while living in their home or in assisted living communities. If you need help with activities of daily living such as eating, dressing, toileting, and bathing, then the EPD program may be of help to you.

To qualify for the EPD Waiver program, you must:

- Be a U.S. citizen or have a qualified immigration status for Medicaid;
- Be a resident of the District of Columbia;
- Be elderly (65 years of age or older) or 18-64 years old with a physical disability;
- Have a DC Medicaid Provider complete a Prescription Order Form (POF);
- Have Liberty Healthcare complete a face-to-face assessment to establish "level of need";
- Have countable assets (ex. saving or checking account) that do not exceed $4,000 for an individual; and
- Have countable income that does not exceed $2,743 a month in 2023 or be able to meet the Spend Down obligation amount for Medicaid eligibility.

Services available under the EPD Waiver Program may include:

- Case Management – a social worker will work with you to identify and coordinate services under the EPD Waiver Program;
- Personal Care Aide (PCA) Services – a trained professional aide will come into your home to assist with activities, i.e. grooming, dressing, eating, toileting, etc.;
- Personal Emergency Response Services (PERS) – an electronic service that allows people to call for assistance;
- Services My Way – a program where you decide how you receive services and who will provide them; and
- Assisted Living - licensed home participants can live in and have access to services they need to maintain independence.

Department of Aging and Community Living
Aging and Disability Resource Center (ADRC)
250 E Street SW
Washington, DC 20024
Hours: 8:30am - 4:30pm
Email: EPDWaiver.dcoa@dc.gov
Fax: (202) 724-2008
Phone: (202) 724-5626
TTY: (202) 724-8925

DC Department of Health Care Finance
Long Term Care Administration
Prescription Order Form Instructions

A Prescription Order Form is required to request an assessment for Long Term Services and Supports as well as for Personal Care Aide Services for MCO enrollees.

Organizations with access to DC Care Connect (DCCC) ***must*** upload the form. Faxed or emailed POFs will not be accepted from organizations with access to DCCC, unless:

1. It is an initial assessment for an individual not known to DC Medicaid and not in DCCC,
2. The enrollee is with a traditional Managed Care Organization (MCO) or Child and Adolescent Supplemental Security Income Program (CASSIP), not a Dual-Special Needs Plan (D-SNP),
3. You are a hospital provider.

TWO WAYS TO SUBMIT THE POF

1. **Electronic Transmission:** Fill out the **on-line form** and click SUBMIT POF. It will be transmitted electronically to Liberty Healthcare and you will receive an email receipt of transmission.
2. **Print a completed form and upload in DCCC or FAX to Liberty Healthcare:** Fill out the **on-line form** and click PRINT POF. You can upload the request in DC Care Connect. If you do not have access to DCCC, FAX the form to 202-698-2075, or email the form to dclibertyias@LibertyHealth.com.

All referring providers must be enrolled as a DC Medicaid Provider. DHCF has a streamlined application process for ordering/referring providers which can be accessed at **www.dcpdms.com** by clicking "Create an account." Providers can then follow the instructions to set up an expedited enrollment package. Please note that providers may enroll as ordering/referring providers only you will not receive payment for any claims submitted and will not be part of the Medicaid-eligible providers' directory, but this will allow us to process the ePOF.

The items marked with an asterisk must be completed. If required items are not completed, you will be prompted to complete these items before you can submit the form electronically or print it out.

ORDERING Physician/APRN Signature

- All forms must be signed by the Ordering Physician or Advance Practice Registered Nurse (APRN*). Note that an exception to the signature requirement has been provided during the COVID Public Health Emergency (PHE) that was declared on March 2020. This waives the hard signature, but the RN/SW **MUST** have a discussion and obtain a telephone order to sign in leu of the MD/APRN signature*
- All referring providers must be enrolled as a DC Medicaid Provider.
- By signing the POF, the referring provider is attesting that he/she have examined this
- patient and certify that long term care services and supports are medically necessary.
- Once the MD/APRN has completed the form no edits are allowed.

DC Department of Health Care Finance
Long Term Care Administration
Prescription Order Form Instructions

Completing the Form

SECTION I: PATIENT INFORMATION

- For individuals enrolled in DC Medicaid, the DC Medicaid Number is required. If the individual does not yet have a number, enter N/A. Full name, date of birth, address and at least one phone number are all required items and are necessary to verify the requesters identity and schedule the assessment.
- Any additional information that you may have such as a secondary phone number, permanent address if it is different than the current address, e-mail-address, current Medicaid coverage (if any) emergency contact information, and information regarding a Legal Guardian/POA.
- If the individual needs interpretive services to schedule and/or participate in the assessment this should be identified in SECTION I., where the primary language spoken is identified.

SECTION II. DETERMINING NEEDS FOR SERVICES

The patient's chronic medical conditions. Please list all medical diagnosis, including chronic medical and other relevant health care conditions. At least one medical diagnosis relating to the need for ordered services is required. This item question is required (*)

- Reason for assessment referral
    - Indicate if this assessment is for recertification of current services, initial assessment for new patient requesting LTSS, change in condition, or request for upload of current assessment from MCO into DCCC. This item question is required (*).
        - If "Change in Condition" was checked, please complete the follow-up reason for change in condition questions to indicate how the patient's condition has changed significantly since the most recent assessment.
    - Indicate the request type in section II. This item question is required (*).
    - Section II also helps to identify hospital discharges for priority purpose, provides additional information for the upload request for patients transitioning from MCO to Long Term Care Fee-For-Service, and clarifies if the patient needs nursing facility placement or discharge for Home and Community Based Services (HCBS).
        - Individuals being assessed for initial entry into a nursing facility should include a completed Pre-Admission Screening and Resident Review (PASRR).

The SUBMITTING INDIVIDUAL:
In this subsection is where you will identify who is submitting the POF on the beneficiary's behalf with your name, and contact information. If the individual submitting the POF is not the contact for scheduling, please include information for the scheduling contact and any special instructions. such as " best time to contact beneficiary 1-2 pm, make sure case manager is present"

SECTION III: PHYSICIAN/APRN INFORMATION

- The physician/APRN name, address, National Provider Identification Number, telephone number, signature and date are required fields. The request for physician/APRN signature can be done either by email or fax. Please select the applicable option.
    - Email – upon selecting email, a new field will open for the physician/APRN email address.
    - Fax – upon selecting fax, three fields will open for physician/APRN fax number, signature, and date.

DISTRICT OF COLUMBIA

Department of Human Services (DHS)
Economic Security Administration (ESA)

Combined Application for Food, Medical, & Cash Benefits

This is a combined application for food benefits, medical, and cash assistance. We can provide information about other helpful services in your community. You can answer ONLY the questions related to the program(s) you are applying for. If you answer ALL the questions on the Assistance Application, we can see if you are eligible for all programs. A friend, relative, or anyone that you wish, may help you complete this application.

Food

Monthly Supplemental Nutrition Assistance (SNAP) benefits to put towards groceries.

Medical

(Doctors, hospitals, prescriptions, labs, and x-rays)

- free or low-cost insurance from Medicaid
- free or low-cost insurance from the D.C. Healthcare Alliance or Immigrant Children's Program
- affordable, private health insurance plans through the Marketplace
- a tax credit that can immediately help pay your premiums for health coverage.

Cash

Temporary Assistance for Needy Families (TANF) or other cash assistance benefits for households with needy children, and individuals waiting for a decision on their Supplemental Security Income (SSI) applications.

NOTE:

If you would like to apply for long-term care services, you will need to complete the Long-Term Care Program Medical Assistance Application. For an application, please contact the Department of Aging and Community Living (DACL) for Elderly and Persons with Physical Disabilities (EPD) waiver at (202) 724-5626, the Department on Disability Services (DDS) for Individuals with Intellectual and Developmental Disabilities (IDD) waiver at 202.730.1700, or if you are in a Nursing Facility or Intermediate Care Facility (ICF), contact your facility administrator for assistance.

You can also pick up this application at your nearest service center or call (202) 727-5355 to have one mailed to your home.

Service Center Locations

Monday – Friday | 7:30am – 4:45pm

Anacostia Service Center
2100 Martin Luther King Jr. Ave., SE
Washington, DC 20020
Fax: (202) 727-3527

Congress Heights Service Center
4049 South Capitol St SW
Washington, DC 20032
Fax: (202) 645-4524

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

Fort Davis Service Center
3851 Alabama Ave., SE
Washington, DC 20020
Fax: (202) 645-6205

H Street Service Center
645 H St., NE
Washington, DC 20002
Fax: (202) 724-8964

Customers may call the ESA Call Center at (202) 727-5355 to learn which Service Center serves their address

NEW MOBILE APPLICATION:

You can now apply for Food, Medical, and Cash assistance, and some Medical programs online by downloading the District Direct mobile app from the Apple App Store or the Google Play Store on your smartphone. Check the app for more information about the scope of Medical program applications available.

FOR AGENCY USE ONLY	Date Received:	Date Disposed:	Case Number:
Programs Applied For:			**Application Type** ☐ Application ☐ Recertification
☐ Cash	☐ Approved ☐ Pended ☐ Denied		
☐ Medical	☐ Approved ☐ Pended ☐ Denied		
☐ Food	☐ Approved ☐ Pended ☐ Denied		

What sections of the application do I need to complete?

Medical Assistance

DC HEALTH LINK
Get the facts. Get covered.

DC Health Link

To apply for affordable private health insurance, a tax credit that can immediately help pay your household's premiums for health coverage, or to see if your household qualifies for free or low-cost insurance from Medicaid DC Healthcare Alliance or, Immigrant Children's Program.

Complete all the sections marked for Medical assistance. If the section is marked for Food, Medical, and Cash assistance, complete all questions in that section, unless the question states it is not required for Medical assistance.

Food Assistance

If you want to apply for food benefits:

Complete all the sections marked for Food assistance. If the section is marked for Food, Medical, and Cash assistance, complete all questions in that section, unless the question states it is not required for Food assistance.

Cash Assistance

If you want to apply for cash benefits:

Complete all the sections marked for Cash assistance which also includes Interim Disability Assistance (IDA). If the section is marked for Food, Medical, and Cash assistance, complete all questions in that section, unless the question states it is not required for Cash assistance.

NOTE:

The following parts of the application are optional – you do NOT need to complete them:

- **Steps 16 and 17** – However, you may be asked to provide these at your application interview, if you are applying for Cash assistance
- **Steps 18 and 19** – You may want to keep the information included in Steps 18 and 19 for your records.

Language Access Support

If you speak another language, you have the right to free language assistance services. Call (202) 727-5355 or TTY/TDD 711 (855) 532-5465. District law requires that agencies provide you with information and assistance in your language for free. If you do not receive help in your language, please call the DC Office of Human Rights at (202) 727-4559 and press 0.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (202) 727-5355 (መስማት ለተሳናቸው: TTY/TDD 711 (855) 532-5465).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電(202) 727-5355 (TTY/TDD 711 (855) 532-5465

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (202) 727-5355 (ATS : TTY/TDD 711 (855) 532-5465).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (202) 727-5355 (TTY/TDD 711 (855) 532-5465.

Dè dɛ nìà kɛ dyédé gbo: Ɔ jǔ ké m̀['Bàsɔ́ɔ̀-wùdù-po-nyɔ̀] jǔ ní, nìí, à wudu kà kò dò po-poɔ̀ bɛ́ìn m̀gbo kpáa. Đá (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-(202) 727-5355 (TTY/TDD 711 (855) 532-5465)।

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(202) 727-5355 (TTY/TDD 711 (855) 532-5465)

まで、お電話にてご連絡ください。
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (202) 727-5355 (TTY/TDD 711 (855) 532-5465)번으로 전화해 주십시오.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บรการช่วยเหลือทางภาษาได้ฟรี โทร (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

What is the Language that you need to read?	❑ English	❑ Spanish	❑ Vietnamese	❑ French	❑ Korean	❑ Amharic	❑ Chinese (Mandarin)	❑ Chinese (Cantonese)	❑ Other
What Language do you need to speak to get ESA services?	❑ English	❑ Spanish	❑ Vietnamese	❑ French	❑ Korean	❑ Amharic	❑ Chinese (Mandarin)	❑ Chinese (Cantonese)	❑ Other
If you need an interpreter, what language do you need interpreted?	❑ English	❑ Spanish	❑ Vietnamese	❑ French	❑ Korean	❑ Amharic	❑ Chinese (Mandarin)	❑ Chinese (Cantonese)	❑ Other

Do you want free language interpretation?

☐ Yes (a case worker will assist you) ☐ No (complete and sign waiver below)

I, _____, acknowledge that The Department of Human Services (DHS) has notified me of my right to a professional and trained interpreter as required by the D.C. Language Access Act of 2004 at no cost to me. By signing below, I agree that I have refused this service and opted to rely on interpreter assistance by someone I have identified. I am aware that this individual was not identified by or vetted through DHS and that DHS is neither responsible for the provision of these services nor does DHS incur any liability that may result from these services. I am also aware that this waiver only applies to this one instance. If I require interpreter assistance from DHS in the future, I will notify the agency directly to request this service.

Sign here Date

_____ _____

Applicant or Representative Signature

OFFICE USE:

This statement was orally translated into (language) _____ by (name) _____, who is a language line interpreter, professional in person interpreter, or multilingual DHS employee because a written translation was not available in that language or the customer was unable to read in his/her spoken language.

STEP 1 Tell us about the person completing this application.

(Complete if you are applying for Food, Medical, or Cash Assistance)

What type of assistance is your household applying for? (check all that apply)

☐ **Food** ☐ **Medical** ☐ **Cash**

First Name	Last Name	
Middle Name	Suffix (Jr., III., etc.)	
Residential Address (where you live)		Unit
City	State	ZIP
Mailing Address (If different)		
City	State	ZIP
Preferred Phone (please note, only mobile phones may receive text messages)	Is your Preferred Phone a mobile or landline phone? ☐ Mobile ☐ Landline	
Email Address		

☐ By checking this box, I consent to receive text messages, email messages, and pre-recorded calls related to my ESA case(s). Consent to these terms is not a condition of the receipt of benefits or services. Message and data rates may apply.

Would you like to name people who can act on your behalf?

☐ Yes – Make sure to complete Appendix C below ☐ No

Would you like to file your application for SNAP immediately?

Right to File (Food Applicants ONLY)

You have the right to immediately file an application for SNAP (food assistance) as long as your name, address, and the signature of a responsible household member or authorized representative are provided on this page. SNAP benefits are provided from the date of application. You will not be approved for benefits until the full application process is complete.

By signing below, I give my permission to DHS to get information about me. DHS can get this from my employer, landlord, bank, and utility company. I give all of these people my permission to give information about me to DHS. I have reviewed the information in my application and I believe that all of my information on this entire form is true and correct including the information concerning the citizenship and alien status of everyone in my household. I know that if I give any 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 with their investigations.

Sign here (Applicant or Representative Signature)	**Date**

STEP 1A

Expedited SNAP (E-SNAP)

(Complete if only applying for Food Assistance)

To qualify for E-SNAP, you must meet one of the following conditions:

1. Income and liquid resources add up to less than the monthly housing expenses
2. Monthly income is less than $150, and liquid resources are $100 or less
3. Be a destitute migrant or seasonal farmworker with liquid resources of $100 or less

If approved for Expedited SNAP, you will receive one or two months of SNAP benefits within 7 days and an initial notice that identifies any information still needed for DHS to determine your eligibility for ongoing benefits after those initial months. After that, you will receive a decision about your eligibility for ongoing benefits within 30 days of submitting your initial SNAP application. You must complete an application, an interview, and verify your identity before you may be approved for E-SNAP.

E-SNAP Screening Questions

1. Will your household income be $150 or more this month? If no, how much? $_____	❑ **Yes** ❑ **No**
2. Does your household have more than $100 in liquid resources (i.e., cash, money in the bank, etc.)? If no, how much? $_____	❑ **Yes** ❑ **No**
3. What will your household pay for housing (rent/mortgage and utilities) this month?	**$**_____
4. This month, is your household income & liquid resources more than you pay for housing?	❑ **Yes** ❑ **No**
5. Are you or anyone in your household a migrant or seasonal farm worker?	❑ **Yes** ❑ **No**

STEP 2

Tell us about everyone in your household, even if you are not requesting benefits for them.

(Complete if you are applying for Food, Medical, or Cash Assistance)

** If you have more than 5 applicants in your household, please use a separate sheet of paper to include their information

** If applying for healthcare coverage, list everyone who will be included on your federal tax return this year (note: you do not need to file taxes to receive assistance)

	Example	Household Member #1 (YOU)	Household Member #2
1. First Name	Maya		
Middle Name	Michelle		
Last Name	Johnson		
Suffix (Jr., Sr., IV, etc.)			

2. Which benefits is this person applying for with your household? (List all that apply. If none, write "N/A")	Food, Cash, Medical		
2a. Do you usually buy and make meals together? (Food assistance only)	Yes	❑ Yes ❑ No	❑ Yes ❑ No
3. Date of Birth	01/23/1987		
4. Sex (male, female)	Female		
5. Are you Hispanic or Latino?	No	❑ Yes ❑ No	❑ Yes ❑ No
6. Race/Ethnicity: (Hispanic/ Black/African American/ Asian/White/ Native Hawaiian or Pacific Islander/ American Indian or Alaskan Native) This question is voluntary. You may list more than one race and ethnicity. This information will not affect your benefits. The District collects and uses this information to monitor and address racial and ethnic disparities in health experiences. Please consider providing this data to support these efforts	African American		
7. Social Security Number (SSN) *(you may leave this blank if the person does not have an SSN or is not applying for benefits)*	555-55-5555		
If this person does not have a Social Security and is applying for benefits, has he/she applied for a Social Security Number? If this person has not applied for an SSN, and is applying for benefits, why has he/she not applied?	❑ Yes ❑ No Not eligible for SSN	❑ Yes ❑ No	❑ Yes ❑ No
8. What is this person's marital status? (Never been married, married, separated, divorced, widowed)	Married		
9. Relationship to you	Daughter	Self	
10. Are you or your spouse the biological or adoptive parents of this person?	Yes	❑ Yes ❑ No	❑ Yes ❑ No
11. Is this person a U.S. citizen or U.S. national? (Applicants only) Many immigrants are eligible for benefits (If you answer no, please complete **Step 3**	Yes	❑ Yes ❑ No	❑ Yes ❑ No
Are you a naturalized or derived US citizen? (Applicants only)	No	❑ Yes ❑ No	❑ Yes ❑ No
If you are a naturalized or derived citizen, what are the alien and certificate numbers on your citizenship document? (this question is only for persons applying for medical assistance and it is optional).	Alien Number Certificate Number	Alien Number Certificate Number	Alien Number Certificate Number
12. Is this person an American Indian or Alaska Native? (Medical Assistance only) (If yes, complete Appendix B. You may be eligible for enhanced benefits)		❑ Yes ❑ No	❑ Yes ❑ No
If yes, what is this person's Tribal Identification Number? (Medical Assistance only)			

13. Is this person in the Military or a U.S. Veteran? If yes, please contact the District of Columbia's Office of Veteran Affairs for potential eligibility for enhanced benefits. The District of Columbia Office of Veteran's Affairs contact information is: 441 4th Street, NW, Suite 870 North, Washington DC 20001 (202) 724-5454, ova@dc.gov	No	❑ Yes ❑ No	❑ Yes ❑ No
14. Does this person currently live in the District of Columbia? (For applicants only)	Yes	❑ Yes ❑ No	❑ Yes ❑ No
If yes, do you intend to stay in the District?	No	❑ Yes ❑ No	❑ Yes ❑ No
If you do not intend to stay in the District, when do you plan to leave?			
If you are not currently in the District, are you living outside the District of Columbia temporarily, but plan to return when the purpose of the absence has been accomplished?			
If you are living outside the District temporarily, what is the reason for your absence? (School attendance, looking or receiving medical care, serving in the military, other (specify).	School attendance		
15. Are you a victim of domestic violence? (Cash and food applicants, and sponsored immigrants applying for medical assistance)	No	❑ Yes ❑ No	❑ Yes ❑ No
16. In the last 10 years, has this person been convicted in Federal or State court of making any false statements about their place of residency or identity to receive assistance from more than one State? (Food and Cash applicants only)	No	❑ Yes ❑ No	❑ Yes ❑ No
If yes, what was this person's conviction date?	mm/dd/yyyy		
17. Has this person graduated from high school or received an equivalent (GED)? (Food and Cash assistance only)	No	❑ Yes ❑ No	❑ Yes ❑ No
Name of school/program (Food and Cash assistance only)	Dunbar High School		
Graduation Month, Year (Food and Cash assistance only)	06/2019		
18. Does this person go to school or a job-training program? (Food and Cash assistance only) If yes, name of the school/program? How many hours per week	Yes; McKinley Tech – 40 Hrs		

20. Is this person hiding or running from the law to avoid prosecution, being taken into custody, going to jail for a felony crime or attempted felony, or violating a condition of parole or probation? (Food and Cash assistance only)	No	☐ Yes ☐ No	☐ Yes ☐ No
21. Has this person been convicted of trading SNAP benefits for drugs after September 22, 1996? (Food assistance only)		☐ Yes ☐ No	☐ Yes ☐ No
22. Has this person been convicted of buying or selling SNAP benefits over $500 in any state after September 22, 1996? (Food assistance only)		☐ Yes ☐ No	☐ Yes ☐ No
23. Has this person been convicted of fraudulently receiving duplicate SNAP benefits in any state after September 22, 1996? (Food assistance only)		☐ Yes ☐ No	☐ Yes ☐ No
If yes, which state?			
24. Has this person been convicted of trading SNAP benefits for guns, ammunitions, or explosives after September 22, 1996? (Food assistance only)		☐ Yes ☐ No	☐ Yes ☐ No

STEP 2a

Further Questions about Household members 1 and 2.

(Complete if you are applying for Food, Medical, or Cash Assistance)

- If you have more than 5 applicants in your household, please use a separate sheet of paper to include their information.
- If applying for healthcare coverage, list everyone who will be included on your federal tax return this year (note: you do not need to file taxes to receive assistance).
- If applying for healthcare coverage ONLY, only answer these questions for persons who are part of your household and who need healthcare coverage. If you are not applying for healthcare coverage for a household member, do not answer these questions.

25. Is this person staying in an institution like a nursing home, hospital, group home, jail, halfway house, drug or alcohol treatment center, or another facility?	No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, what is the name of the institution?	Lakewood Nursing Home		
If yes, what is the institution's address?	123 Main St		
Were you placed in the institution by a District government agency?	Yes	☐ Yes ☐ No	☐ Yes ☐ No
If yes, which agency?	Dept of Human Services		
Does the facility where this person lives provide them with more than one-and-a-half meals per day? (Food and Cash assistance only)	No	☐ Yes ☐ No	☐ Yes ☐ No

26. Are you in the District of Columbia voluntarily?	Yes	❑ Yes ❑ No	❑ Yes ❑ No
27. Are you currently experiencing homelessness in the District?	Yes	❑ Yes ❑ No	❑ Yes ❑ No
If yes, are you participating in any homelessness or housing services? (Food and Cash applicants only)	No	❑ Yes ❑ No	❑ Yes ❑ No
28. Is this person blind?	No	❑ Yes ❑ No	❑ Yes ❑ No
29. Is this person disabled?	No	❑ Yes ❑ No	❑ Yes ❑ No
30. Does this person need help with daily living activities or is living in a medical institution?	No	❑ Yes ❑ No	❑ Yes ❑ No
31. Does this person live in foster care?	No	❑ Yes ❑ No	❑ Yes ❑ No
32. Was this person in foster care at age 18 or older? (Medical assistance only)	Yes	❑ Yes ❑ No	❑ Yes ❑ No
33. Is the person emancipated?	No	❑ Yes ❑ No	❑ Yes ❑ No
34. Is this person currently pregnant or has been pregnant in the last 60 days? (Medical and Cash assistance only)	Yes	❑ Yes ❑ No	❑ Yes ❑ No
If yes, when is the baby due? (Medical and Cash assistance only. For Medical-only applicants, an estimated due date is accepted and will not require verification)	mm/dd/yyyy		
If yes, how many babies are expected during this pregnancy? (Medical assistance only)	1		
If this person was recently pregnant, when did the pregnancy end? (Medical assistance only)	mm/dd/yyyy		
Was this person enrolled in Medicaid during their pregnancy? (Medical assistance only)	Yes	❑ Yes ❑ No	❑ Yes ❑ No
If yes, is this the person's first pregnancy? (Medical and Cash Assistance only)	No	❑ Yes ❑ No	❑ Yes ❑ No

35. Does this person want help paying for medical bills from the last 3 months? The following questions are asked to see if we can help pay any medical bills you had in the 3 months before you applied for coverage. If you do not need help paying for medical bills for the past three months, proceed to question 36 (Medical assistance only)	Yes	❑ Yes ❑ No	❑ Yes ❑ No
If yes, which months does this person have medical bills? (Medical assistance only)	Jan and Feb		
If yes, did this person live outside of the District in the last 3 months? If you answer yes, please complete Appendix D (Medical assistance only)	No	❑ Yes ❑ No	❑ Yes ❑ No
If yes, did this person have a change in U.S. citizenship or qualified immigration status in the last 3 months? If you answer yes, please complete Appendix D. (Medical assistance only)	No	❑ Yes ❑ No	❑ Yes ❑ No
If yes, did this person have a change in their tax filing status in the last 3 months? If you answer yes, please complete Appendix D. (Medical assistance only)	No	❑ Yes ❑ No	❑ Yes ❑ No
If yes, did this person's income change in the last 3 months? If you answer yes, please complete Appendix D. (Medical assistance only)	No	❑ Yes ❑ No	❑ Yes ❑ No
If yes, did this person have a change in their medical coverage in the last 3 months? If you answer yes, please complete Appendix D. (Medical assistance only)	No	❑ Yes ❑ No	❑ Yes ❑ No
If yes, did this person become blind or disabled in the last 3 months? If you answer yes, please complete Appendix D. (Medical assistance only)	No	❑ Yes ❑ No	❑ Yes ❑ No
If yes, did this person's assets change in the last 3 months? If you answer yes, please complete Appendix D. (Medical and Interim Disability Assistance only)	No	❑ Yes ❑ No	❑ Yes ❑ No
36. Has this person had insurance through a job and lost it in the past 3 months? (Medical assistance only)	Yes	❑ Yes ❑ No	❑ Yes ❑ No
If yes, when did the coverage end? (Medical assistance only)	12/31/2020		
If yes, what is reason for the coverage ending? (Medical assistance only)	Laid off		
If yes, is this person a full-time student? (Medical assistance only)	Yes	❑ Yes ❑ No	❑ Yes ❑ No
37. If this person is a child, are there any parents living outside the home? Parents include both biological and adoptive parents. (Medical assistance only)	No	❑ Yes ❑ No	❑ Yes ❑ No
38. Has this person been screened for Breast or Cervical Cancer through Project Wish? (Medical assistance only)	No	❑ Yes ❑ No	❑ Yes ❑ No

STEP 2 **Tell us about everyone in your household, even if you are not requesting benefits for them.**

(Complete if you are applying for Food, Medical, or Cash Assistance)

If you have more than 5 applicants in your household, please use a separate sheet of paper to include their information)

	Household Member #3	Household Member #4	Household Member #5
1. First Name			
Middle Name			
Last Name			
Suffix (Jr., Sr., IV, etc.)			
2. Which benefits is this person applying for with your household? (List all that apply. If none, write "N/A")			
2a. Do you usually buy and make meals together? (Food assistance only)		❑ Yes ❑ No	❑ Yes ❑ No
3. Date of Birth			
4. Gender (male, female)			
5. Are you Hispanic or Latino?		❑ Yes ❑ No	❑ Yes ❑ No
6. Race/Ethnicity: (Hispanic/ Black/African American/ Asian/White/ Native Hawaiian or Pacific Islander/ American Indian or Alaskan Native) This question is voluntary. You may list more than one race and ethnicity. This information will not affect your benefits. The District collects and uses this information to monitor and address racial and ethnic disparities in health experiences. Please consider providing this data to support these efforts.			
7. Social Security Number *(you may leave this blank if the person does not have an SSN or is not applying for benefits)*			
If this person does not have a Social Security and is applying for benefits, has he/she applied for a Social Security Number? If this person has not applied for an SSN, and is applying for benefits, why has he/she not applied?		❑ Yes ❑ No	❑ Yes ❑ No
8. What is this person's marital status? (Never been married, married, separated, divorced, widowed)			
9. Relationship to you			
10. Are you or your spouse the biological or adoptive parents of this person?			

11. Is this person a U.S. citizen or U.S. national? (Applicants only) Many immigrants are eligible for benefits (If you answer no, please complete **Step 3**)		❑ Yes ❑ No	❑ Yes ❑ No
Are you a naturalized or derived US citizen? (Applicants only)			
If you are a naturalized or derived citizen, what are the alien and certificate numbers on your citizenship document? (this question is only for persons applying for medical assistance and it is optional).	Alien Number Certificate Number	Alien Number Certificate Number	Alien Number Certificate Number
12. Is this person an American Indian or Alaska Native? (Medical Assistance only) (If yes, complete Appendix B. You may be eligible for enhanced benefits)		❑ Yes ❑ No	❑ Yes ❑ No
If yes, what is this person's Tribal Identification Number**?** (Medical Assistance only)			
13. Is this person in the Military or a U.S. Veteran? If yes, please contact the District of Columbia's Office of Veteran Affairs for potential eligibility for enhanced benefits. The District of Columbia Office of Veteran's Affairs contact information is: 441 4th Street, NW, Suite 870 North, Washington DC 20001, (202) 724-5454, ova@dc.gov.		❑ Yes ❑ No	❑ Yes ❑ No
14. Does this person currently live in the District of Columbia? (For applicants only)		❑ Yes ❑ No	❑ Yes ❑ No
If yes, do you intend to stay in the District?			
If you do not intend to stay in the District when do you plan to leave?			
If you are not currently in the District, are you living outside of the District of Columbia temporarily, but plan to return when the purpose of the absence has been accomplished?			
If yes, what is the reason for your absence? (School attendance, looking or receiving medical care, serving in the military, Other (specify).			
15. Are you in the District of Columbia voluntarily?		❑ Yes ❑ No	❑ Yes ❑ No
16. Are you a victim of domestic violence? (Cash and food applicants, and sponsored immigrants applying for medical assistance)		❑ Yes ❑ No	❑ Yes ❑ No
17. In the last 10 years, has this person been convicted in Federal or State court of making any false statements about their place of residency or identity to receive assistance from more than one State? (Food and Cash applicants only)		❑ Yes ❑ No	❑ Yes ❑ No

If yes, what was this person's conviction date?			
18. Graduated from high school or equivalent (GED)? (Food and Cash assistance only)		❑ Yes ❑ No	❑ Yes ❑ No
Name of school/program (Food and Cash assistance only)			
Graduation Month, Year (Food and Cash assistance only)			
19. Does this person go to school or a job-training program? (Food and Cash assistance only) If yes, name of the school/program? How many hours per week		❑ Yes ❑ No	❑ Yes ❑ No
20. Is this person hiding or running from the law to avoid prosecution, being taken into custody, going to jail for a felony crime or attempted felony, or violating a condition of parole or probation? (Food and Cash assistance only)		❑ Yes ❑ No	❑ Yes ❑ No
21. Has this person been convicted of trading SNAP benefits for drugs after September 22, 1996? (Food assistance only)		❑ Yes ❑ No	❑ Yes ❑ No
22. Has this person been convicted of buying or selling SNAP benefits over $500 in any state after September 22, 1996? (Food assistance only)		❑ Yes ❑ No	❑ Yes ❑ No
23. Has this person been convicted of fraudulently receiving duplicate SNAP benefits in any state after September 22, 1996? (Food assistance only)		❑ Yes ❑ No	❑ Yes ❑ No
If yes, which state?			
24. Has this person been convicted of trading SNAP benefits for guns, ammunitions, or explosives after September 22, 1996? (Food assistance only)		❑ Yes ❑ No	❑ Yes ❑ No

STEP 2a **Further Questions about Household members..3-5**

(Complete if you are applying for Food, Medical, or Cash Assistance)

- If you have more than 5 applicants in your household, please use a separate sheet of paper to include their information.
- If applying for healthcare coverage, list everyone who will be included on your federal tax return this year (note: you do not need to file taxes to receive assistance).
- If applying for healthcare coverage ONLY, only answer these questions for persons who are part of your household and who need healthcare coverage. If you are not applying for healthcare coverage for a household member, do not answer these questions.

	Household Member #3	Household Member #4	Household Member #5
25. Is this person staying in an institution like a nursing home, hospital, group home, jail, halfway house, drug or alcohol treatment center, or another facility?		❑ Yes ❑ No	❑ Yes ❑ No
If yes, what is the name of the institution?			
If yes, what is the institution's address?			
Were you placed in the institution by a District government agency?		❑ Yes ❑ No	❑ Yes ❑ No
If yes, which agency?			
Does the facility where this person lives provide them with more than one-and-a-half meals per day? (Food and Cash assistance only)		❑ Yes ❑ No	❑ Yes ❑ No
26. Are you in the District of Columbia voluntarily?		❑ Yes ❑ No	❑ Yes ❑ No
27. Are you currently experiencing homelessness in the District?		❑ Yes ❑ No	❑ Yes ❑ No
If yes, are you participating in any homelessness or housing services? (Food and Cash applicants only)			
28. Is this person blind?		❑ Yes ❑ No	❑ Yes ❑ No
29. Is this person disabled?		❑ Yes ❑ No	❑ Yes ❑ No
30. Does this person need help with daily living activities or living in a medical institution?		❑ Yes ❑ No	❑ Yes ❑ No
31. Does this person live in foster care?		❑ Yes ❑ No	❑ Yes ❑ No
32. Was this person in foster care at age 18 or older? (Medical assistance only)		❑ Yes ❑ No	❑ Yes ❑ No
33. Is the person emancipated?		❑ Yes ❑ No	❑ Yes ❑ No

34. Is this person currently pregnant or has been pregnant in the last 60 days? (Medical and Cash assistance only)		❑ Yes ❑ No	❑ Yes ❑ No
If yes, when is the baby due? (Medical and Cash assistance only. For Medical-only applicants, an estimated due date is accepted and will not require verification)			
If yes, how many babies are expected during this pregnancy? (Medical assistance only)			
If this person was recently pregnant, when did the pregnancy end? (Medical assistance only)			
Was this person enrolled in Medicaid during their pregnancy? (Medical assistance only)		❑ Yes ❑ No	❑ Yes ❑ No
If yes, is this the person's first pregnancy? (Medical and Cash assistance only)			
35. Does this person want help paying for medical bills from the last 3 months? The following questions are asked to see if we can help pay any medical bills you had in the 3 months before you applied for coverage. If you do not need help paying for medical bills for the past three months, proceed to question 36 (Medical assistance only)		❑ Yes ❑ No	❑ Yes ❑ No
If yes, which months does this person have medical bills? (Medical assistance only)			
If yes, did this person live outside of the District in the last 3 months? If you answer yes, please complete Appendix D (Medical assistance only)			
If yes, did this person have a change in U.S. citizenship or qualified immigration status in the last 3 months? If you answer yes, please complete Appendix D. (Medical assistance only)			
If yes, did this person have a change in their tax filing status in the last 3 months? If you answer yes, please complete Appendix D. (Medical assistance only)			
If yes, did this person's income change in the last 3 months? If you answer yes, please complete Appendix D. (Medical assistance only)			
If yes, did this person have a change in their medical coverage in the last 3 months? If you answer yes, please complete Appendix D. (Medical assistance only)			
If yes, did this person become blind or disabled in the last 3 months? If you answer yes, please complete Appendix D. (Medical assistance only)			
If yes, did this person's assets change in the last 3 months? If you answer yes, please complete Appendix D. (Medical and Interim Disability Assistance only)			

36. Has this person had insurance through a job and lost it in the past 3 months? (Medical assistance only)		☐ Yes ☐ No	☐ Yes ☐ No
If yes, when did the coverage end? (Medical assistance only)			
If yes, what is reason for the coverage ending? (Medical assistance only)			
If yes, is this person a full-time student? (Medical assistance only)			
37. If this person is a child, are there any parents living outside the home? Parents include both biological and adoptive parents. (Medical assistance only)		☐ Yes ☐ No	☐ Yes ☐ No
38. Has this person been screened for Breast or Cervical Cancer through Project Wish? (Medical assistance only)		☐ Yes ☐ No	☐ es ☐ No

STEP 3 Are you or anyone in your household who is seeking benefits for themselves a non-U.S. citizen?

(Complete if you are applying for Food, Medical, or Cash Assistance.

☐ **Yes** – complete below. ☐ **No** – skip to step 4

Many immigrants are eligible for benefits.

If your status is not listed, please list "other" as your status in the table below.

If you are not applying for benefits for yourself, you do not have to give details about your own immigration status. Instead, you can just give immigration information for the household members who are seeking benefits.

We must ask Immigration Services (USCIS) to verify the status of anyone who is seeking benefits for themselves and is NOT listed as "OTHER." This may affect your eligibility for benefits and the amount of your benefits.

Immigration Statuses

- Lawful Permanent Resident
- Asylee
- Refugee
- Cuban/Haitian entrant
- Conditional Entrant Granted before 1980
- Victim of Trafficking and his/her Spouse, Child, Sibling or Parent
- Temporary Protected Status (TPS)
- Deferred Enforce Departure (DED)
- Lawful Temporary Resident
- Member of a federally recognized Indian tribe or American Indian born in Canada
- Deferred Action Status (Exception: Deferred Action for Childhood Arrivals (DACA) is not an eligible immigration status for applying for health insurance)
- Person granted withholding of deportation
- Person granted parole by the US Department of Homeland Security for a period of at least one year
- Resident of American Samoa
- Administrative order staying removal issues by the Department of Homeland Security
- Citizens of Micronesia, the Marshall Islands, and Palau
- Battered spouse or child with a pending or approved:
  - Self-petition for an immigrant visa
  - Immigrant visa filed for a spouse or child by a US citizen or Lawful Permanent Resident (LPR)
  - Application for cancellation of deportation
- Individual with Non-immigrant Status, includes worker visas (such as H1, H-2A, H-2B), student visas, U-visa, T-visa, and other visas
- Other

Household Member Name	**Alien #**	**Immigration Status** (use categories above)	**Immigration Document Type and Document ID Number**	**Is this person active in the military, a veteran, or the spouse or parent of a veteran or person active in the military?**

The following answers will only be used for determining Medical, Food, and Cash Assistance			
Did anyone above move to the U.S. before August 22, 1996? **Yes** ☐ **No** ☐	**If yes, who?**		
If you are a Lawful Permanent Resident (LPR), do you have a sponsor? **Yes** ☐ **No** ☐ Sponsor full name _____			
Sponsor Address	City	State	ZIP
Sponsor's Employer	Sponsor's Monthly Income $		
Have you, your parents, your spouse, and/or your sponsor ever worked in the U.S.? **Yes** ☐ **No** ☐			
How much support do you receive every month from your sponsor? **$**			

STEP 4 Tax Filing Information

If anyone in your household files taxes, please complete this section
(Complete only If you are applying for Medical Assistance)

Tax Filer Name	Filing Status	Tax Dependents Living with the Tax Flier	Tax Dependents NOT Living with the Tax Flier
Please list each Tax Filer in your household	**Please tell us the Tax Filer's status:** (Head of Household, Single, Married Filing Jointly, or Married Filing Separately) If filing jointly, list who you file jointly with.	**Please list all tax dependents in the home that the tax filer is claiming.**	**Please list all tax dependents that the tax filer is claiming that are not living in the home.**
Tax Filer 1			
Tax Filer 2			

If anyone in your household is a tax dependent of someone not living in your house, please list below:

Tax Dependent Name	Tax Filer Name Claiming Dependent	What is the Tax Filer's relationship to the Tax Dependent?

STEP 5 Does anyone in your household (including non-applicants) have any income?

☐ **Yes** – complete below

☐ **No** – skip to step 6 (Complete if you are applying for Food, Medical, or Cash Assistance)

Who in your household is employed? (include yourself, spouse, and dependents) (write full names)	**Employer's Name** (if self- employed, write "self-employed")	**Employer's Address**	**Employer's Phone**	**Employment Start Date**	**Paycheck Amount** (before taxes and deductions)	**How often?** (e.g. daily, weekly, biweekly, semi-monthly, monthly, yearly, one-time lump sum payment)

Who in your household is self-employed?	**What type of work does the self-employed person do?**	**How often does the self-employed person receive pay?**	**How much does the self-employed person receive each**	**What business-related expenses does the self-employed person have?**		**What is the total of the monthly self-employment expenses?**

What types of income does your household receive?

Report these for all programs:

- Unemployment
- Alimony received under agreements finalized after Dec.31,2018
- Taxable Annuities
- Other taxable income type: _____
- Lottery/Gambling Winnings
- Disability benefits
- Military Retirement Pay
- Net Rental/Royalty?
- Net Farming/Fishing
- Social Security (Non-SSI)
- Pensions and Retirement

Report these for food and cash programs:

- Foster Care/Adoption subsidy
- Help with Expenses
- Child Support
- Social Security (SSI)
- Non- taxable Annuities
- Other taxable income type: _____
- Alimony received under agreements finalized before Jan.1,2019
- Veterans Disability
- Other VA Benefits

Income type	**Who in your household receives this?** (full name)	**Amount** (before taxes & deductions)	**How often?** weekly, biweekly, semi-monthly, monthly, one-time lump sum payment)
Has anyone in the household stopped working or reduced their working hours in the last 60 days? ☐ Yes ☐ No		If yes, who?	
Who was the employer?		Why did this person stop working in this employment?	

Additional Income Questions

(Complete this section if you are applying for Food, Medical, or Cash Assistance)

1. Please check all that can be deducted on the household's tax return: (Medical assistance only)

- ☐ Alimony Paid $_____ (Note that alimony is only deductible if paid under an agreement finalized before Jan. 1, 2019)
- ☐ How often? _____
- ☐ Other deductions type? _____ $_____ How often? _____
- ☐ Student loan interest $_____ How often? _____

If any of these are checked, please list which household member who is claiming these deductions:

_____

If anyone in your household is paying alimony, was the divorce finalized after December 31, 2018? ☐ **Yes** ☐ **No**

2. Has anyone in your household had their student loan(s) discharged? (Medical and DC Alliance only) ☐ **Yes** ☐ **No**

If yes, who? _____

Why was this person's student loan(s) discharged?

☐ Total Disability ☐ Death ☐ Public Service ☐ Loan Forgiveness

3. Does anyone pay your household for meals or to rent a room? (Food and Cash only) ☐ **Yes** ☐ **No**

If yes, person's full name: _____ Monthly Payment: $_____

4. Does anyone in your household have an annuity?

☐ Yes, value of annuity: $_____ ☐ No, skip to step 7

Is the beneficiary of the annuity a member of your household?		☐ Yes	☐ No
If yes, full name(s) of beneficiaries: _____			
What type of annuity is it?	☐ Deferred	☐ Immediate	☐ Retirement
What kind of annuity is it?	☐ Revocable	☐ Non-Assignable	☐ Irrevocable
On what date was the annuity established?	__/__/__		
Does the annuity provide balloon or deferred payment?		☐ No	☐ Yes
Which entity was the annuity purchased through?	☐ Financial	☐ Insurance	☐ Other
What is the source of the annuity funds?	☐ Annuitant	☐ Retirement Plan	☐ Unknown
If the funds were used to purchase the annuit, were the funds from someone in the household?		☐ Yes	☐ No

Full name of funder: _____

STEP 6 Complete this step ONLY if you are applying for Medical or Cash Assistance for Children

If you are blind, disabled, over the age of 65, not a primary caretaker of children, and are applying for Medical Assistance, do not complete this section.

Does any child on this application have a parent outside of the home?

☐ **Yes** – complete below ☐ **No** – skip to step 7

As a condition of eligibility for some types of Cash assistance or Medical assistance other than premium tax credits and cost-sharing reductions, you must tell DHS if any of the children for whom you are seeking benefits have a parent that is absent from the home. If you do not want to provide the details for the absent parent, please see page 54 for a list of reasons that would allow you to be exempt from providing this information.

☐ Check here if you think you may be exempt from providing information about the non-custodial parent

☐ I'd prefer to discuss with my DHS or Child Support worker.

I solemnly swear or affirm under criminal penalties for the making of a false statement that I have read Step 6 (this step) and that the factual statements made in it concerning parentage and paternity are true to the best of my personal knowledge, information and belief. I under- stand and agree that, if I receive Medical Assistance (other than premium tax credits and cost-sharing reductions) and Cash assistance, all child support payments will be collected and disbursed by the District of Columbia, Office of the Attorney General Child Support Services Division (CSSD). I understand that I am assigning my rights to support while receiving Cash and Medical assistance (other than premium tax credits and cost-sharing reductions). I assign support up to the amount I receive from these programs. If I am getting Cash assistance, I may get additional child support payments in excess of the Cash assistance grant. If I receive a payment in error, then I will contact CSSD. I understand that by law any payments received in error shall be returned to CSSD or I may be forced to repay CSSD. I understand there may be reasons that I do not want child support, however it is important to cooperate with CSSD. Therefore, I will contact my CSSD case worker immediately, if I have any concerns.

Sign here _____ Date _____

Applicant or Representative Signature

Complete the questions below on the absent parent(s) only if you are applying for cash assistance for a child. If not, skip to Step 7.

Child One

Child's Full Name			Child's DOB
City and State where child was conceived			
Tell us about the alleged non-custodial parent (provide all information you have)			
Parent's Full Name			Nickname
DOB	Place of Birth: (city, state)		SSN
Race			Phone
Last Known Employer			Dates of Employment
Has paternity been established? ☐ Yes ☐ No			
Child Support Hearing Court/District		City	State
Date Ordered	Amount Ordered		Date you last received money from the Non-Custodial Parent

Child Two

Child's Full Name			Child's DOB
City and State where child was conceived			
Tell us about the alleged non-custodial parent (provide all information you have)			
Parent's Full Name			Nickname
DOB	Place of Birth: (city, state)		SSN
Race			Phone
Last Known Employer			Dates of Employment
Has paternity been established? ☐ Yes ☐ No			
Child Support Hearing Court/District		City	State
Date Ordered	Amount Ordered		Date you last received money from the Non-Custodial Parent

Child Three

Child's Full Name		Child's DOB
City and State where child was conceived		
Tell us about the alleged non-custodial parent (provide all information you have)		
Parent's Full Name		Nickname
DOB	Place of Birth: (city, state)	SSN
Race		Phone
Last Known Employer		Dates of Employment
Has paternity been established? ☐ Yes ☐ No		
Child Support Hearing Court/District	City	State
Date Ordered	Amount Ordered	Date you last received money from the Non-Custodial Parent

Child Four

Child's Full Name		Child's DOB
City and State where child was conceived		
Tell us about the alleged non-custodial parent (provide all information you have)		
Parent's Full Name		Nickname
DOB	Place of Birth: (city, state)	SSN
Race		Phone
Last Known Employer		Dates of Employment
Has paternity been established? ☐ Yes ☐ No		
Child Support Hearing Court/District	City	State
Date Ordered	Amount Ordered	Date you last received money from the Non-Custodial Parent

Child Five

Child's Full Name		Child's DOB
City and State where child was conceived		
Tell us about the alleged non-custodial parent (provide all information you have)		
Parent's Full Name		Nickname
DOB	Place of Birth: (city, state)	SSN
Race		Phone
Last Known Employer		Dates of Employment
Has paternity been established? ☐ Yes ☐ No		
Child Support Hearing Court/District	City	State
Date Ordered	Amount Ordered	Date you last received money from the Non-Custodial Parent

Child Six

Child's Full Name		Child's DOB
City and State where child was conceived		
Tell us about the alleged non-custodial parent (provide all information you have)		
Parent's Full Name		Nickname
DOB	Place of Birth: (city, state)	**SSN**
Race		Phone
Last Known Employer		Dates of Employment
Has paternity been established? ☐ Yes ☐ No		
Child Support Hearing Court/District	City	State
Date Ordered	Amount Ordered	Date you last received money from the Non-Custodial Parent

If you have more than 6 children with non-custodial parents, please list their information on an additional sheet.

STEP 7 **If you are not registered to vote where you live now, would you like to apply to register to vote here today?**

- ☐ **Yes** – complete this step and complete the voter registration application (attached the back of this application)
- ☐ **No** – skip to step 8

If you do not check either box, you will be considered to have decided not to register to vote at this time

The decision to register to vote is absolutely voluntary. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. We keep this information confidential. A decision not to apply as well as the name of the office where your application was submitted will remain confidential and will only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with The District of Columbia Board of Elections and Ethics, 441 4th Street NW, Suite 250, Washington, DC 20001; phone (202) 727-2525.

We have attached a voter registration form for you. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. If you have additional people in your household that would like a voter registration application, please let us know.

Sign here _____ Date _____

Applicant or Representative Signature

Referrals

Information and contacts for other programs that may help you.

- HealthCheck provides free check-ups for children on Medicaid. It also pays for other services that a child needs. HealthCheck can also get you free rides to the doctor. To find out more, call (202) 639-4030.
- WIC is a program for children under five. With WIC, you can save up to $140 each month on food. Also, WIC staff can talk with you about breast-feeding. To find out more, call 1-800-345-1WIC (1-800-345-1942).
- If you are eligible for DC Medicaid, you can get money back for recent medical bills that you have paid. To find out more, call (202) 698-2009.
- The District has a special program for senior and the disabled who need in-home nursing and other home care. This program has a higher income limit than regular Medical Assistance. To find out more, call 1-877-919-2372.

HIV/AIDS testing and services	(202) 671-4900	Medicare	1-800-633-4227
Alcohol and drugs	1-888-7WE-HELP	Social Security	1-800-772-1213
Breast/cervical cancer screening	(202) 442-5900	Public Housing and Section 8	(202) 535-1000

STEP 8 Your Family's Health Coverage

(Medical Assistance ONLY)

1. Is anyone in your household enrolled in health coverage now? ☐ **Yes** ☐ **No**

If yes, check the type of coverage below and write the person(s) name(s) next to the coverage they have:

☐ Medicaid: _____

☐ CHIP: _____

Was this coverage from the District of Columbia?
☐ Yes ☐ No

Was this coverage from another state?
☐ Yes ☐ No

If yes, which state(s)? _____

☐ Employer Insurance: _____

Name of Health Insurance: _____

Policy Number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

If you have insurance, you must complete Appendix A below.

☐ Medicare: _____

☐ TRICARE: _____
Don't check if you have a Direct Care or Line of Duty coverage.

☐ VA Health Care Program: _____

☐ Peace Corps: _____

☐ OTHER

Name of Health Insurance: _____

Policy Number: _____

Is this a limited benefit plan (like a school accident policy)?
☐ Yes ☐ No

STEP 9 Read and Sign This Application

Sign below if you and your household are applying for Medical assistance. If all household members who need medical assistance are children, pregnant women, parents/caretaker relatives, or childless adults, this is all the medical information we need. There will also be further questions starting in Step 10 about Medical Assistance for persons who are elderly, disabled, or blind.

If you are applying for Food and Cash Assistance ONLY, please continue to Step 10

- I'm signing this application 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 federal law if I intentionally provide false or untrue information.
- I know that I must tell DC Health Link if anything changes (and is different than) what I wrote on this application, I can visit DCHealthlink.com or call 1-855-532-5465 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 federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I know that the information I have provided on this application will be kept private as required by law.I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, the following individuals are incarcerated:

_____

(Names of Incarcerated Individuals)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll 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 doesn't match, we may ask you to send us proof.

Renewal of coverage for future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow DC Health Link to use income data, including information from tax returns. DC Health Link will send me a notice and let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

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

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage

If anyone on this application is eligible for Medicaid

I'm giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.

What should I do if I think my eligibility results are wrong?

If you do not agree with our decision about your health insurance or Medical assistance, you have a right to appeal our decision and receive a Fair Hearing. You can appeal a denial, termination, or change in your eligibility for Medicaid, premium tax credits, or cost-sharing assistance. You can also appeal if you disagree with the amount of your premium tax credits or cost-sharing assistance. Once you appeal, you can go before the Administrative Law Judge and explain why you do not agree with our decision.

You have 90 days following the postmark of the notice informing you of the eligibility decision, denial, termination, or change, to appeal the decision stated in the notice you received. If you do not appeal within 90 days, you may lose your appeal right.

You may appeal through any of the following methods:

- Calling DC Health Link Customer Service toll-free at 1-855-532-5465 or TTY at 711.
- Completing the **Appeal Request for Individuals and Families** form and send it by fax to (202) 724-2041, by e-mail to DC.OARA@dc.gov, or by mail to: **Office of Administrative Review and Appeals**, 64 New York Avenue NE, 5th Floor, Washington DC 20002.
- Going to any Department of Human Services Service Center and filling out the **Appeal Request Form**
- Going to the Office of **Administrative Hearings Resource Center**, located at 441 4th Street NW, Suite 450-North, Washington, DC 20001 and filling out the **Hearing Request Form**
- If you receive eligibility through the Medicaid program or DC Alliance, you can request a Fair Hearing by:
- Calling **(202) 698-4650** or (202) 727-8280

Sign this application

The person who filled out **Step 1** should sign this application. If you're an authorized representative, you may sign here as long as you've provided the information required in Appendix C (attached).

Sign here _____ Date _____

Applicant or Representative Signature

Decision Point

OPTION 1

If you only want us to consider your eligibility for Medicaid for individuals who are **not** aged (over 65), blind, or disabled or do not need long term care services, DC Alliance Immigrant Children's Program, or private health insurance, **you can STOP here**. If Appendices A, B, or C below apply to your household, remember to complete and sign Appendices A, B, and/or C.

OPTION 2

If you want to be considered for **food and cash programs** or **other Medical assistance programs**, including Medicaid for individuals who are aged (over 65), blind, or disabled, please continue to Step 10. If you would like to apply for long-term care services, you will need to complete the Long-Term Care Program Medical Assistance Application. For an application, please contact the Department of Aging and Community Living (DACL) for Elderly and Persons with Physical Disabilities (EPD) waiver at 202.724.2008, the Department on Disability Services (DDS) for Individuals with Intellectual and Developmental Disabilities (IDD) waiver at 202.730.1700, or if you are in a Nursing Facility or Intermediate Care Facility (ICF), contact your facility administrator for assistance.

You can also pick up this application at your nearest service center or call (202) 727-5355 to have one mailed to your home.

STEP 10 Tell us about your household's assets

(Complete if you are applying for Food, Medical, or Cash Assistance)

1. Does anyone in your household have cash on hand or in the home? ☐ Yes ☐ No

If yes, who? _____

How much? $ _____

2. Does anyone have any financial accounts? ☐ Yes ☐ No

If yes, list all accounts owned by you and anyone applying with you. Some examples of financial accounts are: Checking/Savings account, 401K, IRA, Annuities, Money Market, Stocks/Bonds/Mutual Funds/etc.

Type	Account Owner(s)	Bank Name	Account Balance
			$
			$
			$

3. Does anyone in your household have any vehicles? (Medical Assistance Only) ☐ Yes ☐ No

- If yes, please list all vehicles owned by your and anyone applying with you. Some examples of vehicles are: Cars. Trucks, Boats, or Watercraft, Motorcycles, motor homes, ATV's, etc.
- If yes, is this vehicle used by someone who is sick or disabled? ☐ Yes ☐ No

Owner	Make/Model	Vehicle ID	Year	Amount Owed
Name D/L# or Non-Driver ID#		VIN# Tag#		$

Name D/L# or Non-Driver ID#		VIN# Tag#		$
Name D/L# or Non-Driver ID#		VIN# Tag#		$

4. Does anyone in your household have any property assets? If yes, please complete the table below for you and anyone applying with you.	☐ **Yes** ☐ **No**

Type	Who owns this?	Fair Market Value	Amount Owed	Date Acquired
Your Home (Medical Assistance Only)		$		
Land		$		
Rental Home (Medical Assistance Only)		$		
Vacation Home		$		
Equipment/Tools		$		
Machinery		$		
Trailers		$		
Livestock		$		
Mineral/Oil Rights		$		
Other:		$		

5. Does anyone in your household have any of the following assets? If yes, complete the table below for you and anyone applying with you.	☐ **Yes** ☐ **No**

Type	Who owns this?	Value	Date Acquired
Life Insurance (Medical Assistance Only)		$	
Trust		$	
Burial Plot		$	
Burial Plan/Contract		$	

6. Has anyone in your household sold, traded, or given away assets in the last 3 months (For Food Assistance and Retroactive Medical coverage only)?	☐ **Yes** ☐ **No**

Who?	What was traded or given away?	Fair Market Value of item given away
		$
		$

STEP 11 Tell us about your household's expenses

(Complete if you are applying for Food, Medical, or Cash Assistance)

Your Food Assistance may increase if you have regular expenses such as rent, mortgage, utilities, child support, dependent care, and medical costs for persons who are disabled or 60+ years. Failure to report or verify any of the expenses listed below will be a statement by your household that you do not want to receive a deduction for the unreported expense.

1. How much does your household pay for the following per month? (Food assistance only)

Rent: $_____ Mortgage: $_____

Property Taxes: $_____ Homeowners Insurance: $_____ Condo Fee/HOAs: $_____

If you answered Question #1 - Who pays? _____

2. Do you pay someone for a room? (Food assistance only) ☐ **Yes** ☐ **No**

If yes, how much do you pay? $_____

When did you start paying for the room? _____

What is the residence type?

☐ Commercial boarding house ☐ Private Residence ☐ Other: _____

How many meals are provided by the owner each day? _____

How often do you pay for the room? (e.g. weekly, monthly, etc.) _____

3. Check all the utilities that your household pays any money for separate from your rent.

☐ Electric ☐ Gas ☐ Fuel ☐ Water ☐ Phone (including cell) ☐ Other:

If you answered Question #3 - Who pays? _____

4. Do you pay for heating or air-conditioning separately from your rent? ☐ **Yes** ☐ **No**
(Food assistance only)

5. In the past 12 months, did you get benefits from the Low-Income Home Energy Assistance Program (LIHEAP)? (Food assistance only) ☐ **Yes** ☐ **No**

If yes, how much did you get $_____

6. Is everyone in your household homeless and not receiving free shelter throughout the month? (Food assistance only) ☐ **Yes** ☐ **No**

7. Does anyone in your household pay child support? ☐ **Yes** ☐ **No**

If yes, who? _____

8. Is the household legally obligated to pay child support? ☐ **Yes** ☐ **No**

If yes, how much are you required to pay each month? $_____

How much do you pay each month? $_____

9. Does anyone in your household pay dependent care expense? ☐ Yes ☐ No

If yes, who? _____

How much does this person pay? $_____

How often? _____ (daily, weekly, monthly, every two weeks, etc.)

To whom? _____ For whom? _____

10. Have you or anyone in your household participated in work/work programs in another state? (Food assistance only) ☐ Yes ☐ No

a. If yes, who? _____

b. How Many Hours per Week?

c. Name of school/Program:

11. Is there anyone in your household who is disabled or 60+ years who pays medical bills? (Food assistance only) ☐ Yes ☐ No

a. If yes, who? _____

b. how much do they pay each month? $_____

STEP 12 General Program Questions

(Complete if you are applying for Food or Cash assistance only)

12. Has anyone in your household been previously terminated from the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) for refusal to cooperate with a Quality Control Reviewer? ☐ Yes ☐ No

(Food and Cash assistance only)

If yes, who? _____

13. Have you or anyone in your household been previously convicted of a felony at the state or federal level as an adult? (Food assistance only)

☐ No

☐ Yes, aggravated sexual abuse

☐ Yes, murder

☐ Yes, offense involving sexual assault

☐ Yes, sexual exploitation and abuse of children

If yes, who? _____

If yes, I attest that _____ (print convicted individual(s) name(s)) is/are complying with the terms of their sentence.

Sign here _____ Date _____

Applicant or Representative Signature

STEP 13 Medical or Interim Disability Assistance (IDA)

(Complete only if you are applying for Temporary Cash Assistance While Awaiting Supplemental Security Income (SSI) Determination)

☐ **Yes** – complete below ☐ **No** – skip to step 14

1. Have you ever filed a Supplemental Security Income (SSI) application with the Social Security Administration (SSA)?	☐ **Yes** ☐ **No**
2. If yes, when did you file your SSI application with SSA? _____	
3. Is your SSI application still in progress?	☐ **Yes** ☐ **No**
4. Were you previously denied SSI eligibility by SSA on a prior application? (IDA only) If yes, when was it filed? _____ If there were any changes to your medical condition to report since the last time you filed an application with SSA for SSI benefits, please list them: _____	☐ **Yes** ☐ **No**

STEP 14 Household Questions

(Complete only if you are applying for Food or Cash Assistance)

1. Which of the following has anyone in your household received in the last 30 days? (check all that apply)

- ☐ Work Incentive Allowance
- ☐ Federal Earned Income Tax Credit (EITC)
- ☐ A lump sum payment of $_____
- ☐ None of the above

2. Did your household receive a diversion lump sum payment in the last 12 months to help retain or accept employment?	☐ **Yes** ☐ **No**
3. Are you now or have you in the past, been a victim of family or domestic violence? (Cash assistance only)	☐ **Yes** ☐ **No**
4. Do you want to be referred for private and confidential supportive services due to experiencing family or domestic violence? (Cash assistance only)	☐ **Yes** ☐ **No**
5. Do you have a physical or mental health condition that makes it hard for you to work or attend a training program? (Food and Cash only)	☐ **Yes** ☐ **No**
6. Is it hard for you to work or attend a training program because it is medically necessary for you to be in the home to care for a physically or mentally incapacitated household member? (Food and Cash only)	☐ **Yes** ☐ **No**
7. Do you expect any child to be absent from the home for more than 90 consecutive days? If yes, who, and from when to when? _____	☐ **Yes** ☐ **No**

STEP 15

Information Exchange & Certification of Application

(Please read and sign these certifications if you are applying for Food, Medical, or Cash Assistance)

DHS May Need to Get Information about You

I give my permission to DHS to get information about me from other people, agencies, and businesses. I understand that DHS may contact people on the list below. I understand that DHS may contact other people not on this list. I know that DHS may contact people in the District as well as in Maryland, Virginia, and other states.

- Hospitals, clinics, and other medical and mental health providers;
- Social service agencies;
- Current and former employers;
- Rental agencies, mortgage lenders, utility companies, landlords, and resident managers;
- Schools (public, chartered, and private);
- Childcare and adult care providers;
- Parents and caretakers of children;
- Department of Behavioral Health (DBH),
- Department of Health (DOH);
- DC Housing Authority (DCHA);
- Department of Employment Services (DOES);
- Office of Tax and Revenue (OTR);
- Internal Revenue Service (IRS);
- Department of Motor Vehicles (DMV);
- Banks, credit unions, and other lending institutions;
- Credit bureaus and other reporting agencies; and
- Any other persons, agencies, and businesses as necessary

I give all these people my permission to give information about me to DHS. This includes details about my health, my income, my assets, my bills, and my family. This also includes any government, medical, and social services records about me. I know that DHS will treat all my information as confidential. I will cooperate with providing any specific written authorizations that any of these people require before they will give DHS my information.

Illegal Use of Benefits and Penalties

The District of Columbia may pursue criminal charges against you and seek to disqualify you from receiving public assistance in the future if you break the public assistance program laws.

You must not:

- Allow someone else to use your Medicaid card/benefits;
- Continue to use your Medicaid card/benefits if no longer a resident of DC;
- Accept payment from a provider in return for receiving Medicaid covered services, unless authorized as part of an approved Department of Health Care Finance (DHCF) program;
- Give false information or withhold information to get or continue to get benefits;
- Engage in SNAP Trafficking including trading or selling SNAP benefits, or electronic benefit transfer (EBT) cards;
- Use SNAP to buy items not allowed, such as alcohol, drugs, and firearms, or for paying on credit accounts;
- Allow a person who is not approved as an authorized representative or nominee to use your EBT PIN (personal identification number);
- Use someone else's benefits;
- Use someone else's EBT Card without authorization; or,
- Use your EBT card containing TANF benefits in a liquor store, adult entertainment venue, such as a strip club or in a gambling establishment such as a casino.

Your SNAP benefits will not increase if your cash assistance is reduced or closed because you did not follow the rules. If a household member commits an Intentional Program Violation (IPV), which means deliberately breaks the rules;

- DHS may disqualify the person from the benefit programs.
- DHS may disqualify this person for 6 months for the first violation (TANF and Program on Work Employment and Responsibility (POWER)).
- DHS may disqualify this person for 12 months for the first violation (SNAP) or second violation (TANF and POWER).
- DHS may disqualify this person for 24 months, for the second violation (SNAP) or after the first time a court finds this person guilty of buying illegal drugs with SNAP benefits.
- DHS may disqualify this person from participating in benefits programs permanently:
    - After the third violation (TANF, POWER, and SNAP), or
    - After the second time a court finds a person guilty of buying illegal drugs with SNAP benefits, or
    - After the first time a court finds this person guilty of buying guns, bullets, or explosives, with SNAP benefits, or
    - After a court finds this person guilty of trafficking SNAP benefits of $500 or more.

DHS may disqualify a person who commits an Intentional Program Violation from participating in benefits programs permanently

DHS may disqualify this person for ten years if found guilty of making a false statement about the person's identity or residence in order to receive multiple benefits at the same time.

Any member who breaks any of the rules on purpose can be barred from the SNAP program for one year to permanently, fined up to $250,000, imprisoned up to 20 years, or both.

A judge can also disqualify this person from receiving TANF and/or SNAP benefits for an additional 18 months. The person may also have to face further prosecution under other federal laws. Individuals who request four (4) or more replacement EBT cards in one year may be referred to the District of Columbia Office of the Inspector General for investigation of trafficking benefits.

I attest and declare under penalty of perjury to the best of my knowledge and belief that the information submitted is correct and the person(s) for whom I am applying for benefits is/are U.S. citizen(s) or are lawfully present in the United States.

Sign here _____ Date _____

Applicant or Representative Signature

STEP 16 **Did you apply for TANF?** **(If you applied for Medical Assistance only, proceed to Step 19)**

☐ **Yes**, make an appointment for your TANF Assessment using the instructions below and bring THIS PAGE (40) AND page 57 with you to your appointment.

☐ **No** – skip to step 17 if you applied for Food assistance.

If you applied for Medical assistance, no more information is needed.

To be approved for TANF (cash) benefits, you must complete an orientation/assessment and sign an Individual Responsibility Plan (IRP). This must be completed within 45 days of submitting this application for benefits.

How do I schedule an appointment?

You must call or come to the Office of Work Opportunity Family Resource Center at one of its locations to schedule an appointment. Appointments are offered Monday-Thursday from 8:15-3:00.

Anacostia 2100 Martin Luther King Jr. Ave. S.E. Suite 402 Washington, D.C. 20020	**Fort Davis** 3851 Alabama Ave. S.E. Washington, D.C. 20020	**Congress Heights** 4049 South Capitol Street. SW Washington, DC 20032
H Street 645 H St. N.E. Washington, D.C. 20002	**Taylor Street** 1207 Taylor Street, N.W. Washington, D.C. 20011	

How long will my orientation/assessment be?

You should plan on spending at least 90 minutes at the office. It is your responsibility to schedule and keep this appointment.

What should I bring to my orientation/assessment?

You must bring this form (page 40) your application receipt (page 57) and a photo ID card.

Are my travel costs to/from my orientation/assessment appointment covered?

Metro assistance/reimbursement may be provided by the Office of Work Opportunity upon request.

Applicant's Full Name	DOB	Case Number

I understand that failure to complete the orientation, assessment and sign the IRP will result in denial of benefits.

Applicant or Representative Signature:_____ Date: _____

OWO Employee Signature:_____ Service Center:_____ Date: _____

Appendix A

Health Coverage from Jobs

(Please complete only if applying for Medical Assistance and someone in the household is eligible for health coverage from a job)

Form Approved OMB No: 0938-1191

Health Coverage from Jobs

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.
Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

Employee Information

Employee name (First, Middle, Last)	Social Security Number (SSN)

Employer Information

Employer name	Employer Identification Number (EIN)	
Employer address	Employer phone number	
City	State	ZIP

Who can we contact about employee health coverage at this job?

Phone number (if different from above)	Email address

Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **Yes** (Continue)

If you're in a waiting or probationary period, when can you enroll in coverage? (mm/dd/yyyy) _____

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____

Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the *health plan* offered by this employer

Does the employer offer a health plan that meets the minimum value standard*? ☐ **Yes** ☐ **No**

For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

* A health plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the minimum value standard.

How much would the employee have to pay in premiums for this plan?	$

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

What change will the employer make for the new plan year (if known)? ❑ Employer won't offer health coverage ❑ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard*(Premium should reflect the discount for wellness programs.)	
How much would the employee have to pay in premiums for this plan?	$
How often? ❑ Weekly ❑ Every two weeks ❑ Twice a month ❑ Once a month ❑ Quarterly ❑ Yearly	
Date of change: (mm/dd/yyyyy)	

Employer Coverage Tool

Form Approved
OMB No: 0938-1191

Use this tool to help answer questions in your Medical assistance application, Appendix A. That part of the application asks about any employer health coverage that you're eligible for (***even if it's from another person's job like a parent or a spouse***). The information in the boxes below match the boxes in Appendix A. For example, you can use the answer to question 14 on this page to answer question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one for *each* employer that offers health coverage that you're eligible for.

Employee Information

The employee needs to fill out this section.

1. Employee name: (First, Middle, Last)	2. Employee Social Security number (SSN)

Employer Information

Ask the employer for this information.

3. Employer name	4. Employer Identification Number (EIN)	
5. Employer address (the Marketplace will send notices to this address)	6. Employer phone number	
7. City	8. State	9. Zip code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Go to question 13a).

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____(mm/dd/yyyy) (Go to next question)

No (STOP and return this form to employee)

Tell us about the *health plan* offered by this employer

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ **Yes, which people?** Spouse Dependent(s)

☐ **No** (Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) **No** (STOP and return this form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan?	$

b. How often? ❑ Weekly ❑ Every two weeks ❑ Twice a month ❑ Once a month ❑ Quarterly ❑ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, **STOP** and return this form to employee.

What change will the employer make for the new plan year (if known)?

❑ Employer won't offer health coverage

❑ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard* (Premium should reflect the discount for wellness programs.)

How much would the employee have to pay in premiums for this plan?	$

How often? ❑ Weekly ❑ Every two weeks ❑ Twice a month ❑ Once a month ❑ Quarterly ❑ Yearly

Date of change:_____ (mm/dd/yyyyy)

Appendix B American Indian/Alaska Native Identification

Form Approved
OMB No: 0938-1191

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Combined Application for Food, Medical, and Cash benefits.

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 also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following question to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN Person 1		**AI/AN Person 2**	
1. Name (First name, Middle name, Last name)	First	Middle	First	Middle
	Last		Last	
2. Member of a federally recognized tribe?	☐ Yes If yes, tribe name:		☐ Yes If yes, tribe name:	
	☐ No		☐ No	

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian Health program, or through a referral from one of these programs?	❑ Yes ❑ No **If no**, is this person eligible to get services from the Indian Health Ser- vice, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ❑ Yes ❑ No	❑ Yes ❑ No **If no**, is this person eligible to get ser- vices from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ❑ Yes ❑ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from 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 often? _____	$ How often? _____

Appendix C Authorized Representative Authorization

You can name people to act on your behalf in up to 3 roles. For Medicaid, you can also pick an organization. See page 54 for details on who can be named in each role.

☐ SNAP
☐ Cash
☐ Medical

REPRESENTATIVE - This person/organization can apply for benefits, provide interview assistance, receive notices, report changes, and make inquiries. Your household will be held liable for any over issuance that results from the representative providing incorrect information.

Full Name		If person, Date of Birth		
Phone		Email		
Address	Unit	City	State	ZIP

I authorize this person to: (check all that apply)

☐ Apply for benefits ☐ Interview assistance ☐ Receive notices
☐ Report Changes ☐ Make inquiries

☐ SNAP
☐ Cash
☐ Same as Representative

NOMINEE - This person will receive only an Electronic Benefit Transfer (EBT) card with their name on it and will be able to access your cash and food benefits on your behalf (Food and Cash only)

Full Name		Date of Birth		
Phone		Email		
Address	Unit	City	State	ZIP

☐ Same as Representative
☐ Same as Nominee

COURIER -This person can pick up your Electronic Benefit Transfer (EBT) card from the EBT Office (Food and Cash only).

Full Name		Date of Birth		
Phone		Email		
Address	Unit	City	State	ZIP

By signing, I certify that the individual(s) designated above is (are) allowed to act on my behalf. I understand that anyone knowingly providing false information may be prosecuted under applicable federal and state statutes. If the District determines that an authorized representative has knowingly provided false information about the household circumstances or has made improper use of benefits, it may disqualify that person from being an authorized representative for up to one year. I understand that the power to act as an authorized representative is valid until I modify the authorization or notify the agency that the representative is no longer authorized to act on my behalf, or the authorized representative informs the agency that he or she no longer is acting in such capacity, or there is a change in the legal authority upon which the individual or organization's authority was based.

Applicant Signature _____ Date _____

I agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

(If authorized representative for Medicaid is a provider or staff member or volunteer of an organization) I affirm that I will adhere to the regulations in 42 CFR part 431, subpart F and at 45 CFR §155.260(f), 42 CFR §447.10, as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information.

Authorized Representative Signature	Date
Authorized Nominee Signature	Date
Authorized Courier Signature	Date

APPENDIX D

Retroactive Medicaid Supplemental Questions

(Please complete only if applying for Medical Assistance and you answered yes to question 36 and any yes to the sub-questions of question 36

If you do not have this information now, you will be able to apply for these months up to 9 months after you submit this application.

Residence History: If you or a member of your household were not a District resident in the 3 months prior to this application, please complete the table below for each person that was not a District resident.

First Month	Month	Year	Second Month	Month	Year	Third Month	Month	Year
Member Name	**State**		**Member Name**	**State**		**Member Name**	**State**	

Citizenship/Eligible Immigration Status Information: If you or a member of your household had a change in their citizenship/eligible immigration status in the 3 months prior to this application, please complete the table below for each person in your household that had this change.

First Month	Month	Year	Second Month	Month	Year	Third Month	Month	Year
Member Name	**Immigration Status**		**Member Name**	**Immigration Status**		**Member Name**	**Immigration Status**	

Tax Information: If you or a member of your household had a change in their tax-filing status in the 3 months prior to this application, please complete the table below for each person in your household that had this change.

First Month	Month	Year	Second Month	Month	Year	Third Month	Month	Year
Member Name	**Tax-Filing Status** (Tax Filer, Tax Dependent, Non-Filer)		**Member Name**	**Tax-Filing Status** (Tax Filer, Tax Dependent, Non-Filer)		**Member Name**	**Tax-Filing Status** (Tax Filer, Tax Dependent, Non-Filer)	

Income History: If you or a member of your household had a change in their income within the 3 months prior to this application, please complete the table below for each person in your household that had this change.

First Month	Month	Year	Second Month	Month	Year	Third Month	Month	Year
Member Name	**Income Type** (Salary/Wages, Pension, Unemployment, Self-Employment Income, Social Security, etc.)		**Member Name**	**Income Type** (Salary/Wages, Pension, Unemployment, Self-Employment Income, Social Security, etc.)		**Member Name**	**Income Type** (Salary/Wages, Pension, Unemployment, Self-Employment Income, Social Security, etc.)	

Other Medical Coverage: If you or a member of your household had a change in their medical coverage within the 3 months prior to this application, please complete the table below for each person in your household that had this change.

First Month	Month	Year	Second Month	Month	Year	Third Month	Month	Year
Member Name	**Coverage Type**	**Did coverage start or end?**	**Member Name**	**Coverage Type**	**Did coverage start or end?**	**Member Name**	**Coverage Type**	**Did Coverage Start or End?**

Disability: If you or a member of your household had a change in their disability status within the 3 months prior to this application, please complete the table below for each person in your household that had this change.

First Month	Month	Year	Second Month	Month	Year	Third Month	Month	Year
Member Name	**Disability Status** (Blind or Disabled)		**Member Name**	**Disability Status** (Blind or Disabled)		**Member Name**	**Disability Status** (Blind or Disabled)	

Assets Information: If you or a member of your household had a change in their assets within the 3 months prior to this application, please complete the table below for each person in your household that had this change.

First Month	Month	Year	Second Month	Month	Year	Third Month	Month	Year
Member Name	**Asset Type**	**Value**	**Member Name**	**Asset Type**	**Value**	**Member Name**	**Asset Type**	**Value**

Appendix E

Certification of Breast or Cervical Cancer Screening

(This Appendix is ONLY to be completed by Project Wish to be used for a Breast and Cervical Cancer Medicaid application.

Medicaid Applicant Name (first, middle, last)	
Social Security Number	Date of Birth

Project Wish Coordinator: Please read the responses below and check YES if the applicant is enrolled in Project Wish.

☐ Yes	This applicant is enrolled in Project Wish, the D.C. Center for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and has received screening and/or diagnostic testing per the NBCCEDP guidelines. (If yes is selected, this form must be completed by the diagnosing or treating physician)
☐ Yes	This applicant was screened by the Center for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) In this state _____ (list the state and program name here), and has received screening and/or diagnostic testing per the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) guidelines. (If YES is selected, this form must be completed by the diagnosing or treating physician).

Diagnosis Information for the Medicaid Applicant

Diagnosis:	
Physician Comments:	
Diagnosis Date:	
Physician Signature:	Date:
Physician Name:	
Facility/Hospital/Clinic Name:	
Facility/Hospital/Clinic Address:	

I am signing this 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 federal law if I willfully provide false or untrue information.

NBCCEDP Coordinator Signature:	Date:
NBCCEDP Coordinator Name:	

STEP 17 Read and sign the TANF agreements below

(Cash Assistance ONLY)

TANF Child Support Cooperation

You are legally required to cooperate in establishing paternity and securing financial and medical support as a condition of eligibility for assistance, absent a determination of good cause. You can claim "good cause" at any time. You have a right to be exempted from the child support and paternity establishment cooperation requirement upon providing substantiating evidence of "good cause," which must be established at a meeting with the Child Support Services Division (CSSD) of the Office of the Attorney General (OAG). Failing to cooperate with the establishment of paternity and child support could result in a 25% sanction on your TANF grant. Cooperation provides the potential benefit to your child of the award of financial or medical support and non-cooperation without determination of good cause can cause financial sanctions on your TANF grant. CSSD shall provide reasonable assistance in obtaining substantiating evidence of good cause.

Good cause shall be found to exist if efforts to cooperate are reasonably anticipated to result in physical, sexual, or emotional harm to the child, with respect to whom assistance is claimed; the applicant or recipient; a household member of the applicant or recipient; or an immediate family member of the applicant or recipient, or if CSSD identifies circumstances that would make cooperation, or actions resulting directly from cooperation, detrimental to the child with respect to whom assistance is claimed including, but not limited to, one (1) of the following:

1. The child was conceived as a result of incest or sexual assault (a conviction for incest or sexual assault is not necessary for this subparagraph to apply);
2. Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction; or
3. The applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

On the basis of the substantiating evidence supplied and any necessary investigation, CSSD shall determine whether cooperation would not be in the best interest of the child with respect to whom assistance is claimed, shall identify the reasons for its determination, and shall provide the determination and reasons to the applicant or recipient in writing. The rights include: the right to a fair hearing to appeal a sanction for non-cooperation if CSSD determines that the applicant or recipient does not have good cause for non-cooperation and the applicant or recipient chooses not to cooperate. Personnel at CSSD may review the findings of staff, as well as the basis for a good cause determination, and may participate in any hearings involving good cause for noncooperation. Personnel at CSSD shall not attempt to establish paternity, collect support, collect third party information, or pursue third parties liable for medical services, in those cases in which a good cause claim is pending or has been granted. CSSD and ESA shall make all reasonable efforts to ensure your or your child's whereabouts are kept confidential and take other measures necessary to protect them from harm if: a good cause claim is pending or has been granted; a civil or temporary protection order has been entered with respect to you or your child; or CSSD has reason to believe that release of the information could result in harm to you or your child; and that TANF benefits shall not be denied, delayed, reduced or discontinued pending the outcome of a good cause claim in which the applicant or recipient has made a good faith effort to substantiate her claim.

TANF Failure to Meet Home Living Requirement

As a pregnant or parenting teen, you are required to cooperate with the eligibility requirements, rights, and responsibilities and exemptions of the home living requirements. An applicant or recipient of TANF benefits who is a pregnant or parenting teen and who has never married shall be eligible for TANF benefits only if the teen and the teen's child reside in a residence maintained by the pregnant or parenting teen's parent or legal guardian, or another adult relative of the pregnant or parenting teen that is the home of the parent, guardian, or adult relative, as determined by the Mayor, unless:

1. The pregnant or parenting teen has no living parent, legal guardian, or other appropriate adult relative;
    a. No parent, legal guardian, or other appropriate adult relative who could otherwise qualify to act as the pregnant or parenting teen's legal guardian allows the pregnant or parenting teen to live in his or her home;
    b. The Department determines, after an investigation in accordance with regulations issued by the Mayor, that the physical or emotional health or safety of the applicant, recipient, or dependent child would be jeopardized if they resided in the same residence with the teen's parent, legal guardian, or other adult relative; or
    c. The Department determines, in accordance with regulations issued by the Mayor, that the circumstances justify a determination of good cause for the applicant or recipient and dependent child to receive assistance while living apart from the pregnant or parenting teen's parent, guardian, or other adult relative (with standards set forth in the regulations including consideration of the best interests of the dependent child).
    d. Investigations shall be carried out by licensed social workers. Other trained professionals, such as doctors, nurses, or physiologists, who are deemed necessary to make sound health and safety determinations by the Department, may also be utilized.
    e. When a pregnant or parenting teen and the applicant's or recipient's dependent child are required to live with the pregnant or parenting teen's parent, legal guardian, or other adult relative, or in a setting described in subsection (e) (1) of this section, then TANF may be paid in the form of a protective payment.
        i. (e)(1) If the pregnant or parenting teen is exempt from the home living requirement, the Department shall provide or assist the pregnant or parenting teen in locating a second chance home, a maternity home, or other appropriate adult-supervised supportive living arrangement, unless the Department determines that the pregnant or parenting teen's current living arrangement is appropriate. The Department shall consider the needs and concerns of the pregnant or parenting teen and the pregnant or parenting teen's child in providing or assisting in locating a living arrangement for the pregnant or parenting teen. The Department shall then determine the appropriate living arrangement for the pregnant or parenting teen and require that the pregnant or parenting teen and the de- pendent child live in such a living arrangement as a condition of continued receipt of TANF benefits. If the Department determines that the pregnant or parenting teen's circumstances have changed and the current arrangement ceases to be appropriate, the pregnant or parenting teen may live in an alternative appropriate arrangement and continue to receive TANF benefits.

TANF and POWER Verification of Good Cause

A verification of Good Cause for failure to attend initial orientation, counseling, or assessment activities, or for failure to participate in or complete other job readiness or job search activities, or for failure to participate in work activities as directed by ESA, shall include one (1) or more of the following

a. A verified, if necessary, physical or mental illness or medical condition of the applicant, or of a member of the applicant's household or immediate family when no other appropriate member of the household or family is available to provide the needed care, which prevents the applicant or recipient from participating in the required activities.

b. The need for childcare for the applicant to participate in or to continue participation in the activities or to accept employment, where appropriate and affordable childcare (formal or informal) is not available within a reasonable distance from the applicant's home or service site. For purposes of this paragraph, there is a need for child care if the applicant is caring for a child under six (6) years of age or for a child who has special health care needs (verified by competent medical evidence, as determined by ESA) that prevents regular attendance at school;

c. The applicant is the parent or other caretaker who personally provides care for a child under six (6) years of age, and participates in the activities or employment, an average of at least twenty (20) hours per week;

d. The applicant resides in a location which is so remote from a program or activity that transportation is not available. The individual shall be considered remote if a round trip of more than two (2) hours by reasonably available public or private transportation, exclusive of time necessary to transport children to and from a childcare facility or school, would be required for a normal work or training day. However, if normal commuting time in the area is more than two (2) hours, then the round-trip commuting time shall not be considered good cause.

e. Discrimination by a non-governmental entity, employer or other program or activity in violation of federal or District law;

f. Working or participating without being paid the work participation allowance;

g. Violations of any workplace protections listed in 29 DCMR § 5811; and

h. An extraordinary and unforeseen circumstance beyond the control of the applicant that prevents the applicant from participating in the required activities, including but not limited to domestic violence, house fires, or car wrecks.

Denials of an applicant's request for good cause shall be in writing and appealable through the fair hearing process. ESA may require reasonable verification of good cause.

TANF Request for Verification of School Enrollment of Minor Children and Attendance of Pregnant or Parenting Teens

As a condition of receiving TANF benefits, school enrollment must be verified for each dependent child ages 16, 17, or 18 and school attendance must be verified for all pregnant teen or parenting teens (male or female) that are younger than 20 years of age and who have not successfully completed a high school education or its equivalent. If school enrollment is not verified for a dependent child, the child is considered ineligible for assistance, and will be dropped from the assistance unit on the last day of the month prior to the child turning 16, 17, or 18. If school attendance is not verified for a pregnant or parenting teen, the teen will lose TANF eligibility for each month attendance requirements are not met.

To provide proof of enrollment or attendance, you can provide one of the documents listed below to a service center during the 45-day application processing period or at the appropriate recertification or change reporting period.

- Verification of School Attendance Form,
- Most recent issued report card for current school year,
- Correspondence from school authorities,
- Correspondence from scholarship boards or other similar organizations, or
- Information from school records obtained through data sharing agreements and exchanges with schools.

A pregnant or parenting teen must attend high school or an equivalent educational, training, or other similar program approved by the Department, unless one of the good cause exceptions are met. Good cause reasons for not complying with school attendance requirements shall include the following:

- The teen's child has special health care needs that prevent the teen's regular attendance at school, which shall be verified by competent medical evidence, as determined by the Director of DHS or his or her designee;
- An extraordinary and unforeseen circumstance determined by DHS to be beyond the control of the teen and prevent him or her from participating in the required activities.
- Has a child who is less than 12 weeks of age
- Appropriate childcare within a reasonable distance from school is unavailable, unaffordable, or unsuitable and the child for whom care is sought is less than six years of age,
- The absence is deemed "excused" by the educational or training institution or program

Signature

- I acknowledge receipt of the notification regarding cooperation with Child Support and Good Cause for not cooperating.
- I acknowledge receipt of the notification of the Failure to meet home living requirements of the TANF program.
- I acknowledge receipt of the notification of the Verification of Good Cause requirements of the TANF program.
- I acknowledge receipt of the notification of the Verification of School Enrollment of Minor Children and Attendance of Pregnant or Parenting Teens requirements of the TANF program.

Sign here Date

_____ _____

Applicant or Representative Signature

STEP 18 Information about your EBT Card

(Food and Cash assistance only)

You will need an EBT card if you get food or cash benefits. The benefits will be put on your EBT card. Your first EBT card is free. You can get one from:

- 611 H Street NE (8:15am-11:45am and 1:00pm-4:45pm)
- 1649 Good Hope Road, SE (8:15am-4:45pm)

Bring your ID, application receipt (this page of this packet) with you.

This is your receipt (Completed by DHS)

This date stamp shows that DHS has received your application. Keep this page for your records. If you have any questions, call the ESA Call Center at 202.727.5355.

Customer's Full Name				DHS ESA DATE STAMP
Case Number				
Type of Application	☐ Application	☐ Recertification	☐ Expedited	
Applied for	☐ Food	☐ Medical	☐ Cash	
Program(s) Approved	☐ Food	☐ Medical	☐ Cash	
Program(s) Denied	☐ Food	☐ Medical	☐ Cash	
Program(s) Pended	☐ Food	☐ Medical	☐ Cash	

STEP 19 Read about your rights and program rules.

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 personal interviews and a review of your medical records. By applying, you agree to cooperate with the State and 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. If a SNAP claim arises against you, the information on this form, including Social Security Numbers (SSNs), may be sent to Federal and State offices, or private claims collection agencies for claims collection action against all adults in the household. Under federal and District law, you must provide your Social Security Number (if you have one) to receive benefits for yourself unless you are applying for the Healthcare Alliance or Immigrant Children Program and do not declare yourself to be a U.S. Citizen or qualified alien (See 22-B DCMR §3304, §3305, and §3306, 42 CFR §435.910, 42 USC

§1320b-7(a)(1), 45 C.F.R. §155.310(a)(3), 7 CFR §273.6, DC Code §4-204.07, §4-205.05a, §4-205.72, §4-217.07, and Mayor's

Order 92-49). The alien status of applicant household members shall be subject to verification by USCIS through the submission of information from the application to USCIS, and the submitted information received from USCIS may affect your household's eligibility and level of benefits.

Your SSN will be used to verify your identity and citizenship, determine eligibility and amount of benefits, prevent receipt of duplicate benefits, and make required program changes. The DHS computer system uses your SSN to verify your income through the Income and eligibility verification system (IEVS) using records from federal and local sources, including the United States Internal Revenue Service (IRS), the United States Social Security Administration (SSA), DC Department of Employment Services (DOES), and the DC Child Support Services Division (CSSD). Information from IEVS will be requested, used, and may be verified through collateral contact when DHS finds discrepancies. This information may affect your household's eligibility and level of benefits. DHS also reserves the right to check your information with income verification services and other local agencies.

Unless you receive a notice of simplified reporting, you must promptly report changes that may affect your eligibility for SNAP and cash benefits such as changes in your income, assets, shelter and childcare costs, and who lives with you. You must promptly report changes that may affect your eligibility for medical assistance; change in residence, income, who lives with you, change in citizen/immigration status, and incarceration. If you receive Medicaid as a person who is aged, blind, or disabled, you must report changes in assets. To report a change, call (202) 727-5355. Except for reportable changes to income in SNAP, which must be reported within ten (10) days of the date the household receives the first payment due to the change, an anticipated absence for more than ninety (90) days of a minor from a home receiving TANF, which is subject to a five (5) day reporting requirement, and interim reports of significant change in income for TANF recipients, which are timely if provided to DHS at least ten (10) days prior to the end of the month, you must call us before the 10th day of the month after the change. Failure to report changes that might impact your eligibility or amount of benefits in a timely manner may result in reduction or loss of benefits and civil or criminal penalties.

All information and documentation gathered for determining your Cash Assistance, Food Assistance, and Medical Assistance eligibility or other program related use is confidential. Each program provides safeguards, restricting the use and disclosure of information about you to purposes directly connected with the administration of the program. Releasing information concerning your eligibility to anyone not authorized to receive the information is a violation of Federal and D.C. law and may result in legal action. We will keep your eligibility information confidential, unless you give us permission (or we are permitted by law) to release information to others.

Authorized Persons

For cash assistance and SNAP, You may not appoint a minor, retailer, homeless meal provider (if you are a SNAP recipient experiencing homelessness), a government employee who handles this case, or an individual disqualified from any food or cash assistance program for an intentional program violation. If you are a resident of a drug or alcohol treatment center, you must appoint an individual to be your SNAP Representative. Your household will be held liable for any cash or SNAP over issuance that results from the authorized representative providing incorrect information unless your drug or alcohol treatment center or other group living arrangement is acting as your authorized representative for SNAP. Anyone knowingly providing false information may be prosecuted under applicable Federal and State statutes for their acts.

Head of Household

The head of household is the person responsible for filling out this application and the person who will be the point of contact for DHS in communicating about your household's benefits. Your household may select a new head of household at each certification action or whenever there is a change in your household's composition. To report a change to the head of household, contact DHS. If you are applying for benefits for only yourself, you are the head of household. If multiple people living in your household are seeking benefits, follow the guidelines below to select your head of household:

- If there are one or more children under the age of 18 living in your household, the head of household must be either a parent, over the age of 18, of the child(ren) or an adult, over the age of 18, who has parental control over the child(ren).
- If there are no children under the age of 18 living in your household, choose a head of household from among the adults over the age of 18 living in your household.

If your household cannot agree on a person to appoint as your head of household, DHS will designate an individual in your household as its head of household.

Recertification

We will send you a recertification notice in the mail. If you get Medical Assistance and your recertification form does not notify you that an interview is required, just complete the form and send it back to DHS/ESA. If you get food assistance (SNAP) or cash assistance (TANF, POWER, GC or IDA), then you will also need to complete an interview and provide any requested verifications. If you do not recertify, then you will lose your benefits. Also, please let us know if you move. It is your responsibility to keep us informed of your current address so that we can send you important forms and notices concerning your benefits. Your address may also be used to provide your benefit card(s). Call **(202) 727-5355** to report your new address.

Privacy Act Statement for Households Applying for SNAP

The collection of this information, including the SSN of each household member, is authorized under Food and Nutrition Act of 2008, as amended, 7 U.S.C. §§2011-2036. The information will be used to determine whether your household is eligible or continues to be eligible to participate in SNAP. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a SNAP claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action. Providing the requested information, including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of SNAP benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

If you do not have an SSN or cannot remember your SSN, we can help you obtain one. If you need help or have any questions, please contact the ESA Call Center at 202-727-5355.

Human Rights

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, gender identity or expression, personal appearance, sexual orientation, 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: Government of the District of Columbia Office of Human Rights | 441 4th Street, N.W., 570N Washington, D.C. 20001 | Telephone: (202) 727-4559 | Fax: (202)727-9589| TTY 711

Fair Hearings

If you think that DHS has made a mistake, then you can get a Fair Hearing. Call (202) 442-9094 to find out more. 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 organizations on the Referrals page (on page 26) to get free legal help. You may request a Fair Hearing through any of the following methods:

- Calling the ESA Call Center (202) 727-5355
- Completing a Request for Hearing form and fax it to (202) 724-2041, or email to DC.OARA@DC.GOV
- Go to any Department of Human Services Service Center to fill out a Request for Hearing.
- Go to the Office of Administrative Hearings (OAH) Resource Center, located at 441 4th Street NW, Suite 450-North, Washington, DC 20001, call OAH (202) 442-9094, or complete a Request for fair hearing form and fax it to (202) 442-4789 or email it to oah.filing@dc.gov.
- (Medical Assistance Only) Contacting the Office of Health Care Ombudsman & Bill of Rights, located at 441 4th Street NW, Suite 250 North, Washington DC 20001, call the Ombudsman at (202) 724 -7491 or 1 (877) 685-6391, by confidential fax at (202) 478-1397, by email at healthcareombudsman@dc.gov , or visit their website at www.healthcareombudsman.dc.gov

You may request an expedited Fair Hearing on Medicaid when the standard time allotted for the Fair Hearings process may jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function. For Medicaid, you must receive a final decision on your Fair Hearing within 90 days, or 7 business days for an expedited Fair Hearing concerning eligibility.

Medical Assistance Rules

Use this application to apply for medical assistance. 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 (202) 727-5355. If you get Medicaid, then you must recertify each year when we send you a recertification notice. There is no time limit for getting Medical Assistance. Also, if you lose TANF, you may still get Medical Assistance.

Child Support: You agree to cooperate fully with the DC Child Support Services Division (CSSD), unless exempt, in establishing paternity and establishing child and medical support as required by law. Pregnant women are not required to cooperate in establishing paternity and obtaining medical support. You can lose your benefits if you do not cooperate. If you have a good reason for not cooperating with CSSD, such as fear for your safety or your families' safety, you do not have to cooperate with CSSD. However, you must apply for an exception to cooperation. If you have questions, call (202) 442-9900.

Estate Recovery: The District will seek recovery for the bills we pay 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. 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, N.W., Suite 1000-South, Washington, DC 20001. If you have questions, call (202) 698-2000.

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 (DHCF).You can get a copy of the form at any ESA office, or you can download a copy at https://www.dcmedicaid.com/dcwebportal/nonsecure/recipientForms

If you have questions or if you need help completing this 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, Suite 303, N.W., Washington, DC 20009-4422, (202) 682-2100, who may assist you in completing the Medicaid reimbursement form.

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 District of Columbia Office of Administrative Hearings (OAH) at

(202) 442-9094. OAH is located at 441 4th Street, N.W. Suite 450 N., Washington, DC 20001-2714.

c. If you are not satisfied with the result of the fair hearing, you may appeal to the District of Columbia Court of Appeals 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, Suite 303, N.W., Washington, DC 20009-4422, (202)682-2100.

Legal help may also be available from these organizations:

Bread for the City Legal Clinic
1525 Seventh Street, NW
(202) 265-2400

Bread for the City Legal Clinic
1640 Good Hope Road, SE
(202) 561-8587

Neighborhood Legal Services
1213 Good Hope Road SE
(202) 678-2000

Legal Aid Society of the District of Columbia
1331 H St. NW Suite 350
(202) 628-1161

Legal Aid Society of the District of Columbia
2041 Martin Luther King Jr. Ave. SE, Suite LL-1
(202) 628-1161

Legal Aid Society of the District of Columbia Friendship Baptist Church,
900 Delaware Ave., SW
(202) 628-1161

Legal Counsel for the Elderly
(for people age 60 and older)
Building A, 4th Floor
601 E St. NW
(202) 434-2120

Social Security Number: For Medicaid, providing the Social Security Number (SSN) of non-applicants is voluntary. In connection with Medicaid, a non-applicant's SSN would be used only to determine an applicant's or beneficiary's eligibility for Medicaid or other insurance affordability program or for a purpose directly connected to the administration of the Medicaid State plan.

The Department of Humans Services (DHS) complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. DHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. DHS:

- Provides 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)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters OR Information written in other languages

If you need these services, contact Surobhi Rooney If you believe that 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: Surobhi Rooney, DHCF Civil Rights Coordinator 441 4th St. NW, Washington, DC 20001 surobhi.rooney@dc.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, 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.

Or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. DHS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Interim Disability Assistance (IDA)

After you apply, you will get a decision about your IDA within 60 days. Applicants for IDA must also apply for Supplemental Security Income (SSI) and provide proof of the date of the SSI application. An application for IDA is considered to be filed when it is received at the designated ESA Service Center and a face-to-face interview is complete. If you do not get a notice within 60 days, you can get a Fair Hearing. Approval of IDA is contingent on the availability of funds. If funds are exhausted at the time the customer is determined to meet all eligibility requirements, the customer will be placed on a waiting list, and approved when funds become available. Also, if you do not think your benefit amount is correct, then you can get a Fair Hearing.

If you get IDA, then you must cooperate with your IDA case manager. This means:

- Give us medical reports and other materials;
- Keep your appointments with the doctor and with the Social Security Administration;
- Keep your appointments with your case manager; and
- Go to treatment programs, as required.

If you do not follow these rules, then you may lose part or all of your IDA benefits. Also, DHS will take out the amount of IDA that you got from your first "lump sum" SSI check; DHS will send the rest of your first SSI check to you. Applicants for IDA must sign a DHS 340, Authorization for Reimbursement of Interim Assistance, agreeing to reimburse ESA for the cost of their IDA payments. The IDA recipient will repay the entire amount of the IDA assistance payments received if the SSI benefits received for the same period equals or exceeds the IDA payments. If the SSI benefits are less than the IDA payments for the same period the SSI benefits were received, the recipient will repay that portion of the IDA payments that equals the amount of SSI benefits. You will be liable for the IDA received if SSA finds you disabled, but you withdraw your SSI application before back benefits are paid.

USDA/HHS Joint Nondiscrimination Statement

This institution is prohibited from discriminating based on race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: https://www.ascr.usda.gov/filing-program-discrimination-complaint-usda-customer , and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410
2. fax: (202) 690-7442; or
3. email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: https://www.fns.usda.gov/snap/state- directory

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (800) 368- 1019 (voice).

This institution is an equal opportunity provider.

TANF (Temporary Assistance for Needy Families)

You have the right to apply for SNAP benefits at the same time that you apply for cash assistance. As part of the application process, you must complete an orientation, assessment and develop an initial self-sufficiency plan as a condition of eligibility for TANF benefits. This requirement does not apply to you if you are receiving Supplemental Security Income (SSI) or if

you are caretaker of a child who is not yours and you are only applying for the child. To schedule an appointment for an assessment, call the DHS Office of Work Opportunity (OWO), Family Resource Center at (202) 698-1860. You will get a decision about your TANF within 45 days. If you do not get a notice within 45 days, you can get a Fair Hearing. Also, if you think your benefit amount is incorrect, then you can get a Fair Hearing.

It is your responsibility to report any minor's absence from the home, if the absence is expected to exceed ninety (90) days. If a minor is absent or expected to be absent from the home for more than ninety (90) days without good cause as defined in 29 DCMR §5802.2, the minor shall be ineligible to receive TANF benefits. If you fail to make a report of a minor's

absence or expected absence for more than ninety (90) days within five days of becoming aware, the needs of the parent or caretaker relative shall be excluded from the TANF benefit for a period of three (3) months, after adequate and timely notice has been given. If you report a minor's absence, or expected absence for more than ninety (90) days late, the needs of the parent or caretaker relative shall be excluded from the TANF benefit for one (1) month, beginning with the month following the absence of the child from the home.

POWER (Program on Work Employment and Responsibility): You can apply for a temporary transfer to POWER at any time if you are eligible for TANF benefits but cannot work. You can apply for POWER by letting us know that you have a physical or mental condition that prevents you from working. You can also be eligible for POWER if you are:

- A pregnant or parenting teen under age 19 enrolled in school
- You are required to take care of someone in your house who is physically or mentally incapacitated
- You are 60 years of age or older
- You are a victim of domestic violence.

Participation Pays while on TANF: When you participate with your TANF providers, you are eligible for stipends and bonus(es). This results in more money for you and your family.

Sanctions: If you do not follow your plan or work requirements, your TANF benefits will be reduced, unless you have a good cause. This is called a work sanction. We want you to put yourself in the best situation to be successful for you and your children. DHS offers services to assist you with preparing for and getting a job, address problems that are preventing you from being successful at a job and help with getting a better job. If you are going to be sanctioned, we will notify you in advance.

EBT (Electronic Benefit Transfer): Your EBT card is the card you use to access your TANF benefits. You are not permitted to use your EBT card in liquor stores, casinos, or strip clubs. If you use the card at any of these locations, the transaction will be blocked. DHS is monitoring the use of the card at these locations. Failure to report to DHS that you used your TANF benefits on your EBT card at one of these prohibited locations will be viewed as a concealment in violation of the public assistance fraud provisions found at DC Official Code §4-218.01(c). (http://www.lexisnexis.com/hottopics/dccode/). The

District may impose penalties pursuant the above code. If you use the card at prohibited locations, you will have your needs removed from your family's TANF benefit and may be permanently disqualified from the program.

Domestic Violence: You have a right to request a domestic violence good cause waiver of the TANF work requirements and the TANF child support cooperation requirements at any point in time. DHS refers victims of domestic violence to

appropriate services. Disclosure of domestic violence is voluntary and will not adversely affect or delay the ability to receive aid. Disclosed information will be confidential; however, disclosed information about child abuse, child neglect or elder abuse must be reported to Child Protective Services or the District's Adult Protective Services Division (APS).

POWER Eligibility

An assistance unit shall be eligible for POWER under the following circumstances:

- The head of the assistance unit is the parent of a minor child;
- The head of the assistance unit is physically or mentally incapacitated; and
- The physical or mental incapacity of the head of the assistance unit is verified by competent medical evidence and when considered with the head of the assistance unit's age, prior work experience, education, and other factors bearing on the head of the assistance unit's ability to work, as determined relevant by ESA:
  - Substantially precludes the ability of the head of the assistance unit to work or to participate in job search or job readiness activities; and
  - Is expected to last more than 30 days.

In addition to the circumstances above, assistance unit shall be eligible for POWER if the head of the assistance unit is the parent of a minor child and:

- Is needed in the home, due to medical necessity, to care for a household member who is physically or mentally incapacitated; or
- Has been determined by the Department to be a victim of domestic violence who is receiving relevant support counseling or services and has received a domestic violence assessment by the Department or the Department's designee that resulted in a recommendation that the work requirement or child support cooperation be waived; or
- Is a pregnant or parenting teen who:
  - Has been certified by the Department as being exempt from the home living requirements;
  - Is enrolled in high school or a General Education Equivalency Degree program; and,
  - Meets her or his work requirements in compliance with her or his TANF Individual Responsibility Plan (IRP) or any equivalent plan developed during her or his participation in POWER.

A person is ineligible for POWER if that person receives

- Temporary Assistance for Needy Families (TANF);
- Supplemental Security Income (SSI); or
- Unemployment Compensation benefits.

Rights of Child Support (TANF)

All child support payments will be collected and disbursed through CSSD. You are assigning your rights to support up to the TANF grant and you may receive the first $150.00 of a current monthly child support obligation or a voluntary child support payment from an absent parent or spouse and any amount above the TANF grant. If you receive a payment in error, please contact CSSD immediately. If you receive a payment in error and you do not return the payment, you may be forced to repay CSSD. If you do not agree to these conditions, then you cannot get TANF. Once you are off TANF, then you can keep any current child support payments. If you use the TANF benefit, then you are telling us that you agree to these conditions.

SNAP (food assistance)

You must file SNAP applications by submitting the forms to a DHS Service Center in person, through an authorized representative, online, or by mail. You have the right to apply or re-apply for SNAP in writing. You have the right to file an application form for SNAP the same day you contact a DHS Service Center during office hours. You do not have to be interviewed before filing the application and may file an incomplete application form as long as it contains the applicant's

name and address and is signed by a responsible member of the household or the household's authorized representative.

The date of application is the date the application is received by DHS at any of our Service Centers. If the application is received outside of normal business hours, the date of application will be the next business day. If the applicant is a

resident of an institution jointly applying for SSI and SNAP prior to leaving the institution, the filing date is the date of release from the institution. A date of application cannot be established and the deadline to process the application does not begin to run if the form is not signed. You have a right to sign a SNAP application in writing. Unwritten signatures will be accepted when necessary to comply with civil rights laws.

DHS must offer to provide you with a copy of the completed application. It may be provided in electronic format. You may file an application for SNAP separately from other benefits. If you are applying for both SNAP and cash assistance and your SNAP benefits are approved first, those SNAP benefits may be reduced, suspended, or terminated when you receive cash assistance. DHS is not required to send you a notice of adverse action in these circumstances. You will get Expedited SNAP within seven (7) days if you are eligible. After you apply, you will get a decision about your SNAP within 30 days. The length of time DHS has to deliver benefits is calculated from the date of application. If you do not get a notice within this period, you can get a Fair Hearing. Also, if you do not think your benefit amount is correct, then you can get a Fair Hearing. You must have an interview with DHS to get SNAP. If you need to do an interview by telephone, please let your worker know. If you drop off, mail in, or fax your application, DHS will attempt to interview you by telephone. DHS must grant a face-to-face interview to any household that requests one. The interview may be completed by the head of the household, spouse, any other responsible member of the household, or by an authorized representative. The disadvantages and requirements

of applying for cash assistance do not apply to SNAP benefits. Receiving SNAP benefits will have no bearing on any other program's time limits that may apply to your household. We encourage you to file an application form for SNAP right

away. Even if you stop receiving cash assistance, you may still qualify for SNAP benefits. You may voluntarily withdraw your application at any time prior to the determination of eligibility. You have the right to reapply at any time after you withdraw your application. SNAP benefits are given for a specific amount of time called a certification period. You must recertify your SNAP benefits before the end of your certification period, or your SNAP benefits will expire. Note: some elderly and disabled customers only must recertify every two years. However, there is no time limit for getting SNAP unless you are a non-exempt able-bodied adult without dependents (ABAWD See Written Statement of the SNAP Work Registration Rights and Responsibilities) during a time period when the ABAWD time limit is not waived for the District. In fact, even if you lose

TANF, you may still get SNAP. **We will check the information you provide in your SNAP application with Federal, State,**

and local officials to find out if it is true. If any of the information that you provide is untrue, we may deny your SNAP application and you may be subject to criminal prosecution for knowingly providing incorrect information. If you get SNAP, you must follow these rules.

- Do not lie or hide information to get SNAP.
- Do not trade or sell your SNAP;
- Do not use someone else's SNAP;

- Do not buy alcohol or tobacco with SNAP.

If you intentionally break the rules, then you could be fined and go to prison for up to 20 years. You may also lose your benefits for one year for the first violation, two years for the second violation, and permanently for the third violation. If you lie about living in the District or your identity, then you cannot get SNAP for ten years. If you sell or trade your SNAP for any purpose (e.g., to get drugs, firearms, ammunition, or explosives) or traffic in $500 or more in benefits, then you may lose your benefits for 2 years on the first offense and permanently on the second offense, if convicted by a court of law.

Non-US Citizen Applicants shall be provided a reasonable opportunity to submit acceptable documentation of their eligible alien status. If you do not wish for DHS to contact USCIS to verify the immigration status of any household member, you have the option of withdrawing the application or electing to participate in SNAP without that household member. You must cooperate with DHS to complete the application process including the interview and verifying certain information on the application. If you refuse to cooperate, the application shall be denied. You must also cooperate in any later review of your eligibility by a Quality Control reviewer. You shall be determined ineligible if you refuse to cooperate. You must report certain changes in circumstance to us. We will provide you with a notice letting you know more about reporting changes

to us. Every non-exempt able-bodied adult without dependents (ABAWD) must report to us when their work hours fall below twenty (20) hours per week averaged over the month. If you receive substantial lottery or gambling winnings (in an amount equal to or greater than the current SNAP elderly or disabled household resource limit in a single game), that must be reported to us and may result in immediate loss of eligibility for SNAP. Homeless households who do not receive free shelter throughout the month have a choice between using a standard homeless shelter deduction or an excess shelter deduction calculated by comparing shelter and utility costs to half of net income after other deductions in calculating their SNAP benefit amount.

SNAP Work Registrant’s Rights & Responsibilities

As a condition of eligibility for SNAP benefits, each non-exempt household member is responsible for complying with the following SNAP work requirements:

- Register for work or be registered by DHS at the time of application and every 12 months after initial registration.
- Participate in a SNAP Employment and Training (E&T) program if assigned by DHS, to the extent required by DHS. At this time, DHS makes participation in E&T programs voluntary.
- Participate in a workfare program if assigned by DHS.
- Provide DHS or its designee with sufficient information about your employment status or availability for work.
- Report to an employer if DHS or its designee refers you to one for suitable employment.
- Accept a bona fide offer of suitable employment at a site or plant not subject to a strike or lockout, at a wage equal to the higher of the Federal or State minimum wage or 80 percent of the wage that would have governed had the

minimum hourly rate under section 6(a)(1) of the Fair Labor Standards Act been applicable to the offer of employment.

- Do not voluntarily and without good cause quit a job of 30 or more hours a week or reduce work effort to less than 30 hours a week.
- The following persons have the right to be exempt from SNAP work requirements:
  - A person younger than 16 years of age or a person 60 years of age or older.
  - A person age 16 or 17 who is not the head of a household or who is attending school, or is enrolled in an employment training program, on at least a half-time basis.
  - A person physically or mentally unfit for employment.
  - A person subject to and complying with any TANF work requirements.
  - A parent or other household member responsible for the care of a dependent child under 6 or an incapacitated person.
  - A person receiving unemployment compensation. A person who has applied for, but is not yet receiving, unemployment compensation is also exempt if that person is complying with work requirements that are part of the Federal-State unemployment compensation application process.
  - A regular participant in a drug addiction or alcoholic treatment and rehabilitation program.
  - An employed or self-employed person working a minimum of 30 hours weekly or earning weekly wages at least equal to the Federal minimum wage multiplied by 30 hours. This includes migrant and seasonal farm workers under contract or

similar agreement with an employer or crew chief to begin employment within 30 days. An employed or self-employed person who voluntarily and without good cause reduces his or her work effort and, after the reduction, is working less than 30 hours per week, is ineligible to participate in SNAP.

- A student enrolled at least half-time in any recognized school, training program, or institution of higher education. Students enrolled at least half-time in an institution of higher education must meet the student eligibility requirements for SNAP. A student will remain exempt during normal periods of class attendance, vacation, and recess.

Any nonexempt individual who refuses or fails without good cause to comply with the SNAP work requirements is ineligible to participate in SNAP and will be considered an ineligible household member. The following disqualification periods will be imposed:

- For the first occurrence of noncompliance, the individual will be disqualified until the later of:
  - The date the individual complies;
  - One month; or
  - Up to three months.
- For the second occurrence, until the later of:
  - The date the individual complies;
  - Three months; or
  - Up to six months.
- For the third or subsequent occurrence, until the later of:
  - The date the individual complies;
  - Six months;
  - A date determined by DHS; or
  - Permanently.

DHS may also disqualify the whole household. You have the right to have DHS explain to you the work requirements, the rights and responsibilities of work-registered household members, and the consequences of failure to comply. You have the right to have DHS provide a written statement of the above to each individual in the household who is registered for work.

Supplemental Form for Long Term Care Benefits

Instructions

This is a supplemental form for those 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 intermediate care facility for the Developmentally Disabled (ICF/DD) and the Home and Community-Based Services (HCBS) Waiver Programs.

The HCBS Waiver Program includes:

- Persons Who Are Elderly or Physically Disabled (EPD),
- Persons with Intellectual and/or Developmental Disabilities (IDD) and
- Individual and Family Support (IFS).

Program Overview

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

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 form the nursing facility.

Institutional Transition

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.

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/IDD 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.

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 60 months (5 year) look-back period. They may be eligible for other Medicaid services.

If you want to apply for EPD services, you must first contact the DC Office of 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 of 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 supplemental form.

When filling out this supplemental form, 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”

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 supplemental form 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 Supplemental Form for Long Term Care Benefits (This form)
- 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 Supplemental Form for Long Term Care Benefits (This form)
- A completed Level of Care Form

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

- A completed and signed Supplemental Form for Long Term Care Benefits (This form)
- A completed and signed Start of Care Form
- For nursing facility, a completed and approved Level of Care by DHCF or its agent
- Please Note: For ICF/IDD facility, a completed and approved Level of Care

Please note that the clinician (Doctor or APRN) that completes your Level of Care Form MUST be a Medicaid provider. If the clinician who completes your Level of Care 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 streamlined application at: https://www.dc-medicaid.com/dcwebal/documenInformation/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 ESA, the application will not be registered and processed. ESA Will only begin processing the application when all of the required documents are signed, completed, and submitted to ESA.

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

What program(s) would you like to apply for?

Institutional Care

- ☐ **Nursing Facility or Skilled Nursing Facility**
- ☐ **Intermediate Care Facilities for Persons with Intellectual and Developmental Disabilities (ICF/IDD)**

Home and Community-Based Waiver

- ☐ **Elderly and Individuals with Physical Disabilities (EPD)**
- ☐ **Intellectual and Developmental Disabilities (IDD)**
- ☐ **Money Follows the Person**
- ☐ **Individual and Family Support (IFS)**

Service Center Locations

Monday – Friday | 7:30am – 4:45pm

Anacostia Service Center

2100 Martin Luther King Jr. Ave., SE
Washington, DC 20020

Fax: (202) 727-3527

Congress Heights Service Center

4049 South Capitol St., SW
Washington, DC 20032

Fax: (202) 645-4524

Taylor Street Service Center

1207 Taylor St., NW
Washington, DC 20011

Fax: (202) 576-8740

Fort Davis Service Center

3851 Alabama Ave., SE
Washington, DC 20020

Fax: (202) 645-6205

H Street Service Center

645 H St., NE
Washington, DC 20002

Fax: (202) 724-8964

Customers may call the ESA Call Center at (202) 727-5355 to learn which Service Center serves their address

Language Access Support

If you speak another language, you have the right to free language assistance services. Call (202) 727-5355 or TTY/TDD 711 (855) 532-5465. District law requires that agencies provide you with information and assistance in your language for free. If you do not receive help in your language, please call the DC Office of Human Rights at (202) 727-4559 and press 0.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (202) 727-5355 (መስማት ለተሳናቸው: TTY/TDD 711 (855) 532-5465).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電(202) 727-5355 (TTY/TDD 711 (855) 532-5465

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (202) 727-5355 (ATS : TTY/TDD 711 (855) 532-5465).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (202) 727-5355 (TTY/TDD 711 (855) 532-5465.

Dè dɛ nìà kɛ dyédé gbo: Ɔ jǔ ké m̀ [B̀àsɔ́ ɔ -wùdù-po-nyɔ̀] jǔ ní, nìí, à wudu kà kò dò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-(202) 727-5355 (TTY/TDD 711 (855) 532-5465)।

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(202) 727-5355 (TTY/TDD 711 (855) 532-5465)

まで、お電話にてご連絡ください。
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (202) 727-5355 (TTY/TDD 711 (855) 532-5465)번으로 전화해 주십시오.

เรียน: ถาคณุ พูดภาษาไทยคณุ สามารถใชบ้ รการชวยเหลอื ทาง ภาษาไดฟ้ รี โทร (202) 727-5355 (TTY/TDD 711 (855) 532-
5465).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (202) 727-5355 (TTY/TDD 711 (855) 532-5465).

What is the Language that you need to read?	❑ English	❑ Spanish	❑ Vietnamese	❑ French	❑ Korean	❑ Amharic	❑ Chinese (Mandarin)	❑ Chinese (Cantonese)	❑ Other
What Language do you need to speak to get ESA services?	❑ English	❑ Spanish	❑ Vietnamese	❑ French	❑ Korean	❑ Amharic	❑ Chinese (Mandarin)	❑ Chinese (Cantonese)	❑ Other
If you need an interpreter, what language do you need interpreted?	❑ English	❑ Spanish	❑ Vietnamese	❑ French	❑ Korean	❑ Amharic	❑ Chinese (Mandarin)	❑ Chinese (Cantonese)	❑ Other

Do you want free language interpretation?

☐ Yes (a case worker will assist you) ☐ No (complete and sign waiver below)

I,_____, acknowledge that The Department of Human Services (DHS) has notified me of my right to a professional and trained interpreter as required by the D.C. Language Access Act of 2004 at no cost to me. By signing below, I agree that I have refused this service and opted to rely on interpreter assistance by someone I have identified. I am aware that this individual was not identified by or vetted through DHS and that DHS is neither responsible for the provision of these services nor does DHS incur any liability that may result from these services. I am also aware that this waiver only applies to this one instance. If I require interpreter assistance from DHS in the future, I will notify the agency directly to request this service.

Sign here Date

_____ _____

Applicant or Representative Signature

OFFICE USE: This statement was orally translated into (language)_____by (name)_____, who is a language line interpreter, professional in person interpreter, or multilingual DHS employee because a written translation was not available in that language or the customer was unable to read in his/her spoken language.

SECTION 1 Personal Information

Name	**Date of Birth**
Sex ☐ Male ☐ Female	**Social Security Number**
Current Address or your address prior to entering the Long Term Care Facility:	**Do you plan on returning to this residence upon discharge?** ☐ Yes ☐ No
Name and Address of the Long Term Care Facility:	**Date you entered Facility:**

SECTION 2 Information on Spouse

(Complete this information even if you are not applying for your spouse)

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

SECTION 2A Please list 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 (SSN)	Relation to You	Do you claim this person as a dependent on you tax return?	Gross Monthly Income

SECTION 3 Legal Representation

(Do you have one of the following acting on your behalf? Please answer)

☐ Yes ☐ No

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

Conservator ☐ Yes ☐ No	**Name**	**Address**
	Do you pay a monthly Conservator fee? ☐ Yes ☐ No	
	If yes, the Fee Amount:	**Telephone Number**
Representative Payee ☐ Yes ☐ No	**Name**	**Address**
	Do you pay a monthly Rep. Payee fee? ☐ Yes ☐ No	
	If yes, the Fee Amount:	**Telephone Number**
Authorized Representative ☐ Yes ☐ No	**First Name**	**Address**
	Last Name	**Telephone Number**

SECTION 4 Income of Applicant and/or Spouse

Please tell us about any income or benefits that you and your spouse are currently receiving, have applied for, or have been denied. If you or your spouse check an income type below, please provide more information about the income type(s) in the table 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	Persons 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	
	☐ Yes ☐ No	☐ Self ☐ Spouse	$	☐ Receiving ☐ Applied For ☐ Denied	

SECTION 5 Assets Currently Owned by You and Your Spouse

Please provide the value(s) of all assets owned by you and your spouse below. If you or your spouse own any assets below, please attach proof when you submit this form. If you or your spouse do not currently own any assets, you can skip this section.

Asset Type	Name of Owner(s)	Fair Market Value	Amount Owed	Date Acquired
Bank or Credit Union Account		$	$	
Stocks/Bonds/Mutual Funds		$	$	
Certificates of Deposit		$	$	
Annuity/Trust Funds/Trust Accounts		$	$	
2nd Bank or Credit Union Account		$	$	
Your Home		$	$	
Vacation Home Address:		$	$	
Land Address:		$	$	
Other Real Property Type: Address:		$	$	
Boats/Recreational Vehicles/Motor Homes Type		$	$	
Cash-Including Cash Surrender Value of any Life Insurance Policies		$	$	

NOTE: If you need additional space to provide additional addresses for the property that you or your spouse own, please attach a separate sheet of paper.

SECTION 6 Assets when you entered the Long Term Care Facility

Married Individuals ONLY:

You or your spouse can request a resource assessment at the beginning of your first continuous period of stay in a facility. Resource assessment is completed to determine how much of a married couple's total resources may be protected or set aside for the spouse in the community, and how much, if any should count towards the spouse who needs care in a facility setting or home and community-based services program. This protection is called "Spousal Impoverishment', which recognizes the importance of protecting a portion of a married couple's total resources to account for the needs of the spouse who remains in the community. Completing Section 6 below will help you to protect the maximum amount of your resources under the law

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	Name of Owner(s)	Fair Market Value	Amount Owed	Date Acquired
Bank or Credit Union Account			$	$
Stocks / Bonds / Mutual Funds			$	$
Certificates of Deposit			$	$
Annuity / Trust Funds / Trust Accounts			$	$
2nd Bank or Credit Union Account			$	$
Your Home			$	$
Vacation Home (Please provide address below)			$	$
Land (Please provide address below)			$	$
Boats/Recreational Vehicles/Motor Homes Type			$	$
Cash-Including Cash Surrender Value of any Life Insurance Policies			$	$

If you own any property, which is different from your current address, please list the addresses below:

Address 1:	Address 2:
Address 3:	Address 4:

NOTE: If you need additional space to provide additional addresses for the property that you or your spouse own, please attach a separate sheet of paper.

SECTION 7

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.)

☐ Yes ☐ No

If **yes**, complete the following:

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

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

Do you own or rent a home?	☐ Yes ☐ No
Do you expect to return to this home within six (6) months?	☐ Yes ☐ No
If you expect to return, will your spouse or any of your dependents continue to stay in your home?	☐ Yes ☐ 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 occupied by your spouse, his/her Spousal Allowance may be increased because 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 $	

SECTION 8 Health Insurance Information

Medicare Information (from your Medicare Card)

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

Other Health Insurance

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

SECTION 9 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, we cannot use the bill to reduce the amount you will need to pay for your LTC/HCBS services. For more information, visit your local ESA Service center or call the DC Department of Human Services Call Center at (202) 727-5355.

SECTION 9 Listing of Past Medical Expenses

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.)

☐ **Yes** ☐ **No**

If you answered "**yes**" to the above question, list the type and amount of these past medical bills that may be used to determine eligibility 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
Type of Medical Service	Date of Medical Service	Amount Billed for Medical Service

Attach another page if you have additional medial expenses

SECTION 9 Listing of Past Medical Expenses

- 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.
- 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 my Rights and Responsibilities attached to this Supplemental Form. 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 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 benefits and agrees to the conditions above.

Nursing Facility and Intermediate Care Facility Applicants/Beneficiaries Only

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 _____

Representative Signature _____ Date _____

Appendix A 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 DC Court of Appeals within 30 days.

You may be able to obtain free legal assistance to help you present your case at the hearing or on appeal. If you are a member of the class certified by the court in Salazar v. District of Columbia, Civil Action No. 93-452 (TSC) (D.D.C.), you may contact Terris, Pravlik & Millian, LLP at 1816 12th Street, NW, Suite 303 Washington, DC 20009 or (202) 682-0578.

Free legal assistance for beneficiaries who are not members of the Salazar class may be available from the following organizations:

Bread for the City Legal Clinic, (202) 480-8950 or (202) 791-3982 Legal Aid Society, (202) 628-1161

Legal Counsel for the Elderly, (202) 434-2120

Neighborhood Legal Services, (202) 832-6577

University Legal Services, (202) 547-4747

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 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 below 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

Legal Counsel for the Elderly (60 years or older)

601 E Street, NW (202) 434-2120

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

Terris Pravlik & Millian, LLP

1816 12th Street NW, Suite 303, Washington, DC 20009 (202) 682-0578

Government of the District of Columbia
Medical Assistance Administration
Office on Disabilities and Aging
Section 1915(c) Home and Community-Based Waiver for the Elderly and Individuals with Physical Disabilities

WAIVER BENEFICIARY FREEDOM OF CHOICE FORM AND PROCEDURE FOR ASSURING BENEFICIARY FREEDOM OF CHOICE

Name of Client: _____

I. Informed Beneficiary Certification

This is to certify that a representative of (name of agency) DC Office on Aging has informed the potential waiver beneficiary and his or her authorized representative of (**a**) the potential beneficiary's right to choose between nursing facility care and home and community-based service under the approved home and community-based services waiver; and (**b**) the potential beneficiary's right to select his/her service provider(s) once approved to receive waiver services, and (**c**) the Medical Assistance Administration reserves the right to impose utilization control, service limits and other restrictions as warranted.

_____ _____
Signature of Agency Representative **Date**

II. Beneficiary Election

This is to attest that I, _____ and/or my authorized Representative _____ have been informed of the right to choose between nursing facility care and home and community-based services under the approved waiver and have chosen the option indicated on the selected line below.

Nursing Facility Care_____ **Home and Community-Based Services** _____

Signed:_____ _____
Beneficiary **Date**

Signed:_____ _____
Authorized Representative **Date**

III. Witness (at least one is required):

NOTE: IT IS A CONFLICT OF INTEREST FOR THE CASE MANAGER TO WITNESS THIS FORM

We, the undersigned, attest that we have witnessed the beneficiary and his/her representative (if applicable) sign this form indicating that the beneficiary and his/her representative have been informed of the right to select either nursing facility or home and community-based services, and that the beneficiary and his/her authorized representative have indicated the above election.

Signed:_____ _____
Witness #1 **Date**

Signed:_____ _____
Witness #2 **Date**

DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION
OFFICE ON DISABILITIES AND AGING
BILL OF RIGHTS & RESPONSIBILITIES

RIGHTS

As a home and community-based services customer, you have the right to be informed of your rights and responsibilities before the initiation of home and community-based services. If a customer has been deemed incompetent to make health care decisions, the customer's family and/or representative may exercise the right to make informed decisions for the customer.

As a home and community-based services customer, you have the right to:

1. Be informed in advance about the proposed services and be provided a response to questions in understandable terms.

2. Receive services appropriate to your needs, and expect the provider to render safe, professional services at the level of intensity needed without unlawful restriction by reason of age, sex, religion, race, color, creed, national origin, place of residence, sexual orientation, or disability.

3. Receive in writing and orally in advance of care, the services offered, coverage of the services by the payment source, a statement of charges and items not covered by the payment source, and any changes in charges or items and services within 15 days after the provider is aware of a change.

4. Obtain a reasonable response to request for services within the capacity of the provider to respond.

5. Have knowledge of available choices of providers, to participate in your care planning from admission to discharge, and to be informed in a reasonable time of anticipated discharge and/or transfer of services.

6. Receive services from staff who are qualified through education and/or experience to render the services to which they are assigned.

7. Know who is responsible for and who is providing care, and to receive information concerning your continuing health needs and choices for meeting those needs, and to be involved in discharge planning, if appropriate.

8. Receive reasonable continuity of care.

9. Refuse treatment to the extent provided by law, and to be informed of the medical consequences of that refusal.

10. Receive confidential treatment of your clinical records in accordance with legal requirements, and to be responsible for prior authorizing any release of information contained therein.

11. Treated with consideration, respect, and dignity, including the provision of privacy during the provision of services.

12. Inspect or receive, for a reasonable fee, a copy of your clinical records; to have information in your clinical record corrected (as appropriate); and to transfer information to any third party, unless against medical advice.

13. Receive available information about community resources that are best suited to your care needs

14. Present grievances and/or recommend changes in your services without fear of discrimination, reprisal, restraint, interference or coercion.

RESPONSIBILITIES

Each customer who is receiving home and community-based services has the responsibility to:

1. Provide a complete and accurate health history and any changes in condition, insurance, address, phone number, and other pertinent information.

2. Indicate level of understanding of the plan of care and other expectations in the provision of services

3. Comply with the prescribed plan of care

4. Treat the providers of services with dignity, courtesy, and respect

5. Notify the provider if unavailable for scheduled visits

Signature of Customer/Representative _____ Signature/Title of Provider _____ Date

APPROVED ELDERLY & PERSONS WITH PHYSICAL DISABILITIES (EPD) WAIVER
CASE MANAGEMENT ONLY

PROVIDER	Administrator	ADDRESS	PHONE/FAX NUMBER	EMAIL ADDRESS
ABSOLUTE HEALTH CARE RESOURCES	Peter Atemnkeng	143 Kennedy Street Washington, DC 20011	Phone: 202-507-8139 Fax: 202-507-8413 After hours: 202-507-8139 Ext. 222	info@ahrhomecare.com
ADVOQUATE HEALTH SERVICES, LLC	Joahana Tingem-Locker	6411 Orchard Avenue Suite 103 Takoma Park, Maryland 20912	Phone: 301-270-0116 Fax: 301-270-0035	info@advoquatehealth.com
ALTASOURCE MANAGEMENT COMPANY	Curtis Ofori	1900 M Street, NW Suite 301 Washington, DC 20036	Phone: 202-499-4747 Fax: 202-747-6526 After hours: 202-499-4747	info@altasourcemanagement.com curtis.ofori@altasourcemanagement.com
ANNA HEALTHCARE	Barbara Stallworth	6495 New Hampshire Avenue Ste. LL33 Hyattsville, MD 20783	Phone: 301-270-1180 Fax: 301-326-4153 After hours: 202-839-1221	casemanagement@annahealthcare.com bstallworth@annahealthcare.com amccarty@annahealthcare.com mrillera@annahealthcare.com

Last Updated 08/30/2019

APPROVED ELDERLY & PERSONS WITH PHYSICAL DISABILITIES (EPD) WAIVER
CASE MANAGEMENT ONLY

PROVIDER	Administrator	ADDRESS	PHONE/FAX NUMBER	EMAIL ADDRESS
AUTUMNLEAF GROUP, INC.	Janine Harrigan	64 New York Ave, NE Suite 100 Washington, DC 20002	Phone: 202-851-2303 Fax: 202-851-2302 After hours: 703-220-3208	jharrigan@autumnleafgroup.com casemanagement@autumnleafgroup.com
CARE CONCEPTS, LLC	Michael Sobowale	2537 Bladensburg Road, NE	Phone: 202-735-5704 Fax: 202-748-5358	casemanagement@careconceptsllc.net Michaelsobowale@careconceptsllc.net
CONTEMPORARY FAMILY SERVICES	Natoya Mitchell	3300 Pennsylvania Avenue, SE Washington, DC 20020 6525 Belcrest Road Suite G-40 Hyattsville, Md. 20782	Phone: 202-735-0761 Fax: 301-779-0258 Phone: 301-779-8345 Fax: 301-779-0258 Cell: (202) 717-3515	nmitchell@contemporaryservices.net

Last Updated 08/30/2019

APPROVED ELDERLY & PERSONS WITH PHYSICAL DISABILITIES (EPD) WAIVER
CASE MANAGEMENT ONLY

PROVIDER	Administrator	ADDRESS	PHONE/FAX NUMBER	EMAIL ADDRESS
EAST RIVER FAMILY STRENGTHENING COLLABORATIVE, INC.	Paulett D. Costley Katedra Sullivan	3917 Minnesota Ave, NE Washington, DC 20019	Phone: 202-543-4880 Ext 132 Fax: 202 388-7691 After hours: 202-748-3352	pcostley@erfsc.org mbest@erfsc.org ksullivan@erfsc.org
FAMILY AND HEALTHCARE SOLUTIONS	Sylvie Fomundam Roger Momjah	4550 Forbes Boulevard Suite 320 Lanham, Maryland 20706	Phone: 202-621-7329 Fax: 202-621-7369 After hours: 202-621-7329	sylvie@familyhealthsolutions.org beatrice@familyhealthsolutions.org daniel@familyhealthsolutions.org
FAMILY WELLNESS CENTER **NOT ACCEPTING NEW/TRANSFER BENEFICIARIES**	Sharon Yorke	2526 Pennsylvania Ave, SE Suite C Washington, DC 20020	Phone: 202-748-5641 Fax: 202-748-5647 After hours: 202-621-7476	syorke@thefwc.net

APPROVED ELDERLY & PERSONS WITH PHYSICAL DISABILITIES (EPD) WAIVER
CASE MANAGEMENT ONLY

PROVIDER	Administrator	ADDRESS	PHONE/FAX NUMBER	EMAIL ADDRESS
JAMALL NURSING SERVICES UNLIMITED, INC	Mamie Bynum	1818 New York Avenue N.E. Suite 214-E Washington, DC 20002	Phone: 202-526-2552 Fax: 202-526-2558 After hours: 202-276-6810	contact@jamallnursingservices.info
KC COMMUNITY SERVICES	Innocent Chia	100 M Street, SE Suite 600 Washington, DC 20003	Phone: 202-957-7456 Fax: 202-747-7754 After hours: 240-481-0557	adm@kccsinc.com ichia@kccsinc.com
MEDSTAR HOUSE CALL PROGRAM (WHC)	Gretchen Nordstrom	100 Irving Street NW Room #EB 3114 Washington, DC 20010	Phone: 202-877-0576 Fax: 202-877-6630 After hours: 202-877-6751	Kellie.C.Jones@medstar.net Ruth.s.Shea@medstar.net Gretchen.j.Nordstrom@medstar.net

Last Updated 08/30/2019

APPROVED ELDERLY & PERSONS WITH PHYSICAL DISABILITIES (EPD) WAIVER
CASE MANAGEMENT ONLY

PROVIDER	Administrator	ADDRESS	PHONE/FAX NUMBER	EMAIL ADDRESS
PREMIER SUPPORT SERVICES	Barbara Awa	6495 New Hampshire Avenue, Suite 234 Hyattsville, Maryland 20783	Phone: 301-557-9598 Direct: 443-802-1258 Fax: 301-557-9621	Bawa@premierssinc.com
PRESTIGE HEALTHCARE	John Smith Wanda Scott	143 Kennedy Street, NW Suite 1 Washington, DC 20011	Phone: 202-558-2448 Fax: 202-204-5758 After hours: 202-558-2448	phri@prestigewecare.com vsona@prestigewecare.com johns@prestigewecare.com wscott@prestigewecare.com
PROGRESSIVE HEALTHCARE, INC.	Denise Harrington	10 G Street, NE Suite 460 Washington, DC 20002	Phone: 202- 548-0588 Fax: 202- 548-0589 After hours: 202- 548-0588	info@Progressivehealthdc.com Denise@progressivehealthdc.com Ken@progressivehealthdc.com

Last Updated 08/30/2019

APPROVED ELDERLY & PERSONS WITH PHYSICAL DISABILITIES (EPD) WAIVER
CASE MANAGEMENT ONLY

PROVIDER	Administrator	ADDRESS	PHONE/FAX NUMBER	EMAIL ADDRESS
Priority Health Systems	George Takam Firmin Djontu	143 Kennedy street NW Unit. 8 Washington, DC 20011	Phone: 202-545-0195 Fax: 202-545-0276 After hours: 240-821-4586	priorityhealthsystem@priorityhealthsystem.com georgetakam@hotmail.com fdjontu@gmail.com
SEABURY RESOURCES FOR AGING ***NOT ACCEPTING NEW/TRANSFER BENEFICIARIES**	Vivian Grayton Dawn Quattlebaum	2501 18th Street, NE Washington, DC 20018 6031 Kansas Ave, NW Washington, DC 20011	Phone: 202-635-9384 Phone: 202-529-8701 Phone: 202-414-6314 Fax: 202-832-4711 Fax: 202-832-0127	vgrayton@seaburyresources.org dquattlebaum@seaburyresources.org
SO OTHERS MIGHT EAT (SOME)	Brittany Kitt Joan Williams	1667 Good Hope Road, SE Washington, DC 20020	Phone: 202-797-8806 Ext 1312 Fax: 202-889-2515	bkitt@some.org jwilliams@some.org

Last Updated 08/30/2019

APPROVED ELDERLY & PERSONS WITH PHYSICAL DISABILITIES (EPD) WAIVER
CASE MANAGEMENT ONLY

PROVIDER	Administrator	ADDRESS	PHONE/FAX NUMBER	EMAIL ADDRESS
TRINITY NURSING MANAGEMENT, LLC	Comfort Bogunjoko	12217 Kings Arrow Street Bowie, Maryland 20721	Phone: 301-249-8549 Phone: 240-354-1632 Phone: 240-486-1607 Fax: 240-245-3910 After hours: 301-249-8549	tnm@trinity-nursing.com cbogunjoko@trinity-nursing.com ookudoh@trinity-nursing.com natuonwu@trinity-nursing.com
ULTIMATE HOME HEALTH SERVICES	Ebun Williams	6937 Lamont Drive Lanham, MD 20706	Phone: 240-755-5582 Fax: 1-877-442-1442 After hours: 240-755-5582	Ewilliams@ultimatehs.org
VTM HEALTH SERVICES, LLC	Naomi Mandishona	1734 Elton Rd, Suite 114 Silver Spring, MD 20903	Phone: 202-450-3608 Fax: 703-579-4403 After hours: 202-450-3608	info@vtm-services.com

APPROVED ELDERLY & PERSONS WITH PHYSICAL DISABILITIES (EPD) WAIVER
CASE MANAGEMENT ONLY

Department of Health Care Finance
Long Term Care Administration
Hotline: 202-442-9533
Fax: 202-610-3209

Last Updated 08/30/2019

District of Columbia Department of Health Care Finance

Medicaid Case Management Beneficiary Freedom of Choice Attestation

Name: _____ Medicaid Number: _____

This is to certify that an agent of the District of Columbia's Department of Health Care Finance (DHCF), has informed the above mentioned Medicaid beneficiary and/or his/her authorized representative of the beneficiary's right to choose the Case Management Agency of their choice to provide Case Management Services (CMA) services.

I have received an information resource package which includes a copy of the following:

- Beneficiary Bill of Rights and Responsibilities
- FACT SHEET: Elderly and Persons with Physical Disabilities Waiver program
- Case Management Agency provider list

My choices are:

1st Choice: _____

2nd Choice: _____

3rd Choice: _____

❍ After receiving information about Case Management services, I have decided to refuse the services at this time.

Beneficiary and/or Authorized Representative Signature Date

_____ _____

DHCF Representative (Print Name) Date

_____ _____

DHCF Representative (Signature) Date

_____ _____

DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH CARE FINANCE

MEDICAID ESTATE RECOVERY FACT SHEET

What is Medicaid Estate Recovery?

Under federal and District of Columbia Municipal Regulations, the Department of Health Care Finance (DHCF) must request repayment from estates of deceased Medicaid beneficiaries for services paid for by Medicaid.

What Is An Estate?

An estate includes all real and personal property, including a home, owned by a deceased beneficiary that does not pass to another person at the time of the beneficiary's death.

Who is Covered by Estate Recovery?

A Medicaid beneficiary who, at age 55 or older, received Medicaid coverage is covered under estate recovery. DHCF must ask the deceased beneficiary's estate to repay the District of Columbia for the services paid for by Medicaid.*

*Estate recovery does not include Medicare Part A and B premiums, deductibles, coinsurance, and copayments with dates of service on or after January 1, 2010.

How Does the District Request Estate Recovery?

The District will notify the estate of its intent to file its claim by putting a lien on the deceased beneficiary's estate (Notice of Proposed Recovery). However, a lien will not be placed if an **Exemption** is met.

Once the lien is placed, the District may only seek estate recovery after the surviving spouse, a child under 21, or a child who is blind or disabled no longer lives in the home and the home is sold.

The District must waive or reduce its claim if there is an **Undue Hardship**.

Frequently Asked Questions: Spend Down

The Medically Needy Spend down program is authorized under 42 CFR § 435.601 and § 435.831 of the Federal Regulations and Title 29 Section 9511 of the District of Columbia Municipal Regulations (DCMR).

What is Medicaid spend down?

Some people have too much income to qualify for Medicaid. This amount is called excess income. Some over income people may qualify for Medicaid if they spend the excess income on medical bills. This is called a spend down. If you meet all the other requirements for Medicaid but your income is higher than the Medicaid limit, you may be placed on a spend down.

How does spend down works?

Spend down works like an insurance policy deductible. The amount of the "deductible" is called the "spenddown amount." When you have collected medical bills (paid or unpaid) within the past three months of the month of application greater than your excess income, you will get Medicaid for that month you met your spend down amount through the end of your spend down budget period. You are responsible for the bills up to the excess amount. Medicaid will only pay those bills over your spend down amount.

What groups can qualify for spend down?

If you fall under one of the eligibility groups below, you may qualify to be placed on a spend down.

- A parent or caretaker relative of a child under 21
- A child age 0-20
- A pregnant woman
- 65 years old or older
- Disabled under the Social Security rules (any age)
- Blind under the Social Security rules (any age)
- Living in a nursing home or other institutional care setting, or
- Receiving waiver services under the Home and Community Based Services (HCBS)

How do I know if I qualify for spend down? Do I get a notice?

Yes. You will receive a notice in the mail from the Department of Human Services' Economic Security Administration (ESA). The notice will state your Medicaid application was denied due to excess income. The notice will explain the spend down process to

include the time period for spend down which is the budget period. Also, the notice will explain the spend down amount.

How is my spend down amount determined?

The amount of your spend down depends on your income. Your spend down amount is the difference between your income that we count and the income limit set by the Federal government. We call this income limit the "Medically Needy Income Level (MNIL)." The MNIL for 2020 is $682.42 per month.

What is a spend down budget period?

A spend down budget period is a period of time when your Medicaid eligibility will be determined under the spend down process. Spend down budget periods are six (6) months long for Long Term Care Medicaid like Home and Community Based Services Waivers and Institutional Care (nursing homes and intermediate care facility) and one (1) month budget periods for other Medicaid groups. If you are placed under spend down, your spend down budget period will start on the month your application is received in the office.

Do I have to submit a new application after my spend down budget period ends?

It depends. If you meet your spend down amount within your spend down budget period when you first apply for Medicaid, you will get a second spend down budget period without submitting a new application. For example, if your application was received in January, your first spend down budget period is from January to June. If you met your spend down amount any time between January and June, you will get a second spend down budget period from July to December without submitting a new application. However, you will need to submit a new application after your second spend down budget period whether or not you meet your spend down amount. If you do not meet your spend down amount from January to June, you will need to submit a new application.

What type of bills can I use to meet my spend down amount?

You can use medical and remedial bills for medically necessary care to meet your spend down amount.

What medical and remedial bills can I use to meet my spend down amount?

Some examples of medical bills that can be used to meet your spend down amount are:

- Dental bills
- Doctor's bills
- Prescription drugs
- Hospital bills (Inpatient and Outpatient)
- Nursing home costs
- Nursing services
- Organ transplant bills
- Prosthetic devices (Artificial teeth, limbs, hearing aid, eyeglasses and crutches)
- Laboratory fees
- Home health care
- Rehabilitative services
- Physical Therapy
- Medical supplies and equipment

- Over-the-counter Medications when prescribed by Physician
- Medicare premium, deductibles, or co-insurance charges
- Health insurance premium, deductibles, or co-insurance charges
- Durable medical equipment
- Personal Care Aide (PCA) services as long as the services are ordered by a doctor and the provider meets the requirements set by D.C. Medicaid.

- Transportation and mileage to and from providers to go to medical appointments, obtain medical supplies, prescriptions or equipment.

- Home and vehicle modifications that are medically necessary and directly related to the applicant/beneficiary's medical condition.

Whose medical and remedial bills can I used to meet my spend down amount?

You can use paid and unpaid medical and remedial bills for services received by you, your spouse, your minor child up to the age of 21, or your adult disabled child that you are financially responsible to pay. The medical bills cannot be subject to payment by third-party insurance.

Can I use old medical and/or remedial bills?

Yes. You can use your old bills for services incurred from the past three months prior to the month you applied for Medicaid towards your spend down as long as you are still responsible for paying the bill. You will need to provide a current copy of the bill showing the date of service to the ESA case worker. For example, you applied for Medicaid in February 2020 and denied due to excess income the same month. If you owe your dentist's office $1,500.00 for a visit on December 1, 2019 and you wanted to use this bill for your spend down, you must provide a copy of the bill to the ESA case worker. The date of service on the bill must be within the last 90 days from the date you applied for Medicaid and still owed to the provider.

Can I use medical and remedial bills that I paid?

Yes. You can use paid medical and remedial bills for incurred expenses from the past three months before you applied for Medicaid or if you paid incurred medical and remedial bills while you are on your spend down budget period.

Can I use my mortgage or rent bill?

No. You can only use medical and remedial bills for medically necessary services towards your spend down.

Are there any other bills that I cannot use towards my spend down?

Yes. Medical bills paid by third party insurance like Medicare or Tricare, or bills paid for by Medicaid cannot be used towards your spend-down. Household bills such as gas bill,

electric bill, grocery bill, car insurance, or car note cannot be used towards your spend down.

Can I use bills paid by someone else towards my spend down amount?

It depends. If the person paid incurred expenses that you are responsible to pay three months before you applied for Medicaid and the person who paid the bill wants to be repaid by you, then yes the bill can be used towards your spend down. The bill cannot be use towards the spend down amount if the bill was paid more than three months before the application was submitted, and if the person does not want repayment. Medicaid will not repay the person who paid your bill.

Can I use the medical bills or receipts more than once to meet my spend down?

No. You can only use the medical and remedial bills or receipts once to meet spend down. For example, if you used an unpaid doctor's bill to meet your spenddown in a budget period, you cannot use a payment receipt for the same doctor's bill to meet your spend down in later months.

What if my medical and remedial bills are more than my spend down amount?

If your medical and remedial bills are more than the spend down amount, the remaining amount of the bill will be used towards your second spend down budget period. We call this amount, "carry-over expenses." Carry-over expenses are the left over balances on your medical and remedial bills that can be used to meet your spend down amount in your next spend down budget period.

What if my medical and remedial bills are less that my spend down amount?

If your medical and remedial bills and receipts are less than your spenddown amount, you will not qualify for Medicaid. You can submit additional medical and remedial bills to the ESA case worker until your total medical and remedial bills are equal to or higher that your spend down amount. These additional medical bills must be submitted within your spend down budget period.

What is considered proof of a bill? What information should my bills have?

To qualify for Medicaid under spend down, you must submit proof of your medical or remedial bills to the ESA case worker. Your proof can be bills, receipts, cancelled checks, money orders or other statements from your doctor, hospital, clinic, drugstore or others who have given you medical care. To be considered as acceptable proof, your bill or receipt must show:

- The type of medical care, drugs or supplies
- Who gave the care
- Who got the care
- The date the care was given
- The cost or amount you have to pay

- The date of the bill or receipt

If I met my spend down, when will my Medicaid start?

Your Medicaid eligibility will start at the beginning of the month when you meet your spend down amount and will end at the end of the month of the spend down budget period. For example, if your spend down budget period is from January to June and you met your spend down amount on March 10th, your Medicaid eligibility is from March 1st to June 30th. Since you met your first spend down budget period, the ESA case worker will place you on a second spend down budget period from July to December without submitting a new application. You have to submit a new application after the second spend down budget period whether or not you meet your spend down amount.

Can I get my medical and remedial bills paid after I qualify for Medicaid?

No. Medicaid will not pay the bills used to meet your spend down amount. You are responsible for payment of those bills.

How do I get more information on spend down?

If you have any questions about the spend down policy, you can contact the Department of Health Care Finance, Division of Eligibility Policy by email at www.DCMedicaidquestions@dc.gov.



DISTRICT OF COLUMBIA *SERVICES MY WAY* PROGRAM

A Medicaid Participant-Directed Service Program

SERVICES *MY WAY*

WHAT IS THE *SERVICES MY WAY* PROGRAM?

The *Services My Way* Program offers District residents enrolled in the Medicaid Elderly and Persons with Physical Disabilities (EPD) Waiver more choice, control, and flexibility over the services they receive by offering participant directed services (PDS) as an alternative to traditional personal care services. The *Services My Way* Program invites you to be an active participant in deciding how you receive your services while living in your home and community.

WHO IS ELIGIBLE?

The *Services My Way* Program is for District of Columbia residents who are enrolled in the Medicaid EPD Waiver Program and live in their natural home.

HOW DOES THE *SERVICES MY WAY* PROGRAM WORK?

- You talk to your EPD Waiver Case Manager to learn more about the Program and your role and responsibilities and develop a person-centered Individual Service Plan (ISP) that includes PDS.
- You confirm that you want to enroll in the Program by completing a *Participant Consent Form* and submitting it to your Support Broker.
- You agree to follow all program rules.
- You receive orientation and training on using PDS and being the employer of your participant directed workers.
- You develop a PDS budget and decide how to spend it with assistance from your support broker.
- You, or your authorized representative, hire, train and manage your participant-directed workers and purchase approved individual-directed goods and services related to your needs.
- A designee of DHCF will issue payroll and payments for your approved PDS and provide other supports.

For more information about the *Services My Way* Program, please call the Program Coordinator at:
202.698.2000
ServicesMyWay@dc.gov

THE SERVICES MY WAY PROGRAM IS ALL ABOUT *your choices.*

The *Services My Way* Program is administered by the District of Columbia's Department of Health Care Finance.
441 4th Street, NW, 10th Floor; Washington, DC 20001

DHCF The Department of Health Care Finance INVESTING IN YOUR HEALTH

WE ARE WASHINGTON DC GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR