GOVERNMENT OF THE DISTRICT OF COLUMBIA

Supplemental Questions for Medical Assistance

The supplemental questions for medical assistance needs to be completed, signed, and submitted along with any additional supporting documents mentioned in your cover letter.

Ways to Submit Your Supplemental Form:

- Fax your supplemental form and all supporting documents to (202)688-1281
- Send by postal mail to:

  Department of Human Services
  Economic Security Administration
  Central Processing Unit
  645 H Street Ne, 4th Flr
  Washington, DC 20001
- Visit a Service Center in-person

Economic Security Administration Service Centers

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

Congress Heights Service Center
4049 South Capitol Street, SW
Washington, DC 20032
Phone: (202) 645-4525
Fax (202) 645-4524

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

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

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

For information or help completing an application please call (202) 698-4746 or visit a service center. If you are hearing impaired and need assistance with this notice please contact the DC Office of the Ombudsman at (202) 724-7491 TTY: 711.

Personal Information				
First Name:	**Last Name:**	**SSN (if available):**	**DOB:**	**Phone:**

1. Is anyone in your household pregnant? (Including self) Yes ☐ No ☐ Expected due date:_____	2. Have you had a child within the last 60 days? Yes ☐ No ☐ Child's Date of Birth: _____

3. If you aren't a U.S. citizen or U.S. national, but have an eligible immigration status; please complete the fields below.

Immigration Document Type:

_____

(ex. I-551, I-571, Arrival/Departure Record I-94)

Document ID Number:

4. Does anyone have Medicare, TRICARE or any other insurance (private insurance, etc.)? Yes ☐ No ☐ *If yes, please provide the policy holder name, insurer, and policy number.*	Person Name:	Person Name:
	Insurance Name or Type:	Insurance Name or Type:
	Policy Number:	Policy Number:

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

Sign this application. The person who filled out this supplemental form should sign below. If you are an authorized representative, you may sign here.

I am signing this application under penalty of perjury which means I have provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.

Signature_____ Date_____