DC Healthy Families

Because some of the best things in life are free.

Application for Health Insurance

For questions and assistance, call:

1-888-557-1116
TDD/TTY 1-877-6-PARENT

www.dchealth.dc.gov/services/healthy_families/index.shtm

Para las aplicaciones del seguro médico en español, llama al 1-888-557-1116.

Để lấy đơn xin bảo hiểm sức khỏe bằng tiếng Việt, xin gọi số 1-888-557-1116

Afin de se procurer des formulaires d'assurance-maladie en français, faites le 1-888-557-1116.

RESPONSIBILITIES

I understand that I may be asked to provide proof of the information that I have given in this Application. My signature on this Application grants permission to verify this information. If I refuse to provide the proof or if I refuse to give my permission, I understand that my Application for DC Healthy Families (Medicaid or Medical Assistance) may be denied.

I understand that I must give complete, accurate, and truthful information. If I refuse to give needed information, my eligibility for assistance may be denied. I understand that by signing this application, I am accepting responsibility for this application. If I knowingly give false, incorrect or incomplete information, or fail to report changes promptly, I could lose my benefits and be prosecuted for fraud, fined and/or imprisoned. I understand that the maximum penalty for Medicaid fraud is a fine of $1,000 and a jail sentence of three years.

I understand that as a condition of eligibility, I may be asked to apply for and cooperate with the Income Maintenance Administration in obtaining a Social Security Number, alien/verification or taxpayer identification number for myself and the persons for whom I am applying for assistance. This information will be used to verify benefits, and make required program changes. Any difference between the information provided and these records will be investigated and may require a home visit. Information from these records may affect my eligibility and the persons for whom I am applying.

I understand that the Department of Human Services (DHS) will verify some of the information that I have given by using computer-generated matching systems. My permission is not required for this. During this process, the Department will take care to protect my rights to confidentiality.

I understand that I must report any changes in my situation that might affect my eligibility and I agree to report such changes no later than 10 days after the changes occur. I also understand that each year DHS will send to me recertification forms, which I must complete, sign and return in a timely manner.

I understand that my case may be chosen for a Quality Control and/or Program Integrity review by the Medical Assistance Program or other governmental agencies. This is a detailed review of all the information in the case record and may include some personal interviews and medical records review. If my case is chosen, I agree to cooperate fully with the state or federal representatives. If I do not cooperate, my Medical Assistance may be terminated.

I understand that by signing this application I agree to cooperate fully with the D.C. Child Support Enforcement Division in establishing paternity and obtaining child and medical support, as required by law. I also understand that I may apply for an exception to this requirement if I have a good reason. An example of a good reason not to cooperate is fear of physical, sexual or emotional harm to myself or my children. Additionally, I understand that if I am pregnant or if I am only applying on behalf of my children, my eligibility or my children's eligibility will not be affected if I do not choose to cooperate.

I understand that if I am eligible for Medical Assistance I am required to use all other available resources such as my health insurance, Medicare, Blue Cross/Blue Shield, veterans' insurance, and veterans' medical facilities before I use my Medical Assistance coverage.

I understand that by signing this application I am assigning to the Department of Health ("DOH") the right to any third party payment or health insurance benefits, for all or part of my medical expenses, that have been incurred by DOH for care and treatment that has been provided or paid for as medical care assistance. Furthermore, if I institute a legal proceeding against or enter into settlement negotiations with a third party, I must provide within 20 calendar days, written notice of the action either by personal services or certified mail to the Medical Assistance Administration, Third Party Liability Section, 33 N Street, N.E., Washington, DC 20002.

RIGHTS

I understand that under federal law, an eligibility determination for receipt of medical benefits will be made within 45 days.

I understand that if I am a DC Healthy Families (Medicaid) recipient and give birth, my baby will receive medical benefits for one year, as long as the infant continues to live with me, and we are residents of the District of Columbia. After one year, the baby may continue to be eligible after an eligibility review.

I understand that if I believe I have been discriminated against because of my race, color, national origin, mental or physical handicap, or any other reason, I may file a complaint within 180 days to the D.C. Department of Human Services.

I understand that if I am dissatisfied with any action or lack of action by the Department of Human Services ("DHS") and/or the Department of Health ("DOH"), I may ask for a fair hearing by calling the Office of Fair Hearings at (202) 724-5432.

I understand that if I have been on Medical Assistance any time since March 20, 1990, I may be entitled to repayment for any money spent for drug prescriptions, doctor visits or hospitalizations. For more information, I can call the Medicaid Recipient Claims Research Team of the Medical Assistance Administration at (202) 727-0725 or Terris, Pravlik & Wagner at (202) 682-0578.

EPSDT/HEALTHCHECK PROGRAM

The Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT or "HealthCheck") provides free check-ups and treatment to Medicaid eligible and/or DC Healthy Families eligible children under age 21. The HealthCheck Program is very important and can be obtained from any doctor or clinic participating in the Medicaid program. For more information about the HealthCheck program, call (202) 442-5988.

PLEASE DETACH AND KEEP THIS PAGE. MAIL THE COMPLETED AND SIGNED APPLICATION, TOGETHER WITH PROOF OF YOUR INCOME, DEPENDENT CARE EXPENSES AND THAT YOU LIVE IN THE DISTRICT OF COLUMBIA, TO:

DC Healthy Families
ATTN: DC Healthy Families Unit
645 H Street, N.E
Washington, DC 20002

INSTRUCTIONS FOR COMPLETING THE DC HEALTHY FAMILIES APPLICATION

MAKE SURE YOU READ THESE INSTRUCTIONS CAREFULLY BEFORE COMPLETING THE APPLICATION

GENERAL INFORMATION

If you are an adult in a family with one or more children under the age of 19, you may use this Application to **apply** for **DC Healthy Families (Medicaid or Medical Assistance).**

WHO SHOULD NOT COMPLETE APPLICATION

If you fall under any of the following categories, you should not use this "Short Form" Application to apply for Medical Assistance, but rather the longer "Combined Application form".

- Childless adults (who are not pregnant)
- Elderly and disabled individuals
- Medicare beneficiaries

Additionally, you must use the longer Combined Application form if you wish to apply for TANF and/or Food Stamps. Please call (202) 724-5506 to get the longer Combined Application form.

COMPLETING THIS APPLICATION

If you need help completing this Application, a friend, relative or other individual may help you, or you can call 1-888-557-1116. If you are completing this Application for someone else, answer each question as if you were that person. If you need to change your answer, write the correct information nearby and put your initials and the date next to the change. If you are applying for DC Healthy Families, are under 21 years of age and live with your parent or legal guardian, they must sign the Application on your behalf.

REQUIRED SUPPORTING DOCUMENTATION

This Application **must** be accompanied by the following supporting documentation for **each** person for whom you are applying. (Attach **copies only.**)

Proof of residence in the District of Columbia (such as a utility or telephone bill with your address, copy of a lease, a rent receipt, a valid District of Columbia drivers license, a voter registration card, or a copy of your income tax return or Earned Income Tax Credit form).

Proof of earned income for one month prior to the date of application. For example, if you are paid:

- weekly you will need your four most recent pay stubs
- bi-weekly you will need your two most recent pay stubs
- monthly you will need your most recent pay stub

Proof of Social Security Number (SSN) or proof that the SSN has been applied for. For example, a copy of:

- Social Security Card
- Social Security Benefits documents showing SSN
- Other federal or state benefits statement showing SSN
- DC Driver's License showing SSN
- Tax return (most recent DC tax return)
- Application for SSN (SS-5)

Please call (202) 724-5506 if you need assistance in applying for a Social Security number.

Proof of dependent care expense for one month (such as a canceled check, bill, statement or receipt from the provider showing who received the care, cost of care and the period during which care was provided). Dependent care expenses are what you pay to care for a child or an elderly or disabled adult who lives with you.

GENERAL INSTRUCTIONS

Please follow these instructions when completing this Application.

1. Please print all answers. Illegible responses will cause delay in processing your application.
2. If you are deaf, have access to TDD/TTY, and need help with completing this application call 1-877-6PARENT.
3. Attach additional sheets of paper if you need more space to complete any section of this Application.
4. Be sure to carefully read the section entitled *YOUR RESPONSIBILITIES AND RIGHTS* and sign the Application.

STEP-BY-STEP INSTRUCTIONS

PART I: APPLICATION FOR HEALTH INSURANCE

Question #1: If you are a parent, guardian, or grandparent you can apply for benefits on behalf of a child who is in your custody. If you are a parent, **legal** guardian, or grandparent you can apply for benefits on behalf of yourself.

Question #2: A **family unit** is defined as parent(s), spouses and/or legal guardian/s and their dependents who live with them and for whom they provide financial support. All members of the family unit count toward family size even if all family members are not applying for benefits. You do not need to provide the Social Security Number for any persons whom you are not applying for benefits. We do not share Social Security numbers with the Immigration and Naturalization Service (INS).

Please enter one of the codes below in the column titled "Race":

Code 1: White (Non-Hispanic Origin)
Code 2: Black (Non-Hispanic Origin)
Code 3: Asian -Pacific Islander
Code 4: American Indian or Alaskan Native
Code 5: Hispanic/Latino
Code 6: Other

Question #3: Gross income refers to the amount of income you make from employment **before** taxes are taken out. If you are self-employed and do not have a tax identification number, please provide a letter from individuals and/or companies for whom you work. You must also provide their address and phone number.

Question #4: Please provide information about income from all sources other than employment.

Question #5: Please provide information on monthly out-of-pocket dependent care expenses that you pay in order for you or anyone in your family unit to work. Please also provide me requested information about the care provider and proof of one month's expenses. (Providing this information may help your family qualify.)

Question #6: Retroactive coverage means that the program will pay your outstanding medical bills for up to three months prior to the date of application for insurance benefits under the DC Healthy Families program.

Question #7: Please provide this information for every child for whom you are seeking quick help with child support. No one is required to provide any information if they have a good reason. An example of a good reason is fear of physical, sexual or emotional harm to you or your children.

Question #8: Please provide this information about anyone for whom you are applying who has health insurance coverage. (Having health insurance does not prevent you from receiving DC Healthy Families.)

Question #9: Please provide this information for anyone for whom you are applying for coverage.

Question#10: This question is asked only for research purposes. Your answer to this question will not affect your eligibility determination.

PART 2: QUESTIONS FOR IMMIGRANTS

If you answered NO to Question 9 on Part I of this Application, you must complete Part 2.

All requested information must be provided, including alien number (if applicable). It is not necessary to attach supporting documentation, but the information provided on the form will be verified. All information regarding immigration status will be kept confidential.

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1-888-557-1116

PART 1: APPLICATION FOR HEALTH INSURANCE

YOU MUST READ ATTACHED INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION

This Application is a statement *of facts about you and the people in your family who need health insurance. You must answer all questions before we will know if we can help you. If you need help completing this form, please call 1-888-557-1116. Please print.*

I received help filling out this application from: ❑ Hotline Staff ❑ Community Worker ❑ I Did It Myself ❑ Other (identify) _____

Were you satisfied with the help you received? ❑ Yes ❑ No

1. Parent or caretaker filling out this Application

(HOH) Last Name	First Name	Middle		
Address Where You Live	Street	City	State	ZIP
Mailing Address (if different)	Street	City	State	ZIP
Home Phone	Work Phone	Phone for Messages		

tear here

2. List all the members of your family unit. (See #2 on the instruction page.) (Please list primary applicant first.)

Name (Last, First, Middle)	Date of Birth	Sex (M/F)	Race (Code) (Optional)	Pregnant (Y/N)	Relationship to You	Relationship to Your Spouse	Applying for Benefits (Y/N)	Social Security Number (**only** for those for whom you want benefits) If the person for whom you want benefits does not have a Social Security Number place an X in the box

3. List all pre-tax Income received from employment for yourself and other adult members of your family unit (including self-employment).

Your Gross Income	Parent or Other Adult Family Member's Gross Income
Amount earned: $_____ ❑ No Income **(circle one)** Hourly Weekly Bi-Weekly Monthly Yearly Hours worked each week:_____	Amount earned: $_____ ❑ No Income **(circle one)** Hourly Weekly Bi-Weekly Monthly Yearly Hours worked each week:_____
Employer Name and Phone Number: If self employed, check here and provide your tax identification number. **If you do not have a tax identification number, write a statement describing your employment and income and include it with your application.** TAX ID #_____ Self-Employed ❑	Employer Name and Phone Number: If self employed, check here and provide your tax identification number. **If you do not have a tax identification number, write a statement describing your employment and income and include it with your application.** TAX ID #_____ Self-Employed ❑

4. List all other income received by members of your family unit (Including income for yourself, your spouse and your children).

Source of income	Who Receives This Income?	Amount of Income	How Often is the Income Received?
Child Support			
Alimony			
Social Security Benefits			
SSI			
Worker's Compensation			
Other (please explain)			

5. If you or someone in your family unit pays for dependent care (child care or for care of an adult who lives with you who cannot care for himself) in order to work, please give us the following information. (Providing this information may help your family qualify.)

Name of Person Who Works	Person(s) Cared For	Monthly Amount Paid?	Name of Dependent Care Provider	Telephone Number of Dependent Care Provider

6. Does anyone for whom you are applying have any paid or unpaid Medical bills (e.g. hospital bills, doctor bills and prescription drugs) from the past 3 months? If YES, we may be able to help you pay these bills. Contact the DC Healthy Families Unit at 202-698-4200. **(circle one) YES NO**

7. We can assist you in establishing paternity and obtaining child support for the children in your care. Do you want these services quickly? **(circle one) YES NO**

For those answering YES: If you know the name of the absent parent, please provide it below. Please also provide as much contact information as you know.

Child's Name (Last, First, Middle)	Absent or Deceased Parent's Name	Absent (A) or Deceased (D)?	Date of Death	Parent's SSN	Last Known Address	Sex (M/F)

8. Does anyone for whom you are applying for benefits currently have other health Insurance (including Medicare)? **(circle one)**
NOTE: If you have health insurance, you can still receive DC Healthy Families. **YES NO**
If YES, please provide the following information:

Name(s) of Applicants With Health Insurance	Name of Policyholder	Name and Address of Insurance Company	Group Number	Policy/Cert/SSN

9. Is everyone for whom you are applying a U.S. citizen? **(circle one)**
If you answered "NO" you MUST complete Part 2 of this application. **YES NO**

10. Would you prefer to receive correspondence in Spanish? ❑ YES, I would prefer to receive notices in Spanish ❑ NO

By my signature below, I certify under penalty of perjury that the information I have provided in this Application is true, complete, and correct to the best of my knowledge and belief. I have read and understand the Rights and Responsibilities and the Medicaid Well-Child Program information printed on Page 3 of this Application.

Signature of Applicant_____ **Date:**_____
(LEGAL SIGNATURE OR "X" MARK)

Signature of Witness to an "X" Mark_____ **Date:**_____
(A witness is required only if the Applicant makes an "X" mark instead of signing his or her name.)

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PART 2: APPLICATION FOR HEALTH INSURANCE

YOU MUST READ ATTACHED INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION

The information that you give us will be kept confidential as required by state and federal law.

Leave this page blank if you answered YES to question 9 on Part 1 of this Application.
Fill out this page if you answered NO to question 9 on Part 1 of this Application.

Immigration Status: Complete the chart below for each family member who is not a U.S. citizen and who is applying for benefits. Your identification with one or more immigration status codes is neither a guarantee of eligibility or indication that you will be denied insurance benefits. For certain status codes, we may contact you to get more information. List only all statuses that have applied to each person who is applying since the person entered the U.S.

Use the numbers below to describe your status:

1. Legal permanent residents (LPR)
2. Refugee
3. Asylee
4. Cuban/Haitian Entrant
5. Person who has had his/or her deportation (removal) withheld
6. Parolee admitted for at least one year
7. Alien who has been present since before April 1, 1980, as “conditional entrants"
8. A person on active duty or a veteran of the U.S. Armed Forces with an honorable discharge
9. Spouse, widow or dependent of someone on active duty or a veteran of the U.S. Armed Forces with an honorable discharge
10. A victim of domestic violence, or a child of such a victim, who is no longer living with the abuser
11. A victim of a severe form of trafficking in human persons as certified by the Office of Refugee Resettlement
12. Other (check here) ❑

Complete the following information ONLY for persons for whom you are applying for benefits and who are not citizens of the U.S. (attach extra page if necessary).
If you checked status #12 (Other) write #12 in the Status Number(s) box.

Name (Last, First, Middle)	Status Number(s) (List all that apply)	U.S. Entry Date	Date Status Awarded	Alien #	Verification # OFFICE USE ONLY