Applying to the EPD Waiver Program

If you are ready to apply to the EPD Waiver Program, you may do so by following the instructions in this packet. Remember, we are here to help you along the way. If you would like assistance with application process, please call us at 202-724-5626.

Step 1: Review and Complete Beneficiary Freedom of Choice and Rights and Responsibilities Form

Your signature on this form tells us that you understand your right to choose between nursing facility care and home- and community-based services (the EPD Waiver Program). This also includes your bill of rights and responsibilities as a home and community-based services customer.

Document:

1) Waiver Beneficiary Freedom of Choice Form

Step 2: Review Case Management Options and Complete Attestation Form

If you are approved for the EPD Waiver Program, you will be assigned a case manager who will work closely with you to develop your plan for the services and supports in your home. Your case manager will be your primary contact when it comes to your ongoing care, so it's important that you have a say in who you work with. You will choose from this list of approved case management agencies.

Documents:

1) List of EPD Waiver Case Management Agencies
3) Case Management Attestation Form

Step 3: Complete the EPD Waiver Application and Gather Supporting Documents

This is your application to the EPD Waiver program. You will need to also provide supporting documentation with your application. Remember to send copies of your documentation, and not the originals. You will find a list of documents you may need to provide on page 5 of the application.

Document:

1) District of Columbia Long-Term Care/Waiver Medicaid Application

Step 4: Have a DC Medicaid Provider Establish Your Level of Care

Your Medicaid provider will complete this form to verify the level of assistance you will require with your daily activities.

Document:

1) Level of Care Form

Step 5: Submit Forms, Application and Supporting Documentation to DCOA

You may submit your completed application packet and supporting documentation in person, by mail, email or fax.

In Person:

8:30am – 5:00pm, Monday - Friday
500 K Street NE,
Washington DC, 20002

By Mail:

DC Office on Aging
Attn: Medicaid Enrollment Unit
500 K Street NE
Washington DC, 20002

* To protect your personal health information, we suggest that you send your packet using U.S. Postal Service certified mail, which requires receipt confirmation.

Electronically:

E-mail: EPDwaiver.dcoa@dc.gov
Fax: 202-724-2008

Step 1: Review and Complete Beneficiary Freedom of Choice and Rights and Responsibilities Form

Document:

1. **Waiver Beneficiary Freedom of Choice Form and Procedure for Assuring Beneficiary Freedom of Choice**
   Directions: Complete the highlighted areas and select "Home and Community-Based Services" in Section II.
   Review your Bill of Rights and Responsibility and sign where highlighted.

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

Step 2: Review Case Management Options and Complete Attestation Form

Documents:

1. **List of EPD Case Management Providers**
   Directions: Review this list of approved EPD Waiver Case Management Agency providers and identify your top three (3) choices.

2. **Medicaid Case Management Beneficiary Freedom of Choice Attestation**
   Directions: Use this form to note your top three choices for EPD wavier case management. Complete the highlighted areas.

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
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 Ext. 6	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 jtlocker@annahealthcare.com

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

PROVIDER	Administrator	ADDRESS	PHONE/FAX NUMBER	EMAIL ADDRESS
AUTUMN LEAF	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
FAMILY AND HEALTHCARE SOLUTIONS	Sylvie Fomundam Roger Momjah	6856 Eastern Ave., NW Suite 358 Washington, DC 20012	Phone: 202-621-7329 Fax: 202-621-7369 After hours: 202-621-7329	familyhealthcaresol@yahoo.com sylvie@familyhealthsolutions.org
FAMILY WELLNESS CENTER	Sharon Cyrus	2526 Pennsylvania Ave, SE Suite C, Washington, DC 20020	Phone: 202-748-5641 Fax: 202-748-5647 After hours: 202-621-7476	scyrus@thefwc.net Dbaylor@thefwc.net
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

Last Updated 2/28/17

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

PROVIDER	Administrator	ADDRESS	PHONE/FAX NUMBER	EMAIL ADDRESS
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
Premier Support Services	Barbara Awa	1629 K Street, NW Suite 300 Washington, DC 20006	Phone: 202 508-3651 443-802-1258 (c) Fax: 202-331-3759 E-Fax: 202-331-3653	Bawa@premierssinc.com
PRESTIGE HEALTHCARE ***NOT ACCEPTING NEW/TRANSFER BENEFICIARIES***	John Smith	145 Kennedy St. 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.	Sean Patterson	220 I Street NE Suite 285 Washington, DC 20002	Phone: 202- 548-0588 Fax: 202- 548-0589 After hours: 202- 548-0588	info@Progressivehealthdc.com Sean@Progressivehealthdc.com Denise@progressivehealthdc.com

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

PROVIDER	Administrator	ADDRESS	PHONE/FAX NUMBER	EMAIL ADDRESS
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	contact@ultimatehs.org Ewilliams@ultimatehomeservices.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
WASHINGTON HOSPITAL CENTER - MEDICAL HOUSE CALL PROGRAM	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 Deanna.y.cho@medstar.net

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

Last Updated 2/28/17

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

_____ _____

Step 3: Complete the EPD Waiver Application and Gather Supporting Documents

Document:

1. **Long Term Care Application:**
   Directions: Refer to the instructions in pages 1 – 5 of the application. Please complete all sections as they apply. Gather your supporting documentation (refer to page 5 for a list of all documentation that may be required), make copies and include with your completed application.

DISTRICT OF COLUMBIA LONG-TERM CARE/WAIVER MEDICAID APPLICATION

Instructions

This application is for individuals 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 an intermediate care facility for the Developmentally Disabled (ICF/DD) and the Home and Community-Based Services (HCBS) Waiver Program. ***Go to page 6 to start the application.***

The HCBS Waiver Program serves:

- *The Elderly and Individuals with Physical Disabilities (EPD), and*
- *Individuals with Intellectual or Developmental Disabilities (IDD).*

Program Overview

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

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/DD 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.

Rev. (December 2016)

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

This is NOT an application for Cash Assistance or Food Stamps. Applications for Cash Assistance and Food Stamps are available online at *http://dcdhs.dc.gov/publication/combined-application-benefits*, at the Department of Human Services Economic Security Administration Service Centers located at:

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

Congress Heights Service Center
4001 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,

Or call (202)727-5355 to have one mailed to you. If you are interested in obtaining Food Stamps or are concerned about food security, you are encouraged to submit a Food Stamp application to the Department of Human Services Economic Security Administration.

If you want to apply for EPD services, you must first contact the DC Office of Aging, 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 on 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 application.

When filling out the application, 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 Application" on **page 5**.

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 application 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 Long-Term Care Medicaid Application
- 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 Long-Term Care/Waiver Medicaid Application
- A completed Form 1728 Level of Care

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

- A completed and signed Long-Term Care/Waiver Medicaid Application
- A completed and signed Start of Care Form
- For nursing facility, a completed and approved LOC by DHCF or its agent
- Please Note: For ICF/DD facility, a completed and approved Form 1728

Please note that the clinician (Doctor or APRN) that completes your LOC Form MUST be a Medicaid provider.

If the clinician who completes your LOC or Form 1728 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 streamline application at https://www.dc-medicaid.com/dcwebal/documentInformation/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 or 1728, 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 the ESA, the application will not be registered and processed. ESA will only begin processing the application when all of the required documentation is signed and completed and submitted to ESA.

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

To start the application, go to page 6.

Checklist of Needed Documentation for your Long-Term Care/Waiver Application

You may need to provide the item(s) listed below to process your application. Do not send originals; send in copies of the documentation with your application. In some cases, you may need to provide additional documentation. If additional documents are needed they will be requested and you will be given additional time to submit these forms.

- ☐ Current bank statements on all accounts owned and co-owned (e.g., checking, savings, credit union, etc.)
- ☐ Power of Attorney or Legal Guardianship
- ☐ Current statement of retirement accounts (e.g., IRA, Keogh Accounts, etc.)
- ☐ Current financial statements on all accounts owned and co-owned
    - ☐ Stocks
    - ☐ Bonds
    - ☐ Money market accounts
    - ☐ Certificate of deposits
    - ☐ Mutual funds
- ☐ Face and current cash value of life insurance policies
- ☐ Current statements of burial accounts
- ☐ Burial plots certificate/deed
- ☐ Life estates deeds
- ☐ Mortgage notes and mortgage deeds
- ☐ Health insurance premium amounts (copy of the bill)
- ☐ Current gross monthly income (award letters) from all sources including:
    - ☐ VA benefits
    - ☐ Railroad retirement
    - ☐ Pensions
    - ☐ Annuities

*** Current documentation cannot be older than 30 days from the month of application. ***

If you want to find out if your spouse can keep some of your monthly income, you must provide

- ☐ Spouse's monthly gross monthly income
- ☐ Rent or Mortgage statement, condo fee statement, property tax bill
- ☐ Utility bills (e.g., electric, gas, etc.)

Additional documentation for applicants who do not have Active DC Medicaid or QMB coverage

- ☐ Proof of District of Columbia residency (e.g. DC driver's license, lease agreement, rent receipt, written statement from the landlord, utility bill)
- ☐ Proof of Identity (e.g. DC driver's license or any government issued photo ID)

Date Application Received by ESA:		*Stamp Required
Worker Name:		
Case Number:		

* ALL MUST BE FIELDS ANSWERED

Initial Application ☐ **Recertification** ☐

Section 1: Application Information	
I am applying for Long-Term Care Medicaid: Institutional Care ☐ Nursing Facility ☐ Do you need Nursing Home Care for less than six months? ☐ Do you need Nursing Home Care for more than six months? ☐ 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

Section 2: Applicant Information ***Please tell us about yourself.***		
First Name:	Middle Name:	Last Name, Suffix (Jr, Sr. etc.):
Maiden Name:		
Social Security Number:	Date of Birth: (Month, Day, Year)	Gender: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
Voluntary Questions:		
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino		
Race: ☐ Black/ African American ☐ Asian ☐ American Indian or Alaskan Native ☐ White ☐ Native Hawaiian or Other Pacific Islander		
What is your primary Language?	Do you need an interpreter? ☐ YES ☐ NO	

Section 2: Applicant Information (Continued) ***Please tell us about yourself.***
Are you a United States citizen or U.S. national? *If yes, continue to Section 3. ☐ YES ☐ NO
If you aren't a US citizen or US nation, do you have eligible immigration status? (**See Appendix A, page 19**) ☐ YES ☐ NO
If yes, then fill in your document type and ID number below. a. Immigration document type: _____ b. Document ID Number _____ c. Have you lived in the U.S. since 1996? ☐ YES ☐ NO d. Are you a veteran or an active duty member of the U.S. military? ☐ YES ☐ NO

Section 3: Applicants' Address ***Please tell us your current and/or prior address.***	
What is your home address or the address of your nursing facility? Street: City: State: Zip:	
Contact Telephone Number:	Is this your mailing address? ☐ YES ☐ NO (If no, provide your mailing address information below)
What is your mailing address? Street: City: State: Zip:	
Are you homeless? ☐ YES ☐ NO	Do you plan to stay in the District of Columbia? ☐ YES ☐ NO
If you are in a nursing facility, what is your previous address prior to entering the facility? Street: City: State: Zip:	
Did you or your spouse own this home? ☐ YES ☐ NO	

Section 4: Benefit Status ***Please tell us about any medical assistance you receive.***
Are you currently receiving Medicaid from the District of Columbia? ☐ YES ☐ NO
If yes, provide your Medicaid ID number:
Are you receiving Medicaid (Medical Assistance) benefits from another State? ☐ YES ☐ NO
If yes, list the state:

Section 4A: Medical Expenses
Do you have any paid and/or unpaid medical bills from the past 3 months? ☐ YES ☐ NO
If yes, do you need Medicaid for medical bills incurred in the past 3 months? ☐ YES ☐ NO
If yes, do you want to apply for Retroactive Medicaid? ☐ YES ☐ NO
* If yes, you need to submit an application for Retroactive Medicaid and provide copies of the bills with your application to the Economic Security Administration (ESA). Retroactive Medicaid is a separate application and evaluation. For more information, review Attachment A: Information on Past Medical Bills/Expenses.

Section 5: Spouse Information ***If married, please tell us about your spouse. Skip this section if you are not married.***		
First Name:	Middle Name:	Last Name, Suffix (Jr, Sr. etc.):
Maiden Name:		
Spouse's Social Security Number: Note: You do not need to provide your Spouse's SSN if she/he is not applying for Medicaid. We may need your spouse's SSN to verify their resources and income		
Spouse's Address: Street: City: State: Zip:		
Do you or your spouse own this home? ☐ YES ☐ NO		

Section 6: Authorized Representative ***If you wish to choose someone to act on your behalf, please tell us about the individual.***		
First Name:	Middle Name:	Last Name, Suffix (Jr, Sr. etc.):
Other Name:		
Mailing Address: Street: City: State: Zip:		
Contact Telephone Number:	What is the authorized representative's relationship to you?	

Section 7: Veteran's Information ***Please complete this section if you are a veteran, a disabled widow(er), or a disabled child of a deceased veteran.*** **(Provide a copy of your military service card.)**			
Veteran's Name:	Relationship:	Veteran's Status:	Military Service Number:

Section 8: Medical Insurance ***Please complete this section if you are insured. If you have more than one, use Section 19 on page 16 or use additional sheets.***		
Policy Holder's Name:	Policy Number:	Group Number:
Relationship to Policy Holder:	Policy Effective Date:	
Insurance Company Name:		
Address: Street: City: State: Zip:		

Section 9: Income of Applicant and/or Spouse

Please tell us about any income or benefits that you and/or your spouse are currently receiving, have applied for, or have been denied. Check all that apply. If you check a benefit or income, complete the details in the boxes 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	Person(s) 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	

Section 10: Income from Working ***Please tell us about any income/money you or your spouse is currently receiving from working, including any sick leave payments.***	
Employer Name:	Type of Job:
Employer Address: Street: City: State: Zip:	
Start Date:	End Date (if you stopped working):
Gross Wages per Pay Period, include tips and commissions: $ per	
Hours of work per pay period:	How often do you get paid? ☐ Weekly ☐ Biweekly ☐ Twice a Month ☐ Monthly

Section 11: Assets ***Please tell us about your assets as of the first of the month. Check all that apply. Then complete the chart for each asset on the list that you and your spouse own individually, jointly, or with other persons. Assets added under "other" should be included in the chart in Section 12.***	
☐ Cash on hand ☐ Checking account ☐ Savings account ☐ Credit Union Account ☐ Trust Account ☐ IRA or Keogh Account	☐ Other Retirement Account ☐ Stocks and Bonds ☐ Treasury Notes or Other Notes ☐ Annuity ☐ Patient Fund Account ☐ Funds or Deposits Held in a Continuing Care Retirement Community ☐ Other (describe):

Section 11: Assets (Continued)				
Asset Type	**Owner(s)**	**Amount/Value**	**Account Number**	**Institution Name**
		$		
		$		
		$		
		$		
		$		
		$		

Section 12: Other Assets ***Please tell us about other assets that you or your spouse own individually, jointly, and with other individual(s). Include vehicles, recreational vehicles, home property, land and other personal property.***			
Asset Type	**Current Fair Market Value**	**Current Amount owed, if any**	**Owner(s)**
		$	
		$	
		$	

☐ **Note** – If you need Additional space to list assets list them in section 19.

Section 13: Transfer of Assets ***Please tell us about assets that you sold, traded, gifted, or disposed of for the last 60 months (5 years). Include personal property, real property (home), motor vehicles (cars, trucks), stocks, bonds, cash, or any other assets.***				
Did you or your spouse sold, traded, gifted, or disposed of any assets in the last 5 years? ☐ YES ☐ NO If yes, complete the boxes below.				
Transfer Date	Type of Asset	Value of Asset at the Time of Transfer	Who received the Asset and Reason for the Transfer	Amount You Received
		$		$
		$		$
		$		$

Section 14: Life Insurance, Long-Term Care (LTC) Insurance, and Funeral Plans ***Please tell us about all the policies you owned regardless of who pays the premium.***					
Do you or your spouse have any life insurance policies, LTC insurance, or pre-paid burial funds? ☐ YES ☐ NO If yes, complete the boxes below.					
Original Face Value or Value of the Plan	Cash Value	Type of Plan	Policy Number or Account Number	Policy Owner(s)	Company, Funeral Home or Bank Name
$	$	☐ Life Insurance ☐ LTC Insurance ☐ Burial Plan			
$	$	☐ Life Insurance • LTC Insurance • Burial Plan			

☐ **Note** – If you need additional space to list assets list them in section 19.

Section 15: Spousal Impoverishment ***If you have a spouse, please complete the section below. List all the assets you and your spouse owned individually or jointly and with other individual(s).***	
☐ Cash on Hand ☐ Checking Account ☐ Savings Account ☐ Credit Union Account ☐ Retirement Account	☐ Annuity ☐ Trust Funds ☐ Stocks, Bonds ☐ Other:

Asset Type	Owner(s)	Amount/Value	Account Number	Institution Name
		$		
		$		
		$		

Section 16: Potential Assets or Income ***Please tell us about any accident settlement, trust fund, inheritance, or any money, property, or assistance that you expect to receive.***	
Do you or your spouse expect to receive any assets, income, or other money? ☐ YES ☐ NO If yes, complete the boxes below.	
Asset Type(s)	Lawyer Name (if any)
Anticipated Date of Receipt	Lawyer Contact Number

Section 17: Residential, Spousal, and Dependent Allowance

You may qualify for certain allowances that can be deducted from your income. You may qualify for allowances if you are in a nursing facility, if you have any dependent, and if you need money to help your spouse. If you would like to be evaluated for these allowances, please complete the section below.

Have you or your spouse been in a nursing facility? ☐ YES ☐ NO If so, who? Me ☐ My Spouse ☐ Both ☐
If yes, provide the following:

Name of the Facility:	Date Entered:

Is there a spouse, child under 21, or any disabled child in the home? ☐ YES ☐ NO
If yes, complete the section below.

Name	Relationship to Applicant	Age	Gross Monthly Income (if any)	Type of Income (if any)	Value of Asset (if any)	Asset Type (if any)

For nursing facility applicants: If you intend to return home within six months and if there is no spouse, child under 21, or a disabled child in the home, complete the section below.

Rent/Mortgage $	Utilities $	Heat (if separate) $
Property Taxes $	Condo Fees $	Home Insurance $
Other Shelter Costs (Specify) $		

Name of Immigrant:	Alien ID#:
Current Status:	Date You Moved to the U.S.:
Were you ever a Refugee or Asylee? ☐ YES ☐ NO	Are you Cuban/Haitian? ☐ YES ☐ NO

Did you move to the United States before August 22, 1996? ☐ YES ☐ NO

For Lawful Permanent Residents (LPRs) only:

Do you have a sponsor? ☐ YES ☐ NO

Have you, your spouse, and/or sponsor ever worked in the U.S.? ☐ YES ☐ NO

Section 18: For Immigrants (Non-Citizens) Applying for Benefits ***Many immigrants are eligible for benefits. For any non-citizen applying for benefits, please provide the immigration information below. We use this information for the purpose of determining your eligibility for Medicaid.***	
Please use the categories for "Current Status" in the table below:	
• Lawful Permanent Resident (LPR) • Refugee or Asylee • Cuban or Haitian entrant • Person who has been granted withholding of deportation (removal) • Parolee admitted for at least on year • Alien who has been present before April 1, 1980 as a "Conditional Entrant" • Hmong/Laotian • Person on active duty in U.S. Armed Forces (or veteran)	• Spouse, widow, or dependent of an American Soldier or veteran • Victim of domestic violence • Victim of a severe form of human trafficking • Native American/Inuit born outside of the United States • Amerasians who came to the U.S. due to the Vietnam War • Other (your status does not match one of those listed above)
Name of Immigrant:	Alien ID#:
Current Status:	Date You Moved to the U.S.:
Were you ever a Refugee or Asylee? ☐ YES ☐ NO	Are you Cuban/Haitian? ☐ YES ☐ NO
Did you move to the United States before August 22, 1996? ☐ YES ☐ NO	
For Lawful Permanent Residents (LPRs) only:	
Do you have a sponsor? ☐YES ☐NO	
Have you, your spouse, and/or sponsor ever worked in the U.S.? ☐ YES ☐ NO	

Section 19: Additional Information ***Use this area for any additional information or any other items that you would like us to know. You may attach additional sheets, if needed.***

Section 20: Signature	
▪ By signing below, I give my permission to Department of Human Services (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 the Notice of My Rights and Responsibilities as outlined in Appendix C of the application. 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 and will become 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 LTC benefits and agrees to the conditions above. **<u>Nursing Facility and Intermediate Care Facility Applicants/Beneficiaries Only</u>** ▪ **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:
Authorized Representative:	Date:

Appendix A:

Eligible immigration status list:
Use this list to answer questions about eligible immigration status. If you see your status below, check the box that says "yes."

***Certain people with an employment authorization document*:**
- Registry applicants
- Order of supervision
- Applicant for Cancellation of Removal or Suspension of Deportation
- Applicant for Legalization under IRCA
- Applicant for Temporary Protected Status (TPS)
- Legalization under the LIFE Act

Applicant for:
- Special Immigrant Juvenile Status
- Adjustment to LPR Status with an approved visa petition
- Victim of trafficking visa
- Asylum who has either been granted employment authorization, OR is under 14 and has had an application for asylum pending for at least 180 days
- Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) who has either been granted employment authorization, OR is under 14 and has had an application for withholding of deportation or withholding removal under the immigration laws or under the CAT pending for at least 180 days
- Asylee
- Refugee
- Cuban/Haitian entrant
- Paroled into the U.S.
- Conditional entrant granted before 1980
- Battered spouse, child, or parent
- Individual with non-immigrant status (including worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS)
- Lawful permanent resident (LPR/Green Card holder)
- Deferred Action Status (Deferred Action for Childhood Arrivals (DACA) isn't an eligible immigration status for applying for health coverage)
- Lawful temporary resident
- Granted an administrative order stay of removal by the Department of Homeland Security (DHS)
- Member of a federally recognized Indian tribe or American Indian born in Canada
- Resident of American Samoa

• Victim of trafficking and his or her spouse, child, sibling, or parent
• Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
• Deferred Enforced Departure (DED)

Immigration status and document types:
If you're an eligible non-citizen applying for health coverage, list your immigration document. See the list below for some common document types. If the document you have isn't listed, you can still write its name.

IF YOU HAVE:	LIST THESE FOR THE DOCUMENT ID:
Permanent Resident Card, "Green Card" (I-551)	• Alien registration number • Card number
Reentry Permit (I-327)	• Alien registration number
Refugee Travel Document (I-571)	• Alien registration number
Employment Authorization Card (I-766)	• Alien registration number • Card number • Expiration date • Category code
Machine Readable Immigrant Visa (with temporary I-551 language)	• Alien registration number • Passport number
Temporary I-551 Stamp (on passport or 1-94/1-94A)	• Alien registration number
Arrival/Departure Record (I-94/I-94A)	• I-94 number
Arrival/Departure Record in foreign passport (I-94)	• I-94 number • Passport number • Expiration date • Country of issuance
Foreign passport	• Passport number • Expiration date • Country of issuance
Certificate of Eligibility for Nonimmigrant Student Status (I-20)	• SEVIS ID
Certificate of Eligibility for Exchange Visitor Status (DS2019)	• SEVIS ID
Notice of Action (I-797)	• Alien registration number **or** an I-94 number

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

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

Appendix B:

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 of those bills. If you don't want us to pay those bills, or Medicaid rules do not allow us to pay the bills, we may be able to reduce what you will need to pay for your long term care services.

You can ask for Medicaid to cover your medical bills for up to three months prior to the month of this application. We call this the retroactive period. For 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 nursing home expenses, but may not cover other long term care services.

If you do not want retroactive benefits, you can ask us to use your unpaid medical bills to 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, or if the bill was previously counted for Medicaid Spend down eligibility, we cannot use the bill to reduce the amount you will need to pay for your LTC/HCBS services. For more information, ask your Medicaid worker.

Appendix C:

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, 1121 12th Street, NW, Washington, DC 20005, (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 United States District Court of the District of Columbia 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 1121 12th Street, NW; Washington, DC 20005 or (202) 682-0578.

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 North 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 above 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

Terris Pravlik & Millian, LLP
1121 12th Street, NW
Washington, DC 20005
(202) 682-0578

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

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

Step 4: Have a DC Medicaid Provider Establish Your Level of Care

Document(s):

1. **Level of Care Form:**

   Directions: Please have this form completed and signed by a DC Medicaid Provider. This form must be signed by a physician, physician assistance, or nurse practitioner.

Government of the District of Columbia
Department of Health Care Finance
Request for Medicaid Nursing Facility Level of Care

Please Print Clearly and Be Sure to Complete All Sections

Level of Care Requested:	❑ Nursing Facility	❑ Adult Day Treatment	❑ Elderly and Individuals with Physical Disabilities (EPD) Waiver

Reason for Request for Nursing Facility (NF) Services:		**Reason for Request for Adult Day Treatment Services:**	**Reason for Request for EPD Waiver Services:**
❑ Return from Hospital after Medicaid Bed-hold has Expired	❑ Initial NF Placement	❑ Initial Assessment	❑ Initial Assessment
❑ Transfer from EPD Waiver to NF	❑ Conversion from Any Other Pay Source to Medicaid (Start On ____/____/_____)		❑ Annual Reassessment
If Medicaid Bed-hold days ≤18 No Level of Care is required.	❑ Transfer from NF to NF		❑ Transfer from NF to EPD Waiver

Part A

Date of Request ___/ ___/ _____ Name _____
Last First Middle Initial

SS# _____ - _____ - _____ Medicaid # (if not available, state if pending) _____

Permanent Address (include name of NF, if applicable)

_____

Phone (_____) _____ – _____ Date of Birth _____ / _____ / _____ Sex _____

Legal Representative (Power of Attorney or Legal Guardian). Indicate N/A, if applicable.

_____
Last First

Address _____

Present Location of Individual (Name and Address of Hospital/NF/Community if Different From Above)

_____

Part B
(Please check one box in each row below)

Activities	Only Independent (Needs no help)	Supervision or Limited Assistance (Needs oversight, encouragement or cueing **OR** highly involved in activity but needs assistance)	Extensive Assistance or Totally Dependent (May help but cannot perform without help from staff **OR** cannot do for self at all)
Activities of Daily Living (ADLs)			
Bathing	❑	❑	❑
Dressing	❑	❑	❑
Overall Mobility	❑	❑	❑
Eating	❑	❑	❑
Toilet Use	❑	❑	❑
Instrumental Activities of Daily Living (IADLs)			
Medication Management	❑	❑	❑
Meal Preparation	❑	❑	❑
Housekeeping	❑	❑	❑
Money Management	❑	❑	❑
Using Telephone	❑	❑	❑

Name _____ Medicaid # _____

Is the individual ventilator-dependent? ❑ Yes ❑ No

If additional supporting documents are included please list them here: _____

_____

Name of Person Completing Form _____ Title _____

Phone (_____) _____ – _____

Signature of Person Completing Form _____ Date _____ / _____ / _____

Part C - Must be Completed by a Physician, Physician Assistant, or Nurse Practitioner Responsible for Patient Care

The information presented above appropriately reflects the patient's functional status.

			Please check appropriate box:
Name	_____	❑	Physician
		❑	Physician Assistant
		❑	Nurse Practitioner
Address	_____	Phone	(_____) _____ - _____
	_____	NPI *	_____
Signature	_____	Date	_____/_____/_____

*Physician assistants should include their supervising physician's NPI number

Part D - To be completed by the Quality Improvement Organization (if needed)

Level of Care	_____	Certification Period (for EPD Only)	_____
Authorized Signature	_____	Date	____/_____/_____

Comments _____

_____

Please return to:

DC Office on Aging Information and Referral/Assistance Unit

Office 202-724-5626 Fax 202-724-2008

Step 5: Submit Forms, Application and Supporting Documentation to DCOA

In Person:
8:30am – 5:00pm, Monday - Friday
500 K Street NE,
Washington DC, 20002

By Mail:
DC Office on Aging
Attn: Medicaid Enrollment Unit
500 K Street NE
Washington DC, 20002

* To protect your personal health information, we suggest that you send your packet using U.S. Postal Service certified mail, which requires receipt confirmation.

Electronically:
E-mail: EPDwaiver.dcoa@dc.gov
Fax: 202-724-2008

What's Next?

Once we receive your completed application, we will contact you to review your file and let you know if you need to provide any additional information. If your file is complete, we will submit it to the EPD Waiver Program. **It can take up to 60 calendar days to make a determination.**

If you are approved for the program, we will contact you and review your next steps for enrollment into the program. If you are denied, we will notify you of the appeals process.