Application for Retroactive Medicaid Coverage

If you and/or a household member requests retroactive Medicaid coverage to pay for medical bills from the past 3 months, please complete, sign and return this application form. This form will be used to determine if you and or a household member qualifies for retroactive Medicaid coverage. You and/or a household member must meet all eligibility requirements for Medicaid during the retroactive period to qualify for Retroactive Medicaid coverage.

How to submit this retroactive Medicaid coverage application

Mail: Department of Human Services
Case Records Management Unit
441 4th Street, NW, Suite 1C-15
Washington, DC 20001

Email: Medicaid@dc.gov

Fax: (202) 535-1122

In Person: Take this completed and signed form to one of the Service Centers listed below. If you have any questions, please Call DC Health Link Customer Service at
(855) 532-5465/TTY (855) 532-5465.

ESA Service Centers: You may drop off the completed and signed form at any of the below service centers.

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

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

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

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

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

1 Tell Us About Yourself and Any Household Members Applying for Retroactive Medicaid Coverage

We will use this information to contact you, if needed.

Your Name *(first, middle, last)*

Social Security Number **or** DC Medicaid Number *Date of Birth (mm/dd/yyyy)*

Home address *(Check here if you are homeless)* ☐

City State ZIP code

Phone number *(if you have one)* _____ Email address *(if you have one)* _____

Are you applying for retroactive coverage for yourself? Yes ☐ No ☐

If additional household members are applying for Retroactive Coverage, please list them here. Tell us the name (first and last), Social Security Number (SSN) **or** Medicaid ID#, and Date of Birth (DOB) of those household members.

Name_____ SSN or DC Medicaid ID#_____ DOB _____

Name_____ SSN or DC Medicaid ID#_____ DOB _____

Name_____ SSN or DC Medicaid ID#_____ DOB _____

2 Residence History

Did you or the household member(s) applying for retroactive coverage live in D.C. throughout the last 3 months?

Yes ☐ No ☐

If no, please tell us which household member(s) did not live in D.C., the state where they used to live, and which month they moved into the District.

Name (first and last)	**State**	**Month (MM/YYYY)**
_____	_____	_____
Name (first and last)	**State**	**Month (MM/YYYY)**
_____	_____	_____
Name (first and last)	**State**	**Month (MM/YYYY)**
_____	_____	_____

3 Citizenship/Eligible Immigration Status* Information

Did you or the household member(s) applying for retroactive coverage have a change in U.S. citizenship/eligible immigration status in the last three months? Yes ☐ No ☐

If yes, please tell us the name of the person(s) whose citizenship/eligible immigration status has changed in the last three months and the month the person became a U.S. citizen or met one of the eligible immigration status categories.

Name (first and last) _____ Month (MM/YYYY) _____

Name (first and last) _____ Month (MM/YYYY) _____

Name (first and last) _____ Month (MM/YYYY) _____

Please see **Attachment B for more information on what is an eligible immigration status for Medicaid.*

4 Income History

Did you or a household member(s) income change in the past three months? Yes ☐ No ☐

If yes, tell us the name of the person whose income changed and what that person's gross income is for each month retroactive coverage is requested**.**

Name (first and last)	Last Month	Two Months Ago	Three Months Ago
_____	$_____	$_____	$_____
Name (first and last)	Last Month	Two Months Ago	Three Months Ago
_____	$_____	$_____	$_____
Name (first and last)	Last Month	Two Months Ago	Three Months Ago
_____	$_____	$_____	$_____

5 Signature

If we have existing records or receive information that does not reasonably match the information you provided on this retroactive Medicaid application form, you may be required to provide additional documentation to verify income, residency or citizenship.

Sign this application. The person who filled out this retroactive Medicaid application should sign below. If you want an authorized representative or want to change the authorized representative you have now, fill out Attachment A on page 4.

☐ Check here if you are an authorized representative. Sign below and fill out Attachment A on page 4.

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_____

Print Name_____

Attachment A

Authorized Representative

You can choose an authorized representative.

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

This person is called an "authorized representative". If you are a legally appointed representative for someone on this retroactive Medicaid application form, submit proof with this application form. If you ever need to change your authorized representative, contact Department of Human Services (DHS).

Name of authorized representative:

Address: Apartment # City State ZIP code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other Number:
Number:

The Medicaid member requesting retroactive coverage needs to sign below to confirm selection of an authorized representative. If the Medicaid member is unable to sign, then the authorized representative will have to provide proof of their appointment to represent the Medicaid member. By signing, you allow this person to sign and submit your retroactive Medicaid application form, get official information about this retroactive Medicaid form, receive copies of notices and other communications from DHS and DC Health Link, and act on your behalf on all future matters with DHS and DC Health Link.

Your Signature:	Date

Printed Name:

Attachment B — Eligible Immigration Status

Eligible Immigration Status Chart	
For all applicants, these are eligible immigration statuses:	**If the person is an individual under the age of 21 or a pregnant woman**, these are additional eligible immigration statuses:
• Lawful Permanent Resident (LPR, or "Green card" holder) • Asylee • Refugee • Cuban or Haitian entrant • Individual paroled into the U.S. for at least one year • Conditional entrant granted before 1980 • Battered spouse, child and parent • Victim of Trafficking and his/her spouse, child, sibling or parent • Individual granted Withholding of Deportation or Withholding of Removal • Amerasian Immigrant • Iraqi and Afghan Special Immigrants • Member of a federally-recognized Indian tribe or American Indian Born in Canada • Veterans or individuals on active duty in the Armed Forces and their immediate family members	• Individual with Non-immigrant Status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau) • Individual with Temporary Protected Status (TPS) or Applicant for Temporary Protected Status (TPS) (with Employment Authorization) • Individuals with Deferred Enforced Departure (DED) • Family Unity beneficiary • Individual with Deferred Action Status • (Except Individual with Deferred Action for Childhood Arrivals (DACA). DACA is not an eligible immigration status)Applicant for Special Immigrant Juvenile Status • Applicant for Adjustment to LPR Status • Applicant for Asylum • Applicant for Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) • Applicant who has filed for creation of record of lawful admission for permanent residence (Registry Applicants) (with Employment Authorization) • Individual released on an order of Supervision (with Employment Authorization) • Applicant for Cancellation of Removal or Suspension of Deportation (with Employment Authorization) • Applicant for Legalization under IRCA (with Employment Authorization) • Legalization under the LIFE Act (with Employment Authorization) • Individual Lawfully Admitted with Temporary Resident Status • Resident of American Samoa • Individual granted administrative order staying removal issued by the Department of Homeland Security