Elderly and Persons with Disabilities Waiver Program
Information Packet

Thank you for your interest in the Elderly and Persons with Disabilities Waiver Program. This packet will provide all of the information you need to help you decide if this program is right for you. We have compiled a list of answers to the most frequently asked questions below, and we are happy to assist you as you review this packet. Please call us at 202-724-5626, if you have any questions.

What is the Elderly and Persons with Disabilities Waiver Program?
Also known as the EPD Waiver Program, this program provides services in the homes of individuals who would otherwise need to live in a nursing home. The goal of the program is to help you live independently in your own home or community.

How does the program work?
If you qualify for the program, you will work with a case manager to decide what type of services you would need to assist you in your daily life. You can also choose who will provide the services in your home, if you'd like. You, your case manager, and doctor will work together to make sure that you have all of the available support you would need to live independently.

Is this program right for me?

- ✓ Are you a resident of the District of Columbia?
- ✓ Are you 65 or older? Or are you 18 or older and have a disability?
- ✓ Do you need assistance in your home with daily activities like dressing, grooming, preparing meals and housecleaning? Or are you considering moving to an Assisted Living community?
- ✓ Is your monthly income less than $2,313?
- ✓ Do you have $4,000 or less in countable assets? Countable assets could be the total amount in your checking, savings, all of your investment accounts,

and the cash value of your life insurance policies, minus $10,000 for burial expenses.

If you can answer "yes" to all of the above, then you may qualify for the program. If you're not sure, or want to talk about your individual situation, call us at 202-724-5626 and we can assist.

How do I apply?

The second half of this packet provides step-by-step directions to apply for the program. Keep in mind that it can take up to 45 days from the time you submit your completed packet to receive an approval or denial.

Where can I learn more?

Please review the additional information included in this packet:

- EPD Waiver Flyer: Provides an overview of the program and examples of services and support that may be available to you.

- Medicaid Estate Recovery Fact Sheet: If you are a homeowner, read this fact sheet carefully. The District may be able to place a lien on your home to receive payments for services paid by Medicaid.

- Services My Way and Consumer Direct Brochures: Did you know that as an EPD Waiver program participant, you can decide who will provide your services? You, or someone you trust, will hire, train and manage the people who will be helping you to live independently. Review these brochures to learn more about the Services My Way and Consumer Direct programs.

You may also contact us at 202-724-5626 to speak with someone over the phone. We are open Monday through Friday, 8:30 a.m. – 4:30 p.m.

DC Medicaid Long Term Care Services

Spousal Impoverishment Protections

"Spousal Impoverishment Protections" refer to special financial protections for spouses of individuals who require institutional or Home Community Based (HCBS) Waiver services.

Spousal impoverishment protections affect married couples when one spouse is in a long-term care facility or receiving HCBS Waiver services, and the other spouse is not. The spouse in the institution or Waiver program is referred to as the "institutionalized spouse." The other spouse is called the "community spouse."

Spousal Impoverishment Protections are allowances and deductions from a couple's income and resources that are designed to prevent the community spouse from becoming impoverished due to the high cost of long term care services.

Spousal Impoverishment Income Protections:

There are special rules for counting income and the amount of income that can be transferred from one spouse to another. For each spouse, one-half of all joint income and all of that spouse's separate income are considered available to that spouse.

Community Spouse Allowance (CSA):

The community spouse is allowed to keep a certain amount of his or her gross countable monthly income, called the Community Spouse Allowance or CSA, each month. The CSA is equal to the Minimum Monthly Maintenance Needs Allowance (MMMNA), which is set annually by CMS. As of January 2019, the MMMNA is $2,057.50.

- If the community spouse's gross countable monthly income is less than the MMMNA amount, the institutionalized spouse can transfer income or income-producing resources to the community spouse to bring him or her up to the MMMNA amount.

- If neither spouse has enough income to reach the MMMNA amount, the community spouse will only receive the amount of income the couple actually has, and will not receive the MMMNA.

The CSA can be higher than the MMMNA amount if a court or fair hearing officer orders a higher amount. The community spouse must prove during a fair hearing that he or she has "exceptional circumstances" requiring a higher CSA. "Exceptional circumstances" may include, but are not limited to, recurring medical expenses, home maintenance or repair expenses, or transportation costs.

Spousal Impoverishment Resource Protections:

There are special rules for counting resources and allocating resources between spouses. The community spouse is allowed to keep a share of the couple's resources to meet current and future needs.

When a spouse first enters a long-term care facility or Waiver program, the District will, if requested, conduct an assessment of the couple's total combined countable resources. The amount of the couple's total combined countable resources at the time of application determines the amount the community spouse can keep.

"Spousal Share" of a Couple's Resources:

Married couples are considered to share each other's resources, regardless of who actually owns the resource. For each spouse, one-half of the couple's total combined countable resources are considered that spouse's "spousal share" of the resources.

Community Spouse Resource Allowance (CSRA):

The community spouse is allowed to keep a certain amount of the couple's total combined countable resources, called the Community Spouse Resource Allowance or CSRA, each year. The CSRA amount is based on minimum and maximum standards that are set by CMS each year.

As of January 2019, the minimum amount is $25,284 and the maximum amount is $126,420.

- If the spousal share (one-half of the couple's total combined countable resources) is over the maximum amount, then the CSRA is equal to the maximum amount and the community spouse only gets to keep resources up to the maximum amount.

- If the community spouse's spousal share is between the minimum and maximum amounts, then the CSRA is equal to the spousal share.

- If the community spouse's spousal share is less than the minimum amount, then the institutionalized spouse can transfer resources to the community spouse to bring him or her up to the minimum amount. If neither spouse has enough resources to reach the minimum amount, the community spouse will only receive the amount of resources the couple actually has, and will not receive the minimum amount.

The CSRA can be higher than the spousal share or the maximum amount if a court or fair hearing officer orders a higher amount. The community spouse must prove during a fair hearing that the amount of resources included in the CSRA do not generate enough income to raise the community spouse's monthly income to the MMMNA amount.

Fair Hearing Rights under Spousal Impoverishment Protections

Either spouse has the right to request a fair hearing on any of the following: the amount of the CSA, the amount of the CSRA, the amount of the spousal share, or the amount of income considered available to each spouse. A fair hearing may be requested by calling the Office of Administrative Hearings at (202) 442-9094.

For More Information

Information provided in this fact sheet is general. For more detailed information, call (202) 727-5355 or visit http://dhs.dc.gov/service/find-service-center-near-you to locate an ESA service center near you.

THE ELDERLY AND PERSONS WITH PHYSICAL DISABILITIES WAIVER

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

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

To qualify for the EPD Waiver program, you must:

- Be a U.S. citizen or have a qualified immigration status for Medicaid;
- Be a resident of the District of Columbia;
- Be elderly (65 years of age or older) or 18-64 years old with a physical disability;
- Have a DC Medicaid Provider complete a Prescription Order Form (POF);
- Have Liberty Healthcare complete a face-to-face assessment to establish "level of need";
- Have countable assets (ex. saving or checking account) that do not exceed $4,000 for an individual; and
- Have countable income that does not exceed $2,313 a month (300% of SSI in 2019) or be able to meet the Spend Down obligation amount for Medicaid eligibility.

Services available under the EPD Waiver Program may include:

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

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

DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH CARE FINANCE

MEDICAID ESTATE RECOVERY FACT SHEET

What is Medicaid Estate Recovery?

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

What Is An Estate?

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

Who is Covered by Estate Recovery?

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

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

How Does the District Request Estate Recovery?

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

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

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

What Are the Exemptions from Repayment?

The District will not pursue the lien under these **Exemptions:**

- The surviving spouse lives in the home, or
- The deceased beneficiary's child who is under age 21 lives in the home, or
- The deceased beneficiary's child is blind or disabled according to Social Security rules and lives in the home.

What is an Undue Hardship?

The District will not pursue estate recovery if it would result in an **Undue Hardship** to the heir or other interested person. Situations that may fall under undue hardship are below.

- If the deceased beneficiary's home is the only income producing asset of a family business and repayment would result in the heir or other interested person losing their source of income.
- If the heir and other interested person may become eligible for financial help without the money from the estate.
- If allowing the heir or other interested person to keep the money from the estate, makes that individual ineligible for financial help.
- If repayment would leave the heir or other interested person without shelter and that individual cannot afford to obtain and maintain shelter.

Other circumstances may be reviewed by DHCF on a case by case basis.

How to File an Exemption or Undue Hardship Application

If you receive a Notice of Proposed Recovery and you think an Exemption or Undue Hardship applies, you should complete the Exemption and/or Undue Hardship Waiver Applications sent along with the Notice of Proposed Recovery and return to DHCF within 30 calendar days from the date you receive it.

How to Find More Information

If you need more information, contact the Health Care Operations Administration, Third Party Liability Division at 202.698.2000. If language services are needed, please call 202.727.5355 and staff will be able to assist.



DISTRICT OF COLUMBIA *SERVICES MY WAY* PROGRAM

A Medicaid Participant-Directed Service Program

SERVICES MY WAY

WHAT IS THE *SERVICES MY WAY* PROGRAM?

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

WHO IS ELIGIBLE?

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

HOW DOES THE *SERVICES MY WAY* PROGRAM WORK?

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

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

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

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

DHCF

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

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 the application process, please call us at 202-724-5626.

Step 1: Have a DC Medicaid Provider Complete a Prescription Order Form (POF)

Your Medicaid provider will complete this form to initiate a face-to-face assessment by Liberty Healthcare.

Document:

1) Prescription Order Form (POF)
2) Prescription Order Form (POF) Frequently Asked Questions

Step 2: 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 3: 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 4: 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 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
250 E Street SW
Washington, DC 20024

By Mail:

Department of Aging and Community Living
Attn: Medicaid Enrollment Unit
250 E Street SW
Washington DC, 20024

* 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: Have a DC Medicaid Complete a Prescription Order Form (POF)

Document(s):

1. **Prescription Order Form (POF):**

Directions: Please have this form completed and signed by a DC Medicaid-enrolled Physician or Advanced Nurse Practitioner. This form will initiate a face-to-face assessment by Liberty Healthcare. The completed form should be submitted with your application to the Aging and Disability Resource Center (ADRC), or faxed directly to Liberty Healthcare at 202-698-2075.

2. Prescription Order Form (POF) Frequently Asked Questions

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE

PRESCRIPTION ORDER FORM (POF)

FOR LONG TERM CARE SERVICES AND SUPPORTS

This completed form must be uploaded to DC Care Connect or faxed to Liberty Healthcare Corporation at 202-698-2075.

This Prescription Order Form (POF) is required by the District of Columbia's Department of Health Care Finance (DHCF) to authorize Medicaid-funded long term care services and supports. Prior to submission, the following items (indicated with a **) **must** be completed.

- Patient Medicaid Number (if available)
- Patient full name
- Patient date of birth
- Patient telephone number
- Provider name
- Provider telephone number
- Patient's chronic medical conditions
- Reason for referral to assessment
- Signature of ordering physician / APRN

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

SECTION I: PATIENT INFORMATION

ADRC Client

A. **Patient DC Medicaid Number (8 digits).
If the individual is new to DC Medicaid and does not yet have a Medicaid number, please note "N/A."

B. **Patient Name (Last, First):

C. **Date of Birth (MM/DD/YYYY):

D. **Telephone Number:

E. Secondary Telephone Number:

F. ** Current Address:

G. Permanent Address (if different than above):

H. Emergency Contact Name:

I. Telephone Number:

SECTION II. DETERMINING NEED FOR SERVICES

A. **This patient has the following chronic medical condition(s) / ICD-10 diagnosis(es):

B.** Reason for referral to assessment: ☐ Hospital ☐ Reassessment ☐ Initial assessment ☐ Change in patient condition

C.** Request Type: ☐ EPD Waiver ☐ State Plan LTSS

D. Retroactive Coverage Request Effective Date (Nursing Facilities Only):

E. **If "Change in patient condition" was checked in section B, please indicate how this patient's condition has changed significantly since his/her most recent assessment:

F. Comments:

SECTION III: PHYSICIAN/APRN INFORMATION

A. **Provider Name (Last, First):

B. **Telephone Number:

C. **National Provider Identifier Number:

D. **Provider Address:

E. **Fax Number:

I have examined this patient and certify that long term care services and supports are medically necessary.

**Signature of Ordering Physician/APRN:

Date:

Version: 9/1/2019

DC Department of Health Care Finance

Eligibility for Medicaid Long Term Care Services & Supports

Long term care services and supports (LTCSS) help people with a chronic illness or disability meet health or personal care needs. Most LTCSS assist people with activities of daily living, such as dressing, bathing and using the bathroom. LTCSS can be provided at home, in the community, or in a nursing home or other facility. A person may need LTCSS for a short period of time after an acute illness or hospitalization or over several months or years.

In order to receive LTCSS through the Medicaid program, an individual must obtain a prescription order form. Eligibility for each service is based on a level of need determination completed through a nurse assessment.

FREQUENTLY ASKED QUESTIONS

What is a Prescription Order Form?

A Prescription Order Form (POF) is an order by a clinician to verify that an individual needs LTC services.

Which LTC services need to be ordered via the POF?

Most LTC services need to be ordered via the POF. Effective July 1, 2017, these include nursing facility services, personal care services, adult day health under the State Plan benefit, and the Elderly and Persons with Physical Disabilities (EPD) Waiver program.

Who can sign a POF?

The POF must be signed by a physician or an advanced practice registered nurse. The POF must be completed in its entirety in order to be processed.

Can an advanced practice registered nurse write the order for all of the LTC services mentioned above?

Yes*, an advanced practice registered nurse can write the order for all of the LTC services mentioned above. However, if an individual is assessed and enrolls in the EPD Waiver and needs occupational or physical therapy, a physician must sign a separate order (prescription) and submit it to the EPD Waiver Case Manager.*

Does the ordering clinician need to meet any other requirements?

Yes, the ordering clinician must be an enrolled Medicaid provider.

What if the ordering clinician is not enrolled as a D.C. Medicaid provider?

The ordering clinician may submit a streamlined enrollment application to become an ordering and referring Medicaid provider. The link to the streamlined application is available at: www.dcpdms.com

Where is the POF submitted?
The POF must be faxed to Liberty Healthcare,The fax number is (202) 698-2075.

How many days is the signature of the ordering clinician valid on the POF?
The signature of the ordering clinician is valid for 90 days. Liberty Healthcare will only conduct the assessment if the ordering clinician signed the POF within 90 days of its receipt.

What happens after the POF is submitted?
After a complete and valid POF is faxed to Liberty Healthcare, a representative of Liberty will contact the individual to ensure that the face-to-face assessment to determine eligibility for LTC services is conducted within 5 calendar days.

What happens if the POF is not complete?
Liberty will make three attempts to contact the ordering clinician to obtain missing information. If the missing information cannot be completed, Liberty will not conduct a face-to-face assessment.

LTC Service Definitions

Nursing Facility services- *Services offered within a long term care facility including the availability of nursing care 24 hours a day, physical therapy, occupational therapy, speech therapy, social services, medications, supplies, equipment, and other services necessary to the health of the patient.*

State Plan Adult Day Health Program - *The ADHP seeks to encourage older adults to live in the community by offering non-residential medical supports and supervised, therapeutic activities in an integrated community setting; foster opportunities for community inclusion; deter more costly facility-based care.*

Personal Care Aide Services- *Services involving assistance with one or more activities of daily living such as bathing, toileting, and eating that is rendered by a qualified personal care aide under the supervision of a registered nurse.*

EPD Waiver Program- *A Medicaid Waiver program that provides the elderly and individuals with physical disabilities with various home and community-based services and supports to enable someone to live safely in the community. Services under the EPD Waiver include: (1) Case Management; (2) Chore Aide; (3) Respite; (4) Personal Care Aide Services; (5) Homemaker; (6) Personal Emergency Response Services (PERS); (7) Environmental Accessibility Adaptation Services (EAA) services; (8)*

Adult Day Health; (9) Occupational Therapy; (10) Physical Therapy; (11) Assisted Living; (12) Participant Directed Community Support Services; and (13) Individual Directed Goods and Services.

For More Information

Information provided in this fact sheet is general. For more detailed information, contact:

LTC Hotline: (202) 442-5933

Liberty Healthcare: (202) 800-7357

The ADRC Information and Referral/Assistance unit: (202) 724-5626.

Step 2: 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.

Institutional Transition

Institutional Transition status provides a range of services for individuals receiving care in a nursing facility who are transitioning to the community to receive services under the EPD Waiver Program. It is limited to the transition period before discharge from the nursing facility.

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.

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 Level of Care Form

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 Level of Care

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 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, 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)

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

*** ALL FIELDS MUST BE ANSWERED** **Initial Application ☐** **Renewal/Recertification ☐**

Section 1: Application Information	
I am applying for Long-Term Care Medicaid: <u>Institutional Care</u> ☐ Nursing Facility or Skilled Nursing Facility ☐ Intermediate Care Facilities for Persons with Intellectual and Developmental Disabilities (ICF/IDD)	<u>Home and Community-Based Waiver</u> ☐ Elderly and Individuals with Physical Disabilities (EPD) ☐ Institutional Transition ☐ Intellectual and Developmental Disabilities (IDD) ☐ Money Follows the Person (ends 12/31/18)

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 national, do you have eligible immigration status?
☐ 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

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

Are you the parent or caretaker relative of a child under age 18? ☐ Yes ☐ No

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? _____

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: Retroactive Coverage-Medical Expenses ***Please complete only if you are applying for Institutional Care (Skilled Nursing Facility, Nursing Facility, and Intermediate Care Facilities for Individuals with Intellectual Disabilities) Medicaid and have any paid or unpaid medical bills from the last three months. Retroactive Coverage Only Applies to Institutional Care (Skilled Nursing Facility, Nursing Facility, and Intermediate Care Facilities for Individuals with Intellectual Disabilities) and does not apply to individuals applying for HCBS Waiver programs. If you are applying for an HCBS Waiver program, please skip this section.***	
Did the applicant applying for retroactive coverage live in D.C. throughout the last 3 months?	Yes ☐ No ☐
Did the applicant applying for retroactive coverage have a change in U.S. citizenship/eligible immigration status in the last three months?	Yes ☐ No ☐
Did you or your spouse's income change in the past three months?	Yes ☐ No ☐
Did you or your spouse's assets change in the past three months?	Yes ☐ No ☐
If yes to any of the questions above, describe the change: _____	

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:		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**	**Financial Institution Name**
		$		
		$		
		$		
		$		
		$		
		$		

Are any of your bank accounts set aside solely for your burial expenses? ☐ Yes ☐ No

What is the account number? _____

What is the name of the Financial Institution? _____

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.

Have 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
		$		$
		$		$
		$		$

Have you sold your home within the past twelve months? ☐ Yes ☐ No
If you sold your home within the past twelve months, do you plan on purchasing a new home? ☐ Yes ☐ No
If you placed the proceeds from the sale of your home in a bank account please provide the account number _____
and name of the financial institution _____

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: Do you intend to return home within six months? ☐ YES ☐ NO

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) $		

<table>
<tr><th colspan="2">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.</th></tr>
<tr><td>Please use the categories for “Current Status” in the table below:</td><td></td></tr>
<tr><td>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)</td><td>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)</td></tr>
<tr><td>Name of Immigrant:</td><td>Alien ID#:</td></tr>
<tr><td>Current Status:</td><td>Date You Moved to the U.S.:</td></tr>
<tr><td>Were you ever a Refugee or Asylee? ☐ YES ☐ NO</td><td>Are you Cuban/Haitian? ☐ YES ☐ NO</td></tr>
<tr><td colspan="2">Did you move to the United States before August 22, 1996? ☐ YES ☐ NO</td></tr>
<tr><td colspan="2">For Lawful Permanent Residents (LPRs) only:</td></tr>
<tr><td colspan="2">Do you have a sponsor? ☐YES ☐NO</td></tr>
<tr><td colspan="2">Have you, your spouse, and/or sponsor ever worked in the U.S.? ☐ YES ☐ NO</td></tr>
</table>

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 B 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:

Information on Past Medical Bills/Expenses

If you have medical bills for services that you received before the month of this application, we may be able to help you pay some or all those bills. If you don't want us to pay those bills, or Medicaid rules do not allow us to pay the bills, we may be able to reduce what you will need to pay for your long term care services.

You can ask for Medicaid to cover your medical bills for up to three months prior to the month of this application. We call this the retroactive period. For District of Columbia (DC) Medicaid to pay for those months, you must have met the Medicaid eligibility requirements during those months and incurred expenses that would have been covered by Medicaid. If you are eligible for the retroactive period, we will reimburse you for the bills you already paid for those months. Retroactive Medicaid may cover prior Skilled Nursing Facility, Nursing Facility, and Intermediate Care Facilities for Individuals with Intellectual Disabilities expenses, but may not cover other long term care services.

If you do not want retroactive benefits, you can ask us to use your unpaid medical bills to help you qualify for Long-Term Care/Home and Community-Based Services (LTC/HCBS) if you are over the income limit or to reduce the amount that you will need to pay for your long term care services for this month and future months if you meet the LTC/HCBS income limits. You can use any unpaid medical bills no matter how old they are. This includes unpaid bills for long-term care services. If you want us to apply your past bills to your future long term care costs, then you will still be responsible for paying those past bills.

If your income is over the Long-Term Care /Home and Community-Based Services (LTC/HCBS) income limit, you may still be able to get LTC/HCBS Services by showing that you have high medical expenses. This is called Medicaid “Spend down.” To get Medicaid under Spend down, you must have a certain amount of medical bills. The total amount of medical bills you need is your “deductible.” When you have enough bills, including some past bills, you will meet your deductible and you may be eligible under Spend down. Medicaid will not pay the bills you count towards your deductible. After you meet your deductible, Medicaid may pay for some or all of your other medical bills. If you are over-income for LTC/HCBS services, you can use past medical bills to meet your Spend down deductible.

Under Spend down rules for LTC, you can also qualify based on the projected Medicaid reimbursement rate cost of the institutional care you expect to receive during a six month Spend down period. If we approve LTC based on the projected Medicaid reimbursement rate costs, you are still responsible for paying these projected costs. If we use your projected LTC costs to Spend down to Medicaid, you can still use your past medical bills to reduce the remaining amount you will need to pay for your LTC. You can use paid and unpaid bills from the current and past three months for Spend down. You can also use unpaid bills that are more

than three months old and old bills that were just paid during the past three months. If you are found to be over-income and need to use Spend down to get LTC/HCBS services, we will send you a notice telling you the amount of your deductible. If you provide bills with your application that you ask us to use for Spend down for LTC/HCBS services, we will send you an additional notice saying how much you still owe. We will use the projected Medicaid reimbursement rate cost of institutional care towards your Spend down. You can also provide any other bills you want to use.

If a third party insurance, like Medicare or other health insurance paid or is responsible for paying your medical bill, 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 B:

Notice of Rights and Responsibilities

General Rules

You must give true and complete information. If you lie or give false information, you may lose your benefits. You could also be fined and go to prison. We may verify your information to make sure it is correct. We may check on your income, your Social Security information, and your immigration information. We verify this information through computer matching programs. We may also interview you and do a home visit.

You may designate someone as your authorized representative. This gives them the authority to file the application on your behalf. If you designate someone to be your authorized representative, the agency will send them copies of notices that they send to you. They may submit verifications on your behalf as well.

Your case may be chosen for a Quality Control review. This is a detailed review of all of your information. It may include some personal interviews and a review of your medical records. By applying, you agree to cooperate with the state or federal reviewers. If you refuse to cooperate, you may lose all or part of your benefits. If you are under investigation or are fleeing to avoid the law, we may share your information with federal and local agencies.

Under federal and District law, you must provide your Social Security Number (if you have one) if you are seeking Medicaid. (See 42 CFR 435.910) Your SSN will be used to verify your identity, prevent receipt of duplicate benefits, and make required program changes. The Department of Human Services (DHS) computer system uses your SSN to verify your income by using records from the Internal Revenue Service, the Social Security Administration, and the DC Child Support Services Division (CSSD).

Medical Assistance Rules

After your complete application is submitted to ESA, you will get a decision about your Medical Assistance within 45 days (or 60 days if DHS must determine if you are disabled). If you do not get a notice within this period, please call the DC Medicaid Branch on (202) 698-4220 or the Change Center on (202) 727-5355.

Out of Pocket Reimbursement Information:

If you paid for drug prescriptions, doctor visits, or hospitalizations during a time that you were eligible for Medicaid, you may be able to be reimbursed for the expenses.

REQUIREMENTS: You may be eligible for reimbursement if during a period of time you or a family member were eligible for Medicaid and

a. You paid for drug prescriptions, doctor visits, or hospitalizations; or
b. You are still paying a bill or are being asked to pay a bill by a pharmacy, clinic, doctor, or hospital for drug prescriptions, doctor visits, or hospitalizations.

If you believe that you are entitled to reimbursement, you must request reimbursement within six (6) months of the date you went to the pharmacy, clinic, doctor, or hospital, or within six (6) months of the date you learned you were eligible for Medicaid, whichever is later.

You must complete and submit a Medicaid Reimbursement Request Form to the DC Department of Health Care Finance. You can get a copy of the form at any ESA office, or you can download a copy at https://www.dc-medicaid.com/dcwebportal/nonsecure/recipientForms.

IF YOU HAVE QUESTIONS OR IF YOU NEED HELP COMPLETING THE FORM OR OBTAINING REQUESTED INFORMATION CONTACT:

a. The Medicaid Recipient Claims Research Team of the D.C. Department of Health Care Finance (DHCF) at (202) 698-2009.
b. Terris Pravlik & Millian, LLP, 1816 12th Street NW, Suite 303, Washington, DC 20009, (202) 682-0578, who will provide you with free legal assistance.

A DECISION ON YOUR REIMBURSEMENT CLAIM MUST BE MADE WITHIN 90 DAYS:

a. The Medicaid Recipient Claims Research Team must make a decision on your reimbursement claim within 90 days from the time you file your claim. If no decision is made within those 90 days, your claim will be treated as valid, and you will be paid within 15 days after the end of the 90 day period.
b. If you are not satisfied with the decision of the Medicaid Recipient Claims Research team, you have a right to a fair hearing. You may request a fair hearing by calling the Office of Administrative Hearings at (202) 442-9094. The Office of Administrative Hearings is located at 441 4th Street, NW; Washington, DC 20001-2714.

c. If you are not satisfied with the result of the fair hearing, you may appeal to the 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 1816 12th Street NW; Suite 303, Washington, DC 20009 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
1816 12th Street NW,
Suite 303, Washington, DC
20009
(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 3: 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 Responsibilities 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 4: 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 Waiver case management. Complete the highlighted areas.

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

_____ _____

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

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

Last Updated 08/30/2019

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

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

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

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

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

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