FORM #1209
Case # < >

Your Medical Assistance Will Soon End!

District of Columbia
Department of Human Services
Economic Security Administration
Medicaid Branch, 5th Floor
645 H Street NE
Washington, DC 20077-0555

<Primary First Name> <Primary Last Name
<Address>
<City>, <State> <Zip Code>

Case No: «CASE_»

Eligibility End Date: «RECERT_DATE»

[IF Alliance] Your Alliance coverage for you and your household will expire on October 31, 2021. You were mailed a recertification form at the beginning of August 2021; however, your form has not been returned. Enclosed is another copy of your recertification form to complete, sign, and return to the District of Columbia Department of Human Services (DHS) Economic Security Administration (ESA) as soon as possible and no later than **<RECERT END DATE>** to avoid termination of your Alliance coverage. Please note there is a change in the interview requirement. The interview is no longer a requirement for the Alliance program.

Please answer all of the questions in the form. Read the information about you and each person in your household or on your tax return. Add any missing information. If any information has changed, write in the correct information. Please complete and submit all pages of this form, including this cover letter and income, residency, and resources (for example, checking and/or saving account) documents by **<RECERT END DATE>**. Return your completed form and all required documents.

If you do not return a completed renewal form and copies of all required documents by **<RECERT End DATE>,** your Alliance coverage will end.

Citation: 22-B DCMR Section 3305.6

(Revised September 2021)

[IF ICP] Your child(ren)'s Immigrant Children's Program (ICP) coverage will expire on October 31, 2021. You were mailed a recertification form at the beginning of August 2021; however, the form has not been returned. Enclosed is another copy of your recertification form to complete, sign, and return to DHS/ESA as soon as possible and no later than **<RECERT END DATE>** to avoid termination of your ICP coverage.

Please read and answer all the questions on the form. Read the information about you and each person in your household or on your tax return. Add any missing information. If any information has changed, write in the updated information. Sign the form and return your completed form, including this cover letter, and all required documents like parents' income information.

If you do not return a completed renewal form and copies of all required documents by **<RECERT END DATE>,** you will lose your ICP coverage.

Citation: 29 DCMR 7300.3

Cross out anyone who has moved. Add new members of your household.		
<First Name> <Last Name>	**<First Name> <Last Name>**	**<First Name> <Last Name>**
<First Name> <Last Name>	**<First Name> <Last Name>**	**<First Name> <Last Name>**

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SECTION 1: ANSWER THE FOLLOWING QUESTIONS

1. Is anyone in your household pregnant? including you? ☐ Yes ☐ No

   Expected Number of Children: _____

   Expected due date: _____

2. Have you or anyone in the household had a child or child added t household since your last application/renewal? ☐ Yes ☐ No

   Child's Name: _____

   Date of Birth: _____

3. Have you moved since last year? ☐ Yes ☐ No

   If **YES**, write your new address here:

   _____

   _____

   _____

4. Has your citizenship/immigration status changed since your last renewal?
   ☐ Yes ☐ No

   If **YES**, tell us whose status changed:

   _____

   _____

5. Do you, your spouse, and/or child(ren) have income?

   ☐ Yes ☐ No

   You **may** attach proof of income (e.g., your last 2 pay stubs, retirement, pension, etc).

4. Do you pay for childcare or eldercare?

   ☐ Yes ☐ No

   If **YES**, you **must** attach proof of your childcare

5. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

6. Is the Alliance or ICP enrollees enrolled in any other health coverage? ☐ Yes ☐ No
   If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have.

☐Medicaid_____
☐ Medicare _____
Policy #: _____
☐CHIP _____
☐TRICARE (Don't check if you have Direct Care or Line of Duty)
_____
☐VA health care program _____
☐Peace Corps_____

☐ Employer Insurance _____

Name of health insurance: _____
Is this COBRA coverage? ☐ Yes ☐ No
Is this a retiree health plan? ☐ Yes ☐ No

☐ Other
Name of health insurance: _____
Policy #: _____
Is this a limited-benefit plan (like school accident policy)?
☐ Yes ☐ No

(Revised September 2021)

7. Did you or anyone in your household previously receive Supplemental Security Income (SSI)? ☐ Yes ☐ No When was the SSI terminated? _____ **Name of the enrollee(s) receiving SSI:** **_____** **Date SSI was terminated: _____**	8. Do you or anyone in your household currently receive a Title II Social Security Benefit (SSA)? ☐ Yes ☐ No When did you or your household member begin receiving a SSA? **Name of the household receiving Social Security Benefit:** **_____** **Date SSA began: _____**

SECTION 2: 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, #2 thru 5b.*** ***If no, proceed to questions #4 and 5.***	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 else's tax return? ¨ Yes ¨ No If **YES**, please list the name of the tax filer: _____ 4b. How are you related to the tax filer? _____

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

SECTION 3: Resources (This section only needs to be completed by Alliance enrollees)

Please tell us about your assets. Check all that apply and indicate if the account is owned: Individually **(I)**, Jointly with spouse **(JS)**, or with Person(s) other than your spouse **(OP)**. If the account is owned jointly with your spouse or another person(s), then you must list their name in the appropriate box below.

	I	**JS Name**	**OP Name**		**I**	**JS Name**	**OP Name**
☐Cash on hand	☐	☐	☐	☐Other Retirement Acct	☐	☐	☐
☐Checking Acct	☐	☐	☐	☐Stocks & Bonds	☐	☐	☐

☐Savings Acct	☐	☐	☐	☐Treasury Notes/ Other Notes	☐	☐	☐
☐Credit Union	☐	☐	☐	☐Annuity	☐	☐	☐
☐Trust Acct	☐	☐	☐	☐Patient Fund Acct	☐	☐	☐
☐IRA/Keogh Acct	☐	☐	☐	☐Other:	☐	☐	☐
☐Funds/Deposits Held in a Continuing Care Retirement Care Retirement Community	☐	☐	☐				

SECTION 4: Additional Information

Health Check provides free check-ups for children on Medicaid. It also pays for other services that a child needs. Health Check can also get you free rides to the doctor. To find out more, call 1-888-557-1116.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a program for pregnant women, breast feeding women, and children under age five. With WIC, you can save up to $140 each month on food. To find out more call (202) 645-5663.

If you qualify for Medicaid, you can get paid back for some bills that you have paid. Medicaid can also pay some unpaid bills. Call (202) 698-2009 to find out more or if you need assistance completing this form. If you are hearing impaired, you can call the TTY telephone number (202) 724-1369.

SECTION 5: SIGN HERE

I believe that all of my information on this two-page form is correct. I have reported all of my changes on this form. I know that if I give false information, I may be breaking the law. I am signing this form under penalty of perjury.

Printed Name:	**Signature:**
Phone:	**Date:**
Authorized Representative Printed Name/Signature:	
Phone:	**Date:**

Ways to Submit the Completed Renewal Form 1209

- **Online (Available October 1, 2021):** Visit **dcbenefits.dhs.gov** and go to the "Alliance/ICP Renewal" tab to submit Alliance or ICP renewal form and verification documents.
- **By mail:** Complete this form and mail it in the enclosed envelope to:

  District of Columbia
  Department of Human Services
  Economic Security Administration
  Medicaid Branch 5th Fl
  645 H Street NE
  Washington DC 20077-0555

- **By fax:** You can also Fax us at **(202) 535-1122.**
- **In person:** Visit any of the ESA service centers listed below.

Service Center	**Address**
Anacostia	2100 Martin Luther King Jr Avenue, SE Washington, DC 20020
Congress Heights	4049 South Capitol Street, SW Washington, DC 20032
H Street	645 H Street, NE Washington, DC 20002