DC | DEPARTMENT of HUMAN SERVICES

Application for Medicaid Recertification/Renewal Form

To renew your medical assistance coverage, please answer all of the questions on the following Medicaid Renewal Form. Sign and return it with any required documents.

How to submit this Medicaid Recertification/Renewal form:

Mail:
Department of Human Services
Economic Security Administration
Outstation/Medicaid Renewal Unit
645 H Street, NE
Washington, DC 20077-0555

Fax:
202-535-1122

In Person:
Please visit any one of our ESA Service Centers listed below:

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

Congress Heights Service Center
4049 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 Jr., Avenue, SE
Washington, DC 20020

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

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>**

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 your household had a child since your most recent application/renewal? ☐ Yes ☐

   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. Have you attached proof of your and/or your spouse's income? ☐ Yes ☐ No You **must** provide proof of income (e.g., your last 2 pay stubs). If you have no income, please check this box. ☐	6. Does anyone have Medicare or other medical insurance? ☐ Yes ☐ No If **YES**, attach copies of your Medicare or private insurance cards. **Note:** You can still get DC Medicaid if you have other insurance.
7. Do you pay for childcare or eldercare? ☐ Yes ☐ No If **YES**, you **must** attach receipts to get this deduction.	8. 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

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: ASSETS

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: REFERRALS

HealthCheck provides free check-ups for children on Medicaid. It also pays for other services that a child needs. HealthCheck 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:**

(Revised 10/19)

Ways to Submit the Completed Renewal Form 1209

- **By mail:** Complete this form and mail it in the enclosed envelope to:

  Department of Human Services
  Economic Security Administration
  Outstation/Medicaid Renewal Unit
  645 H Street NE
  Washington DC 20077-0555

- **By phone:** Just call **(855) 532-5465 (TTY: 711)**
- **By fax:** You can also Fax us at **(202) 535-1122.**
- **In person:** Visit any of our ESA service centers listed on the next page.